

## P E R S P E C T I V E

**Physicians And Prepaid Group Practices**

The U.S. health care system needs to pick up some important lessons from prepaid group practice, which is unlikely to proliferate in the twenty-first century.

by **Stephen C. Schoenbaum**

**ABSTRACT:** Prepaid group practices (PGPs) are complex organizations that directly combine prepayment for health care with a comprehensive health care delivery system. PGPs' ability to manage their physician staffing efficiently must be placed in context with the cost and quality of their care. It seems unlikely that PGPs or their use of staff will proliferate. With increased integration of care through disease management programs and use of clinical information technology, it should be possible for the United States as a whole to come closer to achieving the care delivery goals that PGPs have set in the past.

**P**REPAID GROUP PRACTICES (PGPs) are complex, tightly managed organizations. They conjoin a health care delivery system that provides comprehensive clinical services with an insurance/prepayment mechanism. Today, probably owing to the complexity of PGPs and to public perception that they offer less choice of physicians, there are only four pure staff-model and ten pure group-model organizations, serving fewer than 7.6 million enrollees, compared with forty-two staff-model and fifty-six group-model organizations, serving more than 11.8 million enrollees, a decade ago.<sup>1</sup> An additional thirty-nine staff- or group-model components in "mixed-model" organizations serve 2.8 million enrollees.<sup>2</sup> More efficient use of physicians is just one characteristic of PGPs (albeit an important one), which should be put in context with others such as cost and quality of care.

**Cost Issues In PGPs**

In the 1980s physicians in PGPs hospitalized patients less frequently than fee-for-

service physicians did, and discharge planners in PGPs were able to achieve shorter lengths-of-stay for people who were hospitalized. This allowed PGPs to achieve lower costs, offer a lower price versus indemnity insurance, and grow their membership. In the 1990s independent practice association (IPA) and network-model managed care organizations (MCOs) adopted appropriateness protocols and financial incentives for physicians (such as capitation payments) and narrowed the gap in hospitalization rates. They also provided discharge planning services, markedly reducing differences in lengths-of-stay.

Furthermore, empirical evidence suggested that MCOs could, at least in some markets, achieve ambulatory care costs similar to those of PGPs. This was related in part to MCOs' contracting for physician and other services at discounted prices. But there were other factors, such as the overhead of nonphysician staffing. PGPs employ not only physicians and other clinicians, but also large numbers of managers. Also, full-time-equivalent (FTE) PGP physicians saw about 20 percent fewer

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patients than fee-for-service physicians in group practices. To address this, many PGPs had to introduce a productivity-related component of compensation. Overall, most PGPs, despite having fewer FTE physicians, did not sustain a cost advantage compared with the rest of health care in the United States.

### Quality Issues In PGPs

Several national leaders in the field of quality improvement, including Don Berwick, Ed Wagner, and Gail Warden, have worked in PGPs and have applied their knowledge to other care settings. PGPs were pioneers in developing performance measures (such as the Health Plan Employer Data and Information Set, or HEDIS) and adopting clinical information systems—tools that many consider essential for providing optimal care.<sup>3</sup> The PGPs that Jonathan Weiner studied are believed to provide excellent care. In the past, however, PGP performance, as documented in formal studies, has not consistently been better than that achieved in fee-for-service practice.<sup>4</sup>

Perhaps the most disturbing findings about care in PGPs come from the work of Dana Safran and her colleagues.<sup>5</sup> From patient survey data, they have shown that PGPs consistently perform more poorly than IPA/network-model health maintenance organization (HMOs) and indemnity plans on such measures as visit-based continuity of care, integration of care, and clinical interactions such as physical examinations and communication. Patients in PGPs report lower levels of trust than those in indemnity plans do.

PGPs have had to struggle with “lack of ownership”—the tendency of physicians to behave as employees, which they are, rather than owners of their practices. This can contribute to long waiting times for appointments and lack of continuity in care: Physicians in PGPs often think that because large coverage

groups and urgent care services ensure that someone is around to see each patient when care is needed, it isn't critical that each personally attend to his or her own patients most of the time. In a PGP, the probability of a patient's seeing his or her own primary care physician of record for a primary care visit may be as low as 40–50 percent (based on my own experience).

### PGP Staffing

Many physician-staffing methods are available to PGPs, including direct employment, hiring part time versus full time, and contracting on a basis such as time spent or patients seen versus paying fee-for-service. In a marketplace in which PGP staffing has accounted for a relatively small percentage of the overall physician and physician-substitute workforce, PGPs have usually had the advantage of being able to staff with the most efficient and effective mechanism for their

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population. They can substitute nonphysicians for physicians, and they can substitute telephone encounters with a primary care or specialty physician for face-to-face interactions without concern about whether the services are going to be reimbursed by insurers.<sup>6</sup>

### Lessons And Speculations

PGPs do provide an alternative, highly managed model of care delivery that works best in densely populated areas. It is likely that the PGPs Weiner studied have survived in their marketplaces because of a combination of excellent performance and adaptation to the environment; that is, they represent “survival of the fittest.” Ideally, one would demonstrate with comprehensive new studies that these surviving, successful PGPs are providing as good or better care at the same or lower cost with lower use of highly trained physicians. If so, it would also be important to determine the factors most clearly related to performance—for example, using nonphysicians creatively, being very large group practices, having access

to capital, or having a tight bond between a health care delivery system and prepayment.

In the absence of such data, I have the following speculations: (1) To achieve the staffing patterns and ratios that Weiner describes outside PGPs would require a shift from solo practice and small groups of physicians to large multispecialty groups and a concomitant change in the payment model.<sup>7</sup> This is not likely to occur. In short, PGPs are not likely to proliferate in the twenty-first century. (2) It should be possible to emulate PGPs' standardization of care by creating and implementing clinical guidelines and national standards of performance.<sup>8</sup> With the development of a national health information infrastructure, it should become increasingly possible to provide clinical management tools to physicians in small practices, to enable them to have and transfer the information they need to perform to standard.<sup>9</sup> (3) Clinical information systems should also connect patients, physicians, other suppliers of care services, and insurers and facilitate effective management of preventive, acute, chronic, and terminal care. (4) The surviving PGPs have great organizational and financial strengths. In the twentieth century they provided leadership in reducing unnecessary use of hospital services and improving quality of care. In the twenty-first century they, and other health care organizations with global budgets such as the Veterans Health Administration, are likely to keep striving for excellence and efficiency and provide a challenge for the rest of the U.S. health care system.

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*The views presented here are those of the author and should not be attributed to the Commonwealth Fund, its directors, or its officers.*

#### NOTES

1. Richard Hamer, InterStudy, personal communication, 8 December 2003
2. Ibid.
3. The development of HEDIS is described in S.C. Schoenbaum, "What's Ahead in Quality: The Managed Care Perspective," *Physician Executive* 19, no. 6 (1993): 40-42. Early adoption of an electronic medical record system is described in S.C. Schoenbaum and G.O. Barnett, "Automated Am-

bulatory Medical Records Systems: An Orphan Technology," *International Journal of Technology Assessment in Health Care* 8, no. 4 (1992): 598-609.

4. There are three key reviews of managed care versus fee-for-service performance in the literature: R.H. Miller and H.S. Luft, "Managed Care Plan Performance since 1980: A Literature Analysis," *Journal of the American Medical Association* 271, no. 19 (1994): 1512-1519; R.H. Miller and H.S. Luft, "Does Managed Care Lead to Better or Worse Quality of Care?" *Health Affairs* (Sep/Oct 1997): 7-25; and R.H. Miller and H.S. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001," *Health Affairs* (July/Aug 2002): 63-86. Not all of the studies summarized in these reviews clearly distinguish PGP performance from that of other forms of managed care.
5. D.G. Safran et al., "Primary Care Quality in the Medicare Program: Comparing the Performance of Medicare Health Maintenance Organizations and Traditional Fee-for-Service Medicare," *Archives of Internal Medicine* 162, no. 7 (2002): 757-765; and D.G. Safran et al., "Organizational and Financial Characteristics of Health Plans: Are They Related to Primary Care Performance?" *Archives of Internal Medicine* 160, no. 1 (2000): 69-76.
6. These methods are discussed in detail, with examples, in S.C. Schoenbaum "Employment of Physicians at Harvard Community Health Plan," in *From Physician Shortage to Patient Shortage: The Uncertain Future of Medical Practice*, ed. E. Ginzberg (Boulder and London: Westview Press, 1986), 95-117. Available at [www.cmf.org/programs/quality/schoenbaum\\_employmentphysician5.pdf](http://www.cmf.org/programs/quality/schoenbaum_employmentphysician5.pdf).
7. More than two-thirds of U.S. physicians practice in groups of fewer than ten.
8. S.C. Schoenbaum, A.-M. Audet, and K. Davis, "Obtaining Greater Value from Health Care: The Roles of the U.S. Government," *Health Affairs* (Sep/Oct 2003): 183-190.
9. D.E. Detmer, "Building the National Health Information Infrastructure for Personal Health, Health Care Services, Public Health, and Research," *BMC Medical Informatics and Decision Making* 3, no. 1 (2003), [www.biomedcentral.com/1472-6947/3/1](http://www.biomedcentral.com/1472-6947/3/1) (9 January 2003).