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Why big is out

Doctors' desire for autonomy, coupled with the retreat of capitation, has made big groups less attractive.

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In the mid '90s, more and more doctors were joining groups, and some experts believed the trend would continue. But that hasn't happened. While there has been some decline in solo and two-doctor practices and some growth in small and medium-sized groups, the percentage of doctors in large groups has flattened out and remains a small fraction of the total.

According to a study of 12 large markets by FP Lawrence P. Casalino of the University of Chicago and several colleagues around the country, the percentage of noninstitutional physicians in groups of 20 or more barely inched up to 9.5 percent in 2001 from 9.3 percent in 1997. ("Noninstitutional" means not employed by hospitals, HMOs, academic medical centers, or government.) The portion in groups of 100 or more remained even at 2.8 percent during those four years. And the percentage of doctors who were soloists or had only one partner dropped just slightly, from 54 percent in 1997 to 47 percent in 2001.

Even more striking is the AMA's finding that in 2003, only 30 percent of doctors who were not employed by the federal government or institutions were in private groups of three or more. In 1995, that figure was 34 percent.

Economic factors play a major role in most doctors' aversion to group practice. But the biggest reason why they avoid groups is that they don't want anyone else telling them how to practice medicine.

When Casalino's team asked health leaders in 12 communities to list the barriers to forming large group practices, the most frequently cited reason was "physicians' desire for autonomy and difficulty in cooperating with one another." Or, as Atlanta health care consultant Gary Matthews puts it, "Doctors do not come together well." They're all

individualists, he points out, and even if they do belong to a group, they often practice like soloists, without much regard to what their colleagues are doing.

Here are some other reasons why large groups never took off.

Managed care's retreat made small look good

Many physicians joined or formed groups in the '90s to gain negotiating clout with managed care plans, notes Matthews. "The marketplace—and especially capitation and prepaid health plans—drove the formation of groups," he says. But after the plans withdrew risk contracts in many regions, and it became clear that HMOs weren't going to dominate the business, there was less reason for doctors to practice in groups.

It also became obvious that even large groups don't necessarily have a strong bargaining position. Health plans won't yield much on rates, observes Matthews. They sometimes won't even accept every physician in a group, says Michael LaPenna, a consultant in Grand Rapids, MI. "At one point, it was thought that if you joined a group, you'd automatically be able to participate in an HMO because the group was on the panel. But that was never shown to be the case," he says.

Casalino believes that large multispecialty groups can have bargaining power. In his study, he notes, the desire for leverage with health plans was frequently cited as a reason for forming a group. However, no new large groups were being formed in the markets he surveyed.

Another explanation for doctors' reluctance to join group practices is that they've witnessed the breakup of many large groups over the past several years. In the mid '90s, physician practice management companies went on a buying craze, gobbling up private practices. When the PPM industry went bust, some well-known organizations fell victim.

Others went under because of managed care cost-cutting. Nor did doctors fare well in the primary care groups that had been formed by hospitals from practices they'd purchased as a defensive maneuver, notes LaPenna. When the hospitals discovered that these thrown-together groups were losing boatloads of money, they often threw the doctors overboard.

Multispecialty groups have also had their share of woes. Tensions between primary care physicians and specialists are typical: The primary care doctors don't think they're adequately compensated for patient management and referrals, and the consultants feel they're subsidizing the primaries. As the market shifted from capitated HMOs with narrow networks to fee-for-service PPOs and open access, many specialists felt they could make more on their own.

According to the Medical Group Management Association's 2003 Physician Compensation and Production Survey, doctors in single-specialty groups do generally earn more than those in multispecialty groups. In 2002, for instance, noninvasive cardiologists practicing in multispecialty groups earned a median \$284,700; those in cardiology-only practices earned \$355,600.

On the other hand, LaPenna points out that young physicians coming out of residency these days are more likely to join a group than to start up a practice. This is especially true in California, where compensation is low and living costs are high. In that state, large groups are growing about 3 to 4 percent a year, notes Jack Lewin, CEO of the California Medical Association.

But LaPenna, who consults mostly in the eastern half of the country, says that, lately, he's been taking apart more groups than he's been putting together. And Matthews, who works largely in the Southeast, says he's seen more doctors leaving groups to go solo than he has in six or seven years.

Medium-sized groups grow in a time of uncertainty

From 1997 to 2001, the Casalino team found, there was some growth in groups of three to nine and 10 to 19 doctors. Casalino, who's an assistant professor at the University of Chicago, thinks the uncertainty, hassles, and rising overhead associated with managed care might explain the urge to merge. "If it was harder to run the business and profits were lower, those were good reasons for doctors to form these small and medium-sized groups."

While most of these groups don't have leverage with health plans, he adds, some have clout in certain markets. For example, he says, a five-doctor neurosurgery group or a 10-doctor cardiology group would be "enormous" in a small city. "But in Miami, it doesn't mean that much."

Some physicians group up to take advantage of ancillary services such as labs, imaging facilities, ambulatory surgery centers, and specialty hospitals. Casalino has found that single-specialty groups are merging partly in order to raise capital for investment in these facilities. Large primary care groups have been buying income-producing equipment like treadmills and bone scanners, notes Casalino, but he feels ancillary income is a less important reason for formation of primary care groups than for multispecialty groups.

Economies of scale have been shown to peak when a practice has six to seven doctors, says Casalino, adding that those studies were done in the '80s, before managed care arrived in most of the country. "My feeling is that those economies of scale may peak at a larger practice size now," he says, because doctors now need better management, information systems, and diagnostic equipment, and small practices often can't afford those things. However, he admits, one- or two-doctor practices can "run on a shoestring" and be very cost-effective—although they might not deliver cost-effective care.

"The concept of the economy of scale has never been proven in a doctor group," declares LaPenna. "That's largely because if 10 doctors get together, they have to take on a level of management and infrastructure that 10 individual doctors would never have."

While bearing these additional costs, larger groups don't get a price break on many other overhead components, notes LaPenna. The rule of thumb that you need one billing person for every two doctors is as true in a 10-doctor group as in a two-doctor group, he points

out. Similarly, each doctor needs a nurse and two or three exam rooms, no matter how large his group is.

Whether the days of the large group are gone or not, the days when people can succeed as soloists in the long term may be drawing to an end. While capitation might not return, notes Matthews, "I think there will be a movement back to groups because of the cost side. Doctors have to move to electronic medical records, they've got to comply with HIPAA. And these involve huge investments that small practices are pretty blind to now."

HIPAA may be just the beginning. Employers, health plans, the federal government, and medical societies are all pushing for quality improvement, which requires an infrastructure that most small practices don't have. "The fact that most US doctors continue to practice in small groups is a major challenge to improving care," says Stephen Shortell, dean of the School of Public Health at the University of California at Berkeley.

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