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# GP corporatisation: lessons to be learned

M Kevin Outtersson

*To benefit from the US experience of corporatisation, Australia must focus on the clinical advantages rather than the financial windfalls*

*From the annual reports of two publicly traded physician practice management corporations:*

... The Company enhances clinic operations by centralizing administrative functions and introducing management tools such as clinical guidelines, utilization review and outcomes measurement. The Company provides affiliated physicians with access to capital and advanced management information systems ...

The Company offers medical group practices and independent physicians a range of affiliation models. These affiliations are carried out by the acquisition of [practice] entities or practice assets, either for cash or through an equity exchange, or by affiliation on a contractual basis. In all instances, the Company enters into long-term practice management agreements that provide for the management of the affiliated physicians by the Company while assuring the clinical independence of the physicians.

... As an integral element of these alliances, the Company utilizes sophisticated information systems to improve the operational efficiency of, and reduce the costs associated with, operating the Company's network and the practices of the affiliated physicians. ...<sup>1</sup>

... [The Company] acquires and operates multi-specialty medical clinics ... [Its] objective is to organize physicians into professionally managed networks that assist physicians in assuming increased responsibility for delivering cost-effective medical care, while attaining high-quality clinical outcomes and patient satisfaction. ...<sup>2</sup>

AS YOU MAY HAVE GUESSED, these companies are not operating in Australia, although their plans may sound familiar. When these reports were written in 1997, the United States had 26 publicly traded physician practice management corporations.<sup>3</sup> The two US public corporations described above employed 5650 physicians, with over 25 000 additional affiliated physicians. These two companies enjoyed peak stock-market value in excess of US\$6 billion. In the 10 months following December 1997, the 15 largest publicly traded physician practice management companies lost US\$4.8 billion in stockmarket value.<sup>4</sup> Today, MedPartners has utterly abandoned its physician division, while PhyCor is currently trading at less than 10 cents per share, down from a high of

over US\$37. Most other companies are either delisted or in bankruptcy. A few became dotcoms. Something went terribly wrong with corporatisation of physician practice management in the United States. Given the current developments in Australia,<sup>5</sup> perhaps some lessons can be learned from the US experience. This article will briefly examine three claims that physician practice management corporations make to attract physicians to corporate practice: clinical independence, efficiency gains, and access to capital.

## Clinical independence

Physicians selling to a corporate practice are promised clinical independence — that the allure of profits will not impair their clinical judgement. However, strong corporate pressures are brought to bear on referral patterns. If the practice owns a pathology or imaging centre, physicians are naturally inclined to use these facilities. For practices owned or affiliated with hospitals, the hospital benefits from inpatient admissions. Physicians owning equity in outpatient surgery centres likewise perform procedures in these centres. Primary care physicians employed by a multispecialty corporate practice may be encouraged to refer patients to specialists within the group. For example, one of MedPartners' large multispecialty clinics was the Summit Medical Group in New Jersey. After a concerted effort to redirect referrals, the use of outside specialists dropped from 30% to 18% of total referrals over a two-year period ending in 1996.<sup>6</sup>

Defenders of these practices make two points: (i) that existing independent practices are subject to the same financial pressures — a solo surgeon makes money by performing surgery, not by prescribing pharmaceuticals — and (ii) that quality is not compromised, even as referral patterns change.<sup>3</sup> Given the poor quality of truly comparable data on outcomes of medical treatment in the United States, this quality assertion can not be proved.<sup>7</sup> But, if one assumes that physicians were choosing high quality providers before, then why switch? If financial incentives under managed care can compromise quality,<sup>8</sup> the same may be true under corporate ownership.

The first argument is more difficult to counter. Physicians in independent practices have a direct financial incentive to see many patients and provide intensive and expensive treatments. This is a moral hazard for physicians, tempered by their ethical commitments to patients. The difference with corporations is the institutionalisation of ethical conflicts. Instead of answering to their own conscience, physicians in a large corporate practice must answer to a corporate superior, who will be analysing practice patterns.

This could also be an advantage. If a corporate review

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using an evidence-based medicine system identifies physicians with inappropriate clinical practice patterns, then quality may improve in a corporate system.<sup>6</sup> However, if the review is primarily with an eye to profitability, the opposite could result.

Federal regulations in the United States discourage financial incentives for both referrals and some forms of cost cutting, unless the pool of physicians and patients involved is large enough to give the physician a negligible financial incentive with regard to any particular patient.<sup>9</sup> The premise is that while a physician might subject a patient to unnecessary and potentially dangerous treatment for a \$1000 financial reward, the same amount of money, spread over dozens of patients, will prove to be an inadequate incentive to overcome professional ethics.

### Efficiency

Corporations were supposed to bring modern management practices to the cottage industry of physician practices. In retrospect, they added management layers as well as costs,<sup>4</sup> where before there had been a single decision-maker. The cost of overheads was very difficult to control,<sup>10</sup> particularly once corporate physicians became agitated and combative. Many corporate physicians chafed under what they called micromanagement. Nurse staffing levels, operating hours, and innumerable management details were modified to suit corporate objectives.

Physician productivity also lagged behind expectations: the entrepreneurial energies of solo physicians were dissipated in the salaried corporate environment, particularly after receiving large payments for the sale of practices and goodwill.<sup>11</sup> Some physicians who sold their practices to corporate entities in the late 1990s repurchased them at a fraction of the price a few years later. Others filed suit against their corporations, seeking damages for broken promises and a return to private practice.<sup>11</sup>

One article which is required reading for anyone considering involvement with a physician practice management corporation is *The rise and fall of the physician practice management industry*, by Professor Uwe E Reinhardt of Princeton University.<sup>4</sup> He describes the "Ponzi schemes" and "pyramid scheme" (two fraudulent schemes which falsely lure an ever-increasing group of victims to invest money) which eventually characterised the US industry. The corporations chased unsustainable earnings per share growth, primarily through acquisitions, and neglected actual efficiency gains through "same store" growth (ie, increasing the size of each physician's practice).<sup>4</sup>

Optimists continue to point to the clinical efficiency of an integrated, multispecialty group practice, particularly if the practice maintains a single medical record. This practice model may offer the opportunity for quality and efficiency gains, but does not require corporate ownership. In the United States, many successful multispecialty group prac-

tices, such as the Mayo Clinic, are owned either by non-profit foundations or by physicians, without any equity investment of non-physicians.

### Access to capital

Public companies by definition can access public capital markets that are closed to independent medical practices, and can deploy the capital to improve services. During the rapid growth phase of the American practice management sector, when company shares were trading at 40 times their earnings, promises of lavish clinical spending were easy to make and believe.

When the bottom fell out of the market, the capital markets abandoned the sector quickly.<sup>11</sup> Some clinics found their projects cancelled or delayed without warning. Capital spending decisions should be made for clinical reasons, with financial projections based on return on investment, not unrealistic multiples of projected earnings.

### The opportunity in Australia

Australian corporations have the opportunity to improve quality and efficiency of care. Robust investment in clinical information systems and adoption of best business practices may be more likely in a corporate environment. However, so, too, will be ethical conflicts, short-term focus on profits, and opportunists who care little about healthcare.

If Australia is to benefit from the US experience, then its focus must be on the long term and on the clinical advantages of consolidation rather than the US preoccupation with earnings growth and financial windfalls.

### References

1. MedPartners, Inc. 1996 Annual report, Form 10-K, filed with the US Securities and Exchange Commission on 31 March, 1997. Available on Edgar at: <<http://www.sec.gov/cgi-bin/srch-edgar>> (accessed June 2001).
2. Phycor, Inc. 1996 Annual report, Form 10-K, filed with the US Securities and Exchange Commission on 31 March, 1997. Available on Edgar at: <<http://www.sec.gov/cgi-bin/srch-edgar>> (accessed June 2001).
3. Heller Financial. The physician practice management company. Alternative to the solo practice (winter 1998). Chicago: Heller Financial, 1998.
4. Reinhardt UE. The rise and fall of the physician practice management industry. *Health Affairs* 2000; 19 (Jan/Feb): 42-55.
5. Catchlove BR. GP corporatisation. The why and the wherefore. *Med J Aust* 2001; 175: 68-70.
6. Robinson JC. Consolidation of medical groups into physician practice management organizations. *JAMA* 1998; 279: 144, 148.
7. McGlynn EA. Six challenges in measuring the quality of health care. *Health Affairs* 1997; 16 (May/June): 7-21.
8. Grumbach K, Osmond D, Vranizan K, et al. Primary care physicians' experience of financial incentives in managed-care systems. *N Engl J Med* 1998; 339: 1516-1521.
9. Department of Health and Human Services, Health Care Financing Administration, Center for Health Plans and Providers, Medicare Managed Care Group. Physician Incentive Plan Regulations, 42 CFR. § 417.479 (2001). Baltimore, MD: DHHS, 2001.
10. Moody's Investors Service. Not-for-profit health care: 1999. Outlook and medians. September 1999, pp 9-10. New York: Moody's Investors Service, 1999.
11. Bank of America. Healthcare industry review and outlook: 1998 third quarter. October 1998, p 37, 34-40. New York: Bank of America, 1998. □