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PROVIDER PERSPECTIVES ON THE CURRENT HEALTH CARE MARKETPLACE

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- o Hospital strategies in delivering and financing care (e.g., Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), joint ventures, etc.)
- o Physician reaction to current market
- o Physician strategies in delivering and financing care (e.g., medical association, HMOs, PPOs, etc.)
- o Provider reaction to managed care programs

MR. JAMES A. KENWORTHY, JR.: David Mandel asked us to come and share some of our personal observations and experiences as it relates to provider's reactions to the health care marketplace and maybe more specifically Alternative Delivery Systems (ADS) programs.

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I'm also going to try to focus on the South. We have four different speakers from four different parts of the country. I come from the Midwest. I thought the Midwest was conservative until I came to the South. I found that the hospitals and physicians in the South, are probably as conservative, if not more conservative than anywhere else in the country.

One of the unusual things about the South that puts things in perspective, is really the population growth. I now live in Atlanta, Georgia. In Atlanta, we can lay claim to fame that we have both the number one fastest growing county in the nation, Gwineth, and also the tenth fastest growing county in the nation, Cobb. All within the Atlanta metropolitan area. Walter McClure, who Jerry knows from Interstudy, has been preaching for some time, the pro-competitive movement. What we have to do is create competition. If we can create competition, we can affect health care cost. Well, when you're in a population center like Atlanta, Georgia, the sunbelt, and you've got that kind of growth going on, you've got providers who aren't threatened yet. They're not seeing an erosion of their patient base. They've got more patients, in many instances, than they really need. Occupancy levels in most hospitals still remains relatively high. So as you come in and try to develop an alternative delivery system, you find many of the providers shying away from those kind of things, because they just don't need them yet. They don't need to deal with those patient acquisition strategies or those patient maintenance strategies.

There's an offensive and a defensive strategy. The defensive strategy that I've seen in the South, at least as it relates to the hospitals, is as the various insurance companies or payors come in developing an alternative delivery system, a PPO if you will, they've elected to join them all. They say if we join them all, we're not going to lose any patients. We'll continue on, just doing the same thing that we've always done.

One of the things that I've been seeing of late, is that we've been going in negotiating some sort of payment mechanism. I'll just use discounts off charges, as an example. What everybody was afraid was going to happen, is happening. The providers are sitting out there saying "Yeah, we'll be happy to give you a price break, we'll give you a 10% discount off charges." They'll probably just raise their charges 20%. That's happening. It's not happening just to one payor, it's happening to all payors. But that's their defensive strategy. As

for their offensive strategy, they've taken the position that the best offense is a good defense. So they do the same thing developing their own systems. A lot of them have put together their own coalition, if you will, of hospitals and health care providers saying that "If we are the right institutions, all of the folks are gonna want us." So if we just hold our ground, we don't have to negotiate charges. Those people will come to us, because it's so important for them to have a presence. They'll just take, basically, what we'll give them.

I got into the PPO business about five years ago, back in 1982. Back in 1982, I think you could probably count on your hands the number of PPOs that were in the nation. I read the other day in an article in *Medical Economics*, that somebody had done a head count of operational PPOs. There are about 485 different PPOs, throughout the country. What do you do when all hospitals join all programs? What have you got? You've basically got the same thing all over again. Walter McClure, in his wisdom, was really saying, that what we need to do is to identify the cost efficient providers, whoever they are. Cost efficient doesn't necessarily mean that they've negotiated a payment system and discounted their charges in some fashion. It's really how they have managed the health care delivery system. Once we're able to identify those cost effective providers, we need to reward them. The past payment systems haven't been able to do that.

The best way we can reward those providers is really to steer more patients to them. Because if we can steer more patients to them, we're all going to win. We as payors are going to win, by lowering our costs. The employees are going to have access to quality care. The health care providers are going to get what they want and what they need desperately, and that's patients.

In the health care industry we all talk about cost containment. I don't know anybody that has really contained costs. The cost of health care still continues to rise, and it will be 12% of the GNP. I don't think there's anything we can do to prevent that from happening. What we can do, is manage costs. Employers have fiddled around with benefit package design. In many instances that has resulted in shifting of costs from the employer's pocket to the employee, hoping to get the employees to be more prudent shoppers and buyers in health care. I think that's all fine. I think employees should be far more aware of it. But I don't know what that has done to truly affect the cost of health care. It has

affected the cost of employee benefit programs, but it hasn't changed the price of a day in a hospital. In fact, in many cases, that's increased.

It is my feeling that if we are to control health care costs and manage the system, and truly save costs, one of the things we're going to have to do is close some of the hospitals. That's pure and simple. I think it's a long time coming, because a hospital is a relatively community sensitive issue, like education. Nobody wants to close his hospital. Especially if you get out into the small outlying community, you'll find that a hospital happens to be one of the city's major employers. So who wants to cut that revenue stream out of that city's economy? Closing hospitals is difficult.

I think the key to the future really rests in utilization review (UR) and utilization management. It's the ability to control utilization of services. Fiddle around with pricing systems, hospital pricing or physician fee schedules if you will, but to me that isn't going to have as much impact on the cost of the total health care delivery system as is our ability to manage the services. Another key is to force hospitals to consider whether they want that Lithotripter. Right now, every hospital wants a Lithotripter because, to be a quality institution, you've got to have high tech. If you're high tech you're going to attract the patients. I think hospitals have to make economic decisions as to whether they have the patient flow and the patient base to pay for the Lithotripter.

Who really is not in an ADS program? I doubt that you can find many providers not participating in an HMO or PPO of some fashion. This raises a critical issue as to two categories of institutions. These are institutions that primarily provide indigent care and teaching facilities. Traditionally, those two types of institutions have higher costs than the general hospital. As we start developing alternative delivery systems, and in many cases, searching for a cost efficient hospital, nobody wants to affiliate themselves with a hospital that has many residents and interns. Having residents and interns mean that they're ordering more tests. Consequently, it means a higher cost. They also have to have the technology, if you will, to support those programs.

Those institutions and people are going to be left out of ADS programs. It may be good in the long run. Maybe it does limit the number of physicians that will hit the marketplace. But I still think we have to be careful how we handle

those teaching institutions. Likewise, I think it's dangerous for the indigent care facilities, with the federal government cracking down, and with the State government cracking down. Somebody is going to have to take care of those folks. All in all, I guess it's interesting to watch the providers and how they react to some of these programs. As I indicated earlier, I originally come from Iowa. We lived about 240 miles away from Minneapolis in Iowa. We watched a few local physicians and a few hospitals attempt to take the very aggressive strategy. They started off with a simple non-threatening PPO approach where they didn't have to worry about sharing in the risk or getting hurt too tremendously. Those hospitals have now proceeded to do their own HMO, to bear as much risk as they possibly can. They found that if you are a cost efficient provider, there are new ways of making money. You do have excess premium out there if you can provide that care for a cheaper cost.

Unfortunately, in the South I just haven't seen that yet. But I don't think those days are too far off. You have a tremendous amount of activity in the South as far as ADS programs. I think that just their mere presence and the employers response to ADS programs, will eventually cause a tremendous shift in provider reaction in the South.

MR. DAVID B. MANDEL: We'll now move from the South to the Midwest, where Minneapolis is a hotbed of HMO competition. Jerry Meier represents American MedCenters which has about 300,000 enrollees in Minneapolis. MedCenters has been successfully established there for a number of years and has now started to expand to other northcentral cities.

MR. JERRY MEIER: I have been asked to speak on provider reactions and strategies, both present and potential future strategies, in the health care marketplace. What we find in the upper Midwest is very similar to what you find throughout the rest of the country. What is happening in the upper Midwest varies from town to town and from day to day. The reason is that there is no one health care system in this country. There's a whole series of regionally based health care systems and they all are in some stage of evolution. In Minneapolis, certainly, we've reached what I think the economists call a mature market. In outlaying areas, there isn't much of a market yet at all.

I think when you talk about provider strategies, you've got to acknowledge where you are and which providers you're dealing with. So, what I'm going to cover is what I assess to be the strategies that not only are taking place in Minneapolis and Chicago and the larger urban areas, but also the strategies that exist today in outlaying areas, and how they're likely to change.

First of all I'd like to review the competitive areas, like Chicago, where at last count as I understand it, there were 95 HMO-PPO-like programs in some stage of development, operation, or demise. Areas like that, highly competitive areas, have strategies that their providers have undertaken. Basically, these can be lumped together as a market retention strategy.

I'll just briefly review what we see as physician strategies at least in the Mid-west, in this area. Solo physicians, small group physicians and some of the larger group physicians are coalescing into still larger organizations. These organizations may be medical groups or Individual Practice Associations (IPAs), Medical Society sponsored programs, or joint ventures with hospitals. All of this restructuring of the physician component of the medical care system is taking place. Again, I'm probably not telling you anything that isn't happening in your own area. But it seems to have accelerated considerably in the Midwest.

Solo practitioners and small groups especially are contracting with multiple insurance or HMO plans. It's really business as usual; the name of the payors are a little different, but physicians contract with anybody that comes down the pike. This also includes some direct contracting with self-insured employers. We also see solos and small groups giving discounts on fee-for-service and accepting withholds through their fee-for-service payments much more readily than they have in the past. They acknowledge that they're never going to see those withholds again. So what they look at is, what's the structure and how much do they have to give up (and perhaps make up in some additional visits and services) in order to still maintain a decent income.

Some of the primary care physicians are accepting capitation now for primary care services. I don't know if there's a lot of data out on how well they are doing on this, but it seems to be much more readily accepted. Larger groups have been, and I think more readily today, taking capitation for a much larger

array of services than just primary care, including capitation for the hospital and the hospital risk.

Physicians, I think, also are performing more of the traditional hospital based services in their offices. There is certainly a trend toward ambulatory or office based surgery, preadmission testing, etc., to maximize revenue. Groups, especially larger groups are investing much more heavily in hospital service replacement strategies. They have the wherewithal to do this.

Finally, we've seen primary care physicians who are referring less frequently now than they have in the past, and attempting to handle more complicated cases on their own. Again, in all likelihood, this is done in order to maximize revenue from those cases.

Next we'll look at the hospital strategies that we see evolving in our area. These are characterized as both market retention strategies and diversification or integration strategies. Certainly hospitals are consolidating or reducing staff.

Hospitals are reducing their bed census, mothballing beds and streamlining to reduce marginal costs and some of their fixed costs. They're seeking mergers and acquisitions and organizational restructuring for new ventures and capital acquirement. And they're looking into ambulatory and long-term care. I think hospitals, at least from what we're seeing, are going much more forcefully into the physician domain by buying practices and setting up new physicians in offices that the hospitals own, where the physicians are somewhat beholden to them for their establishment in a local area.

Hospitals are also contracting with as many payment sources as they can including self-insured employers at times. They usually are negotiating on a volume basis, a discounted per diem or per case. Hospitals are beginning to sponsor HMOs and more easily, PPOs, and put other managed care programs in place, if they think they can bring their physicians along. They are accepting risk more readily for their services under DRG or under some fixed per diem reimbursement. We've had a few cases of capitation. Hospitals are also unbundling some services that they can then price more competitively. These are usually the services that are more demanded by Managed Care programs.

Finally, I think hospitals when in a position to do so, are providing financial support to physicians to organize joint ventures. These are strategies that we see right now in the Midwest area. I suspect that they're replicated elsewhere throughout the country, especially in competitive marketplaces.

The noncompetitive marketplaces are generally, from what we've seen, the smaller metropolitan areas. They're usually noncompetitive because the physicians have colluded to avoid any competition from HMOs and PPOs. I think also though, that many of these physicians are under a state of siege from HMO and PPO organizations in these small towns. It's really a question of how much longer they're going to be able to hold out against a crack in the monolith that causes competition to evolve in these smaller areas. Many of them are creating community wide organizations, be they IPAs or joint ventures, just in case they do end up contracting with some outside agency that wants to set up a managed care program. In some cases they are attempting to create their own managed care programs, again as a community wide effort of all the physicians, in order to stave off the competition.

Hospitals in these communities seem to be pretty much at the mercy of what physicians do or don't want to do. They can cautiously work on vertical integration, but they really can't go heavily into any other kind of managed care program without the physicians in the community signing off. Obviously, there are exceptions to all this, but there seems to be a general pattern that we're seeing.

I'd like to discuss what future strategies might be used by providers. I'm going to break that down into two parts, also. One is what physicians and hospitals are likely to do, and two, a wish list of what they ought to do.

In competitive markets, physicians and hospitals are going to continue to contract with all payors.

This is a short-term strategy, designed again for patient retention and market share retention.

I'm not sure how well this strategy is going to serve them in the long term, and we'll get into that in a few minutes. I think that you may see physicians and

hospitals come to view themselves as the agents of the managed care plans. I think that many of them will resent this role in the future, unless they have some vested interest (i.e., ownership) in those plans. So, I think that there will be in the future an ownership position by physicians and hospitals in the managed care plans that they now deal with. If they aren't able to achieve that, you may eventually see a rebellion against managed care plans by physicians because there will continue to be financial pressures exerted on physicians and hospitals by these programs as price competition becomes the dominant driver in any mature market. I'm not sure what this form of rebellion is likely to be. I suspect it will be law suits and litigation. I suspect you may even see unionization. But, some formation of an organization that has the leverage to fight back may likely come down the road.

In the noncompetitive marketplaces, everybody is going to sit around and wait for the first one to crack the monolith and then the whole place is going to be a free-for-all. In fact, I could name a number of communities right now where every major provider in the community has an HMO or PPO program on the shelf waiting for the first one to make a move. I suspect you could name similar communities in your area.

I think a key issue for providers in their strategy for the future, is whether or not they continue to contract with all payor sources. As a market matures, its managed care plans are forced to compete almost solely on price because there is no distinction among provider panels. The managed care plans are going to have to continue to squeeze the providers in order to survive. There's just so much margin in the management of the business. The only other major margin is in the provider's reimbursement.

There is one other alternative I suppose, but I don't see that lasting very long, and that is for a managed care plan to game the risk selection. That's not likely to last very long because the competition is very ready, willing, and able to point that out to the regulators. So, I don't know if gaming selection really has a place in the future.

Providers essentially compete against themselves on price. Therefore, in a mature market where there really is no longer an adequate fee-for-service base to make up the discounts that you give the managed care plans, real income is

going to drop. I'm not sure to what extent there is a fee-for-service business left in the Twin Cities. Sixty percent of the population in the Twin Cities is in HMOs at this present time. There's a real question about whether or not fee for service has any future there. It seems to me that the only way to avoid this kind of a situation is for a provider at some point to choose the most efficient managed care plan and to sign up exclusively. That's going to be hard to do because you're going to have a significant short-term decrease of market share in a mature market. Ultimately, if you've chosen the right plan and everything has gone favorably, it should be recovered over time.

This is a wish list that I put together for providers to consider for future strategies, especially in a mature competitive marketplace.

1. I think they have to form joint ventures that create and market managed care products. Whether or not they do that on their own or in conjunction with some expertise, such as a management company, is up to them. In some areas of the country they still have the opportunity to do so on their own. In most areas of the country, you can't afford the learning curve to do something like this on your own.

2. I think they have to become familiar with and accept risk, especially through capitation. The reason for capitation is that it's the only way for a provider to get control over the dollars at the front end. That's essentially what it's going to take to manage the system. The only way you can manage the provider delivery system is to have control over all the dollars going into it.

3. I think they have to expand their scope of controlled services to include all kinds of ancillaries; home health, skilled nursing facility (SNF), mental health, durable medical equipment (DME), etc., to have one total system of services available.

4. I think they have to create the systems and the data bases to better assess the quality, to measure the productivity, and standardize to some extent, service delivery, in order to be as efficient as they can be.

5. They have to trim cost, especially institutional cost, to allow managed care plans to compete on price. I think they have to network community wide primary care physician access while keeping a specialty panel as small as possible to continue to deliver the broad spectrum of services. I think you have to emphasize cost control and quality simultaneously in everything you do. Another thing that we have seen in the Twin Cities in the recent past is the emphasis physicians themselves have put on marketing in all patient interactions, while at the same time (and this is particularly hard for physicians) developing an awareness that the physician-patient relationship is becoming much more a business transaction that it ever was before. I think you are going to have to identify and propagate internally more efficient treatment techniques and regimens in order to enhance the price advantage in the market place. Finally you will have to assess the efficiency and quality of this by screening and reviewing the results of referrals.

MR. MANDEL: It is interesting to contrast Jerry's experience with the proactive providers that he is dealing with in the Midwest and Minnesota with what Jim Kenworthy described in the Southeast.

Up to four or five years ago probably none of you had heard of US HealthCare, the only real program which physicians and hospitals had to worry about was Blue Cross. Now, within the last four years, US HealthCare has grown from essentially zero to approximately 400,000 people in the Philadelphia and Southern New Jersey metropolitan areas. US HealthCare accounts for around 20% of the commercial private-pay patient market share in these areas. One of the people who has experienced that directly in personal private practice is Dr. Harvey Nassau.

DR. HARVEY B. NASSAU: I actually wear several different hats. One of them is as the Associate Medical Director for Partners Health Plans in the Philadelphia market area. Jerry said a few minutes ago that he has been involved in cities that are sophisticated and not sophisticated. I will maintain that Philadelphia, the fourth largest metropolitan area in the United States, is not sophisticated when it comes to HMO, PPO and alternative delivery systems. We are extremely naive.

Physicians, as a rule, have been known to be naive business-wise and unsophisticated. The more work I have done with Partners, and the more contact I have had in various geographic sections in the metropolitan area, the more I believe that the doctors there are in for an incredibly rude awakening that some of you in the Far West and Midwest have gone through already. What took twenty years to develop on the West Coast, five to ten years in the Central part of the country, and is ongoing in the Southern portion, is going to take a year and one-half or two in my area. The fear that many of the physicians have in our medical community is that these large provider groups are going to leave the community with no private fee-for-service patients, and leave physicians with no market share of their own. They are up in arms to do something about that.

So, having said that, I am going to take off my Partners hat and introduce myself to you as a family doctor of ten years duration in the Philadelphia suburban area. Having graduated in a residency program, naive and interested in starting medicine, I began practice 25 miles outside of Philadelphia at a 500 bed teaching hospital that had made the commitment to have new young family physicians in the area. They said to us in our training program, whatever patients go into the program with you, you are more than welcome to take out with you into the community so that you will stay in our geographic area and feed into the hospital. This was a highly enlightened attitude in 1977 when I graduated.

I was in the first graduating class of that program, I was chief resident by weight, not by brains. It was flattering of them and I continued part time as Assistant Medical Director in their residency training program. Basically, that was their gift to me, too, to say, "Harvey, we know you are not going to make a lot of money when you start practice, and we want to help you get through the formative years." Now, 40 graduates later, 15 of whom have settled within 10 miles of our hospital, 10 of whom have settled within 25 miles of our hospital, their strategy has been successful in a family practice division of about 50 active admitters, including group practices. They have put 20 new young people who are loyal to the hospital into the community.

When I came out, HMO Pennsylvania, a division of US HealthCare (HMO-PA), was a brand new entity. It started just about when I did. I did not like this concept of someone else being inside the patient room with me, a third party with whom to contract. My relationship was with my patient. I owed him the

best and wanted to give it to him and get paid for it appropriately. For five years I managed to conduct a reasonably high quality-of-care practice in this community.

At that point, I was getting tired. I had two children. I did not need the job as Assistant Medical Director of the residency program. I gave that up in my sixth year of practice and did take an associate.

When I took an associate, we made an agreement that we would take on HMO-PA patients because it was, at this point, starting to steam roll. HMO-PA began with 1,000 members. It took them three years to hit the 10,000 member point. It took them only two more years to hit the 100,000 member point. In our geographic community, seven miles away from corporate headquarters, it had a tremendous impact. So, we agreed to do this. Overnight, patients who I thought had been mine but I hadn't seen for a while, suddenly were mine again, but this time with an HMO card. They came back.

The most interesting phenomenon you learn when you start to work in a panel of patients is who you are not seeing. All of us in our community are upset with HMO-PA. We say, "We see too many patients." "We are working too hard." "The dollars per encounter have dropped."

It depends on how you look at those dollars. I can say HMO-PA is very good to me. I have almost 3,000 HMO members on my capitation list. From those people I receive a capitated check twice a month. There is a withhold, but there are dollars up front to pay for my 50% office overhead. Those dollars are very welcome indeed. Of those 3,000 members I generate roughly 700 patient visits per month. Now I have roughly 2,000 HMO charts, so there are about 1,000 members I am not seeing and getting paid for. So, even though I complain that I am working to hard taking care of these people, there are some folks I have never seen and I am getting paid very nicely.

On the other side we have about 3,000, of what we presume to be active charts. I cannot tell you how many of these people we have not seen. I can only tell you that we have about 500 visits per month in the private sphere. So, there is a difference. The private sphere folks come in about 2.1-2.3 visits a year. My HMO population for the 2,000 I take care of, are coming in about 4 times per

year. There is no inhibition for them to come in. They say, "Doctor I have the sniffles, it's clear, my fever's burning up at 99 degrees and I insist you see me for $2 and change at 9 p.m. on a Thursday." The private patient for whom that same visit is $25 may endure a temperature of 101 degrees before he calls me up. It is a very interesting phenomenon.

Having said all that, our hospital and physicians, in an effort not to once again succumb to one monolithic alternative delivery system, decided it would be in our best interest to join together. Getting one doctor to agree with himself is difficult enough. He hedges as much as possible. Getting 175 of them to agree on something is uniquely formidable. To get them then to cooperate with a hospital (and these have never been the best of bed fellows to begin with) has been an incredible challenge.

It is our feeling, as already has been indicated, that quality, although not an easily measurable thing, is still important to our patients, to the employers who are paying for some of the product and important to those physicians who pride themselves on delivering high quality care. We use the word quality loosely. I think we all deliver reasonable quality. We think, at my hospital, that we deliver a better than reasonable product. We have a teaching hospital with 66 interns and residents. We have also a major teaching affiliation with expertise to deliver many specialized services. Quality is a major issue for us.

The cost is the second thing. Most of us feel that it is critical that we get paid back for the efforts we extend. Some of us, though, have this ridiculously old fashioned idea that the consumer should help us, that the $2 co-payment doesn't put enough burden on the person who is seeking the care.

I would refer all of you to this month's *Medical Economics*. The cover story and the entire issue is devoted to joint venture requirements. The issue is superb. To summarize a couple of things they talk about, one of them is this thing that doctor's have never heard of called a business plan. They say if you are going to joint venture, you probably ought to do it with a road map. You ought to know where the dangers and pitfalls are, and you ought to know what you need before you start up. They want you to even go so far as to document the need of the services that you are going to joint venture for them. It is dandy for us to joint venture with a Magnetic Resonance Imaging (MRI) center -- we think we

are going to make lots of bucks. But, if third party does not pay for it or there is an MRI down the street, then you have a real problem. They ask you to look at who your partners are, what their track record is in their economic ventures, and whether or not you can associate with them. Is the association mutually acceptable? Do you both bring important things to the table together? They ask you to assess something that physicians don't really look at too carefully, which is the tax burden of the association. They ask you to look at the legal burden which is increasingly important because of charges of antitrust, monopolies, boycotting, restrained trade. All of these things are becoming more and more critical. They ask you to look at whether or not you need Licenses for Accreditation or Certificates of Need.

A very important ethical issue (and ethics is a word that sometimes doesn't seem to fit into these ventures), is can the venture stand on its own without the individual physician's referral? If I buy into a lab, will I be obligated to send all of my patients to that laboratory? Can I tell my patients with a straight face to go to this lab because it is better? Can I provide them with a list of alternative laboratories to go to if they don't want to use mine? If the lab doesn't need my referral, I will feel a lot cleaner about that issue.

They talk about enough capitalization. This is a critical issue. I think most failures of joint ventures over the last two or three years in our community have been because the joint ventures have been woefully under capitalized. At lunch, we were talking about our joint venture with the hospital. We have capitalized for $1,000,000 and we were proud that we raised that much money. We patted ourselves on the back. That occurred in May of 1986. Eleven months later we have had so many different things we are exploring and have paid for, including several feasibility studies and some management contracts that we are going to have to have a second stock offer. A million dollars seemed like a lot of money at the time.

Physician control is an extremely important aspect to us, and we feel that physicians should have a majority say in the medical aspect of any joint venture.

One of the other issues that seems sticky is advertising. Advertising must be ethical. Doctors have a hard time with neon signs. We recognize the increasing importance of the managed care in our community. We were very concerned

about the loss of physician control. In fact, when we polled our members we sent out 334 surveys to our entire medical staff. We had 213 responses, which is an incredibly large response. Of those responses we had 161 that were favorable, that they would participate in an IPA structured joint venture with the hospital.

The issues raised in order of importance were: quality of care, dehumanization of patient care, patients often receiving less than adequate care in HMO models, policies that encourage the withholding of medical care, delays introduced by the requirement for the gatekeeper to issue referrals for services, reimbursement schedules, and lack of responsiveness and sensitivity of the HMOs.

The positive aspects of joining together were improving negotiating leverage and participating in quality assurance (QA) and utilization review (UR). Your physicians want badly to help make up policy, to be involved in the peer review in sanctioning and grievance procedures, and in expanding of the patient base. Our hospital staff suffers from full schedules. We are in a very active and very busy suburban area. All of us are busy. Some of us are busy with HMO patients, but all of us have full schedules. None-the-less, we look at the future in Philadelphia where 500,000 patients are HMO-type patients, and 400,000 of those HMO-PA. The even conservative projection is that in 1991, 1,100,000 or double the current number will be HMO or PPO patients. We feel that we don't want the attrition of those patients. We feel that it is important that we pick which third party providers will be the winners.

We also feel that by picking the winning ones and by endorsing them, since Abbington has a quality name itself, and since the physician staff is a high quality staff that we will be promoting those winners to win sooner. We don't want to be involved with HMOs that are going to be bought out or to fold.

Central coordination of paperwork is a recurrent theme. If I participate in 11 HMOs, I've got 71 different paper forms to fill out. If you have IPA, you are going to have a universal IPA form that gets submitted to a central office and sent out to the various insurance companies. This will simplify what the physicians do significantly.

We have gotten an estimate that it will take 6,500 members in our own IPA to break even. Our projection is that we will have those in one year's time. Conservatively speaking, we think we will actually have 8,000 in two years but optimistically we think we will do it sooner. I think the important issues for us are not what is the model of Abbington but what is the generic philosophy, what's going on. What's going on is that everyone is looking very critically at how health care is going to be administered and delivered.

Quality is one of the major issues that everyone is having trouble assessing, and from that point of view, I would refer you to a very excellent article in the February 28, 1987, issue of *Modern Health Care*. It had a 15-page summary of how quality is defined by the Federal government, by the local state governments, by the providers, by the physicians and by the patients. It is an excellent review. It is interesting how those different groups perceive different things. Jim commented earlier that high tech Lithotripter is a big issue. The hospitals want this. They feel that this makes them look more prestigious. The patients, when asked what makes Abbington Hospital so lovely, responded that Abbington has a four-story glass atrium, it has guest menus and it has valet parking. The physicians, when asked what makes Abbington Hospital so desirable, indicated it is the presence of residents which is an extreme expense in medical care. Every resident costs us $100,000 a year to the hospital budget and sixty residents is $6,000,000. Their malpractice insurance is enormous. Third party payers are cutting back. The federal government is cutting back 3% this year on the hospitals that have teaching staffs -- a huge cutback. So, we see quality medical staffs as the major things that make the hospitals better, not the bricks and mortar. There are lots of different issues here, and lots of different perceptions. I even think that after hearing what the two previous speakers have said, I am coming away with more questions than answers.

MR. MANDEL: Dr. Nassau said the changes that have occurred in California in the last 10-20 years are going to occur in Philadelphia and in the Northeast in just a couple of years. One of the people who has been involved in those changes is Dr. Standridge, who is now the Vice President of Medical Affairs for Partners National Health Plans. Previously, Dr. Standridge was with Fountain Valley Health Plan (FHP) in Orange County, California. As you probably know FHP had the same effect on Southern California and the Southwest as US HealthCare had in Dr. Nassau's area.

DR. RICHARD STANDRIDGE: I thought I would present this in three parts. The first part is about the past and what is going on now, "Under the Lash." The second part of my presentation describes what is now happening among physicians and will continue to happen, which I think they call "Backlash." The third part of my presentation describes some of the things that are just beginning to be seen, that Dr. Nassau alluded to, which I called "Whiplash."

Let's start with "Under the Lash." Early on, Kaiser came along with the introduction of the first of the managed care programs. Kaiser is a German name and this phenomenon that we think is so new and wonderful has taken place once before in history. Kaiser's program really had no effect on the individual practitioner, the small group, the partnership, or the physicians out in the community. They did not notice any effect from this.

Some of the early attempts took place over 30 years ago. FHP began in Long Beach out of one small group of physicians and grew over those many years to where it is now. It did not really effect 99% of the individual practitioners. Business as usual proceeded.

The second thing that began to happen, as we saw early development going on in California and in Minnesota primarily, was that there began to be the development of individual practitioner associations. There was a banding together of physicians in the group models which were supposedly to get that essential economy of scale. We can all rent in one building. We don't have to all pay the same overhead; we will use the same system. This will put more in our pockets.

Next, along came the early HMO attempts to deal with other than the staff models where the physicians were hired. (And, by the way, Kaiser does not consider itself a staff model, it considers itself a group model. The differences are a little esoteric.) As we began to get out of group models and into the general physician population, we saw some contracts with individual physicians or groups to supplement what was going on in the staff model.

There was very little experience amongst the physicians about what to do with these contracts. And the pre-paid managers had the physicians sign some contracts in which the physicians didn't do very well. So there was never much

negotiation going on there, certainly not much utilization review, and almost no quality assurance.

I was a part of an experimental program in Arizona, the Arizona Health Care Cost Containment System. And if you want to cut your teeth on management of medical care, that was the place to do it.

In the beginning, there was cost containment. I disagree with the fact that we can't contain costs. That program contained costs. It contained costs by not providing services, and quality completely deteriorted. It worked like a charm if you were just looking at the finances of the individual practitioners who were involved in it; they made a lot of money. There were, in fact, a couple of individuals who raked off about $2.5 million dollars in the first year of access. The system is still trying to get back that money from those two individuals.

It was an early experiment and what it showed was that it is possible to do things on a pre-paid basis, but you have to have management. You have to have control.

The federal government introduced Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) risk contracting. The Peer Review Organizations (PROs) and Professional Standards Review Organizations (PSROs) were also introduced by the federal government. These organizations were considered to be policemen who have a quota. It's better than what we had before, but it just hasn't been a good system. This statement generally characterized developments in the first stage of "Under the Lash."

The second stage is "Backlash." We talked about the offensive and defensive formations within medical staffs and what differences those made. The offensive formations were groups of doctors who saw beyond the next year and saw what was coming down the pike. This is reality. How are we going to best deal with it? Let's be prepared for it. Let's know better than anybody else around how to deal with these things. Usually the characteristic is that there is a core of very knowledgeable people who are interested. They are interested because they saw a lot of fat in the system. They wanted to cut off the fat but keep the quality. They frequently associated with a "savvy hospital" where the hospital administrator feels the same way. He saw that this was no longer going

to be "How do we get more money?" but "How do we survive?" The predictions that I am sure you have all seen say 40% of hospitals in the United States are going to close their doors in the next few years. That's pretty scary if you're a hospital administrator. These groups have strong internal controls. They police their own. They usually have, but not always, the younger and not the mainstream staff. By the term *mainstream*, I mean those that were always the greatest admitters to the hospital, i.e., those physicians that made the hospital administrator happy because they left a patient in for 7 weeks with pneumonia instead of getting it treated and getting her home in 4 days. These people recognize the inevitability of some changes because they saw the health portion of the GNP just going up and up.

Defensive formations usually involve the entire medical staff and are strictly to defend against competition. They're frequently associated with the so-called head-in-the-sand or ostrich hospital where they don't feel the threat -- "We've got 80% occupancy, why should we worry about it, we have the fastest population growth rate in the country, we don't need to worry about it." But even those hospitals are beginning to see a real loss of income, of bottom line income, because of the pressures that are being applied to them. These people say, "We're not going to participate. We're going to carry on as usual." There's been a group formed in Los Angeles, I believe it's called The Association for Responsible Medicine. It's based in Los Angeles County. They're not going to let us come in and tell them how to practice medicine. They are going to continue as usual.

The third aspect of "backlash" that had been mentioned earlier was the possibility of unionization. There's a lot of unionization that's going on in the San Francisco area. Group Health in Washington, D.C., has some problems with a physicians' union just recently.

This is where I'm going to comment about the fact that history should teach us a lesson. For those of you who don't know about this piece of history, there has been a phenomenon almost exactly like this one time previously. It happened in the early 1930s in Germany. There was the introduction of things that look almost exactly like our HMOs. They were pre-paid health plans. The reaction was a unionization of the physicians nationwide in Germany. The result was that medical care fell apart just before World War II. It was a mess.

For those who think that we're going to do it better, I would say we'd better be very, very careful. Physicians are not stupid either, although we're much more heterogeneous than they were in that European country of smaller size and we have greater ethnic differences. They can get organized if need be. That is a possibility for the future.

The last section is my "Whiplash" section. The consumers, the employers, are demanding that we disclose all kinds of information to them. They want to know everything that's going on with their employees. They want to know everything that they can find out to reduce their costs and, to a certain extent, to maintain quality of care for their members. Consumer groups are the people's group on health care. There are many things going on, but they want to know everything that's going on. And to a certain degree, we have not been forthcoming with statistics in the past. We've had an atmosphere where we protected the bad physician, the physicians who don't do as good a job, and the hospitals to a certain degree. The question is, how much information should we give on an individual physician? What's going to happen if a physician gets labeled? That may end a career. I'm not sure whether that's wrong. I'm not sure that we don't have a responsibility to police our ranks just as other professions are supposed to police their ranks, to accentuate those who deliver high quality care and to do something about those who don't. There are also many physician plans being formed now. The medical societies are forming their own plans. Coalitions are being formed in Los Angeles.

The last thing is "Enter the attorneys." We're seeing, potential liability here. We're seeing contracts that are 40 pages long to provide for pre-paid health care. We're seeing incredible legal ramifications now in contracting with the physicians in a management health care system. We're talking about liability for utilization review; we're talking about restraint of trade suits; we're talking about all of these things.

I've heard of lawsuits that are being filed. There are a couple of them in Minneapolis right now where physicians have filed suits against pre-paid groups saying that what was originally promised hasn't been done, a breach of contract thing, or saying that we were lied to, we came into this with misunderstandings. There is also the question of good faith of plans contracting with physicians, but we're talking about physicians primarily.

In summary, what we're really looking for here from you is a low cost, capitated, free access, tightly controlled, fee for service, high quality provider. We want to do it without the decrease in real income of either the physicians or the hospitals. When you've solved that problem for us in management, we will be happy with you, and you will get a bonus.

MR. BRENT GREENWOOD: Dr. Nassau, it seems as though the US HealthCare patients were a pretty big portion of your total practice -- maybe 60% or so. At what point do you, as a provider, get somewhat concerned over the leverage that that HMO is going to have over you so when they start making a change without your consent, that it's going to affect your whole practice? And second, should a provider keep an even distribution of his patients to try to keep things evenly distributed between the fee for service pre-paid traffic?

DR. NASSAU: You can't help but be a little bit concerned by somebody who has 50% of your volume, 40% of your income, and 60% of your time. You're a 100% owner. If they say jump, you have to ask how high? And that's a difficult issue. It's something that grew rather rapidly.

It was that issue that made us all look at what was going on as a group and get together. One provider says, "Well, now Abbington Hospital's contract is coming up for re-negotiations June 1, and we can have beds for $100 a day less at the hospital down the street. It doesn't have interns or residents, but we save $100 a day and they project 350 beds per 1,000 members, so in my panel that's 1,000 beds times $100. That's from my personal withholding from my hospital pool. So some of that money I could make."

But what would be the sacrifice if we give up Abbington Hospital? The sacrifice would be that the surgeon who operated on me, the surgeon that operated on my daughter, isn't available at the other hospital. The intern that stands between my asthmatic kid and death isn't at that other hospital. So I say to you at US HealthCare I'm on staff at Abbington and that's it. And they turn around and say, "Don't you want to keep those patients?" And I say, "Yeah, I do, but so do the other 175 physicians with whom I work. And we represent 40,000 of your patients and some of the largest employer groups in your community who want us very badly. So let's negotiate like gentlemen," and we do. That's the

reason we want to be in a position of equality or strength. We don't want any more single providers having that much control.

I'm very willing for the short term to think that market decreases will happen by alienating US HealthCare. I wouldn't like them all to go tomorrow. My associate would leave the next day. We'd have a hard time continuing to make our overhead, but I could certainly tolerate a little mild attrition knowing that Partners Health Plan is extremely active. Since I'm its associate medical director it has to be. That Prudential HMO is opening up. It is 5 miles from our door. PruCare has 24,000 employees right in its own home. And they all want to use Abbington Hospital. They're all going to negotiate with our IPA, and they've signed a letter of understanding on how they would agree to work with our organization.

I feel much stronger knowing that in 3 years, PruCare will represent 10% of the market share, and Partners will represent 8% or 10%. HMO-PA, which today represents 77% of the HMO industry in our area, will be 46%. It will still have obtained some gain. It will have gone from 375,000 to 502,000 members, but it won't be monolithic. It will be a lot more sensitive. The people there are excellent businessmen. They don't come right in with intimidation.

I do maintain that you can practice quality care medicine in a gatekeeper concept. I think it's critical that you be selective before you let physicians into a panel. I think the physicians who run that, the backbone, should be that young innovative group, not the physician who keeps the patient in the hospital for 7 days and then when he or she can't get a lift home or it's snowing says, "Well, we'll keep her another day in the hospital." Those days are long past. That was still going on when I entered into practice, but that was 10 years ago. It doesn't happen any more.

HMOs won't let it, we won't let it. Primary care physicians, and for the most part, family physicians who are board certified, have had 3 years of professional post-graduate training to be the patient's advocate and assistant.

We teach graduating medical students. They come through in their six weeks time. They look at our books. They look at our scheduling. We schedule 4 patients per hour.

Those patients are not assigned a date and time depending on whether they belong to an HMO, Blue Cross or private. Those are for human beings. If they have a temperature of 99 degrees and a slightly runny nose, we tell them not to come in. If they can't handle that, they find another doctor. But if they've got a 104 degree fever, we tell them to come in. If they say they can't afford it, we tell them to come in. They'll wash the car or baby-sit the kid. If it's two dollars, we still have people who don't want to come in; they don't have time. But we tell those folks to come in. We have to make a diagnosis.

To the patient, the system is transparent. I get 80% of my dollars on those patients. If I don't see the other 20%, we can make it. We don't have to be pigs about it. I'd like to see my withhold back. So I don't order CAT scans for $750 on every headache that comes in. But if a patient smells like multiple sclerosis, I'll order that scan. I want to do that. I want to order that test. And I feel good that that patient belongs to an HMO, and he doesn't have to hesitate getting that study done because there is no charge to him. I don't feel adversarial about it, that I'm increasing the expense, as I might with a Blue Shield patient who has to pay 20% out of his pocket. So there's a good and bad side to a pre-paid system, and it's our job as responsible physicians to assure that that care is available to those patients.

DR. STANDRIDGE: I have good news and bad news. For Dr. Nassau, the bad news is that there probably will be such a consolidation in the next 10 years that everyone will be significantly affected. All providers in any kind of a metropolitan or semi-metropolitan area will have a significant impact on their practice by pre-paid plans because of the consolidation. Right now, US Health-Care may have X% and Prudential may have Y%, so when we buy them all, we'll have all percent. I'm saying that facetiously, but that's the kind of thing that's happening. Look at Maxicare, and its recent huge acquisition.

The good news is that the physicians and the hospitals are learning quickly that the only way for this to work is to have everyone pulling in tandem, to have all the incentives in the same direction, and have it be a shared risk/shared reward system. Physicians have to be part owners in these plans, in my opinion, eventually. Hospitals have to be part owners so that there is a reasonable sharing of the risks that are involved in having pre-paid medicine, and there is a reasonable sharing of the rewards that come from doing it well.

MR. MEIER: I'd like to also comment on Brent's questions. Rick referred to this lawsuit that is in Minneapolis today. The irony of that lawsuit, for those of you not aware of it, is physicians are suing their own County Medical Society sponsored IPA. They believe that the board of that IPA, even though it consists of their fellow physicians, is making decisions that are not in their best interest. So when we talk about ownership, physicians appear to have ownership in that program, but they still are not satisfied with the decisions that are being made. It's the traditional practice of playing all your reimbursement sources off against each other so that no one reimbursement source dominates. Furthermore, what kind of mixture of pre-paid and fee-for-service business should you have? I don't know how you answer that in a mature market place where there is no fee-for-service business, and all you have is HMO business. I think the point that I tried to make in my presentation is that sooner or later, physicians are going to be forced in their own best interest to choose the winner and go with that one. In the short term, that's going to mean a decline in revenue, but you can't afford in the future in a mature market place to try and play off all the payment sources against each other because you're just competing against yourself.

MR. HARRY L. SUTTON: What, if any, role do you see for an insurance company in this environment?

DR. STANDRIDGE: We have to see a role for the insurance companies since they own most of it. What role do we see for the insurance companies? Employers primarily now are beginning to demand very flexible, very consumer-oriented types of programs. And those orientations will have to be not just for pre-paid care, but for creative new "multi-option" kinds of programs which give the employer the ability to offer several different things to the same group of providers. Insurance companies, I think, play a role in the formation of that kind of multi-option plan in that they have the greatest experience with the indemnity side of the business.

MR. KENWORTHY: I think there's a big role, but they're still the enemy. I see it from a physician and hospital perspective. They're still the people who control the payment. They're the ones who say whether or not we're going to pay for this test, and how much we're going to pay. I think there is that adversarial relationship that is created in any kind of a payer situation. But I

think that hospitals and physicians are realizing that in order to survive, it is going to have to be an integrated system of financing and delivery. And that will come about.

DR. NASSAU: We have to re-establish credibility with the insurers. We have to demonstrate some sensitivity to each other. It's intolerable for a primary care physician, such as my practice, which is 25% pediatrics, to have a reimbursement rate on kids below age seven that's $4 a month, when my cost on that age group with vaccines and the malpractice risk of giving them is much higher. Think about that for a minute. If I live long enough to vaccinate 100,000 children, I would kill 3 of them. If I don't vaccinate those children, I'll go to jail for malpractice. That's a very high burden. And the cost of that vaccine a few years ago was $14 for 10 shots. It's now $161. My malpractice costs, when I opened up, were $800. They're now $8,000. I need the insurance company to understand that and respond quickly to increase the capitation appropriately.

FROM THE FLOOR: I have a comment and a question. Mr. Kenworthy mentioned the oversupply of hospital beds and he talked about lithotripiters and an oversupply of these types of equipment. This points out that the real means of cost containment is really to cut down on this supply which gets to "How do you do it?" I guess one comment is that up until recent times, one approach has been through health care planning within the communities. Recently though, I think the federal administration has eliminated health planning. How do you see health planning affecting this supply? What else can be done?

MR. KENWORTHY: Some others might have some observations, but prior to moving into the ADS business, I spent eight and a half years in a hospital. During that time, we were involved in all sorts of health planning. We got everything we wanted. I didn't have any problems going to the patient population data and justifying why I needed a piece of equipment. It may have stalled the process a little bit. I may have wanted it now, and I may have obtained it 2 years later, but it didn't prevent me from doing any of those services.

I still look at hospitals attracting patients, in many instances, through high tech types of things. Who wants to take your son or your daughter to an institution that, if something does happen, if he or she gets sicker for one reason or

another, doesn't have the capability of taking care of him or her? I don't. I'm going to take my child to that place that I know either has it or will get it for me. So to me, it's still a high tech type of system.

I think part of the answer is you're just going to have to close some hospitals. There are going to have to be winners and losers. The PPO movement as I see it, or at least as I saw it in the beginning, is intended to create competition, to steer some of those patients through benefit package design to certain providers. Those are the providers that are going to survive, and some of those other people aren't going to have the patient base, if you will, to pass those expenses on, or their per case expense is going to skyrocket to make it even worse. They're not going to stay in business. But it seems to me, that until such time as we are willing to start shifting business to these more cost efficient systems, be it a PPO or an HMO, and reward those people with that population, and take them away from these other guys, nothing's going to change. You've got to make winners and losers, and that's the reality of it.

DR. STANDRIDGE: I was just going to agree with what Jim said. We were a mature market in Los Angeles. We were both a mature and an immature market, depending upon which area you were in. Inevitably there are going to be some closings of hospitals very soon.

On the other hand, we're trying hard not to, I think, in this country develop a system like there is in Scandinavia. In Scandinavia, there are primary hospitals in the periphery, and secondary and tertiary hospitals that are regionally based. We're trying very hard to avoid having it be that structured and that rigid. I'm not sure we're going to be able to avoid it. I'm not preaching for that.

Let's take cardiothoracic surgery. There are recent studies that show that if you don't do a certain number of procedures per year, that you lose that fine edge of ability. Now the question is, do we increase utilization to get that skillful, or do we shut down some of them and regionalize those services? This makes those people have a bigger effective patient population to deal with, therefore maintains high quality for those particular regionalized institutions. I think that the market pressure we're feeling now, and the cost-driven aspect of things, will be the thing that thins out the ranks.

But the issue of quality will be what finally decides how the health care system is going to look. There are a lot of attempts to define quality. As systems, that is, provider systems and institutional systems, grow bigger and more sophisticated, I think they're going to be able to give us the capability to tell exactly which physician is providing quality care, to give us norms and expectations at any time during a year, and to tell us who's doing the best job on what procedures. I don't think this is pie in the sky. I think it's not far away at all.

MR. MEIER: Ten years ago I moved to Minneapolis. There were 12,000 beds in that community, and about 80% occupancy in 39 hospitals.

I happened to look at an article about 2 weeks ago. With 60% of the population in HMOs, they still had 34 hospitals in the community. They've got just over 10,000 licensed beds in that community. So in terms of an impact, the problem on resources is going to be a slow, expensive process.

Of those 10,000 licensed beds in the community, occupancy is about 55%. and only 7,000 of them are operating. So the crunch, as everybody has said for the last 10 years, still has to happen. But it is going to happen. It's just very slow and very expensive to maintain that.

On the physician side, I don't have any numbers, but I do have anecdotes. I think people have generally conceded that you could not set up a new practice in Minneapolis-St. Paul for the past 5 years and make a go of it as a solo practitioner. And when I go into outlying areas in Minnesota, they're all very well served by every specialty that's available now. Half of these specialists are refugees from the Twin Cities.

DR. NASSAU: The problem that we're seeing now in an immature market in Philadelphia is not that there isn't a need for more physicians, particularly primary care, it's that they can't afford to open solo.

When I went and bit the bullet to open my practice, the bank was very willing to give me a line of credit for $50,000, which is just about what it actually cost me in 1977. I spent about $30,000 of their money before I started to break even in 6 months. Today to start a solo practice would run a young practitioner

$100,000, and he would spend it all. And if he didn't contract with a third-party payer, if he couldn't mate with an HMO, he couldn't make it. And if he did, it would take him that much longer because he's going to get 80%, and he's going to get adverse selection. He's going to get the dissatisfied patient who's wandering from practice to practice or the very sick patient who feels he isn't getting the best of services from his various hospitals or physicians.

To go back to your original question about which hospital will be a survivor, my hope is, it's going to be that hospital that's not an ostrich and that staff that leads with the younger aggressive people. I hope it's the hospital that does joint venture on a variety of levels to bundle the services to make up for the deficit of inpatient bed losses by having the ancillary services as well.

MR. KENWORTHY: I think Medicare did us a real disservice about 3 or 4 years ago. That was about the time I was in the midst of creating a PPO. I can tell you the hospitals that I was associated with were scared to death. The physicians were scared to death. What's this new thing, DRG, going to do to us? The government now has all our figures, and it knows what it costs us to take care of these patients and the government is not going to pay us any more than that amount. Somehow we're going to have to make up that deficit. So we want to create and get involved with these alternative delivery systems to have access to more patients so we can offset the losses that DRGs are going to create.

But low and behold, I don't know of any hospital that's lost money on DRGs. During the first year of DRGs, the hospital I was associated with made more money than it had ever made before in a single year. All of a sudden it became complacent again, and I think we're still in that era of complacency, if you will, because a lot of the hospitals out there are finding that DRGs aren't as threatening as they were intended to be. However, I think things are going to change.

MR. STARR E. BABBITT: I'm Starr Babbitt with the Tennessee Department of Insurance and 3 times so far today, I've heard MDs say that cost containment doesn't work. DRG is a form of cost containment, of course. On the other hand, 27 years ago I was with Connecticut General, and it was already talking about second surgical opinions. That company is still using them, so they must work. The company isn't so dumb that it would still be doing it if it didn't

work. It pays for the second surgical opinions. It pays for third surgical opinions, if necessary.

I think CNA sent in something like 87 cost containment provisions for its Matrix contract for approval. Now it doesn't put them all on the same contract, of course. But they do work. They must work or the companies wouldn't be using them.

Here is good example of how that second surgical opinion works. Maybe it's my age showing, but I haven't heard of anybody in years having what we used to call the cottontail operation. In fact, I don't know how many proctologists there are in business today. So medicine has gone along, and I think perhaps insurance has helped it.

As to the hospital costs, I understand that there was a tax provision not too many years ago that made it very nice for a hospital to add a couple hundred more rooms and beds, and then, all of a sudden, its occupancy went down, and we have cost shifting. We now have two kinds of cost shifting. It's not just from the indigents over to the insured patients, it's from the empty beds over to the insured patients. That's another aspect of this oversized hospital situation that we have.

Dr. Standridge mentioned the German situation. I don't like these pop psychologists and these pop astronomers and so forth who write the paperback books. Lewis Thomas remembered in one of his books going around with his father on his practice, 75 or 100 years ago. He said that medicine until World War II consisted entirely of diagnosis and prognosis. So what happened in Germany in 1930 is not what we call medicine today.

DR. STANDRIDGE: I would agree with you totally and disagree with you. How's that for a good, strong position? Looking at cost containment, on a procedure by procedure basis you're right, it does make a difference. The problem is, that if you look at it globally, it hasn't made a difference. What has happened is unbundling of services and increasing the services that are more desired, the outpatient services. Therefore it's a different kind of cost shifting.

When I first started into medical management. I used to liken my job to a butcher. If you think about what a T-bone looks like, there is a piece of fat that goes all the way around, and it's kind of thin. And then on the other side there's a big glob of fat. I think that piece of fat going all the way around the outside is ambulatory outpatient utilization fat. And this big glob over here is inpatient fat. We went for the big glob, and we whacked it off and said, "Aren't we good?" So what we've done is we've focused on the easy stuff, and we're now doing the easy stuff pretty well. Now we've got to come to the hard stuff. In other words, it varies from place to place whether we're doing it well or not.

On the other issue about the Germans, you're right. Medicine is totally different -- penicillin wasn't even around, or had just been discovered at that time. I wasn't talking about the field of medicine so much as I was the field of management. That's what I'm concerned about, the business rather than health. The unfortunate thing is that health is going to be a business from now on, or at least until some reaction changes it back to what it has been in the past.

MR. GREG HERRLE: A couple of comments in jest. I got the impression from Dr. Nassau that you probably came out okay on your capitation arrangement with HMO-PA, and I thought it was kind of refreshing that someone would at least come close to admitting that. I was wondering if you could share some experience of the withhold program that you've experienced. I get a lot of questions on "Does anyone ever return any withhold?"

DR. NASSAU: I will again say to you, HMO has been very good to a lot of us. We would not have been, in our area, so deeply entrenched into it had we had a choice. The amount of volume that it represents is a little bit awesome.

As I said earlier, we're a two and a half person office. I just called back home before I went in here. Our half time associate just delivered a little boy, so we're ecstatic. But she's going to be out for 6 weeks. Dealing with the volume of that practice, for the two of us now, is going to be very, very difficult. It's at those times that the amount of care that we have to render, that is, by my definition not critical care is most visible. My definition of critical is not as important as the patient's. The patient perceives his problems to be the most

significant, and therefore demands and deserves the care, so we have to render the service. But it's going to be tough for the next 6 weeks for us.

In terms of "Do I think the capitation is adequate?" It's not bad. There are practices in my community that are larger HMO based than my own. There are some that are 85%. A six man, two office group is almost entirely HMO-PA, and they take a much larger risk than we do. They have a manager just for that, and are extremely comfortable with it. In fact, they prefer the system just because of what I said earlier, they never feel adversarial with their patients. If the patient requires a study, no matter how expensive, he gets it. HMO-PA, because it is so well entrenched in our community, has a service available for every emergency, has medical experts across the United States, will fly patients for heart surgery to the best institutions, and arrange and put up the expense of the hotel room for the spouse. They have a cancer screening program that I think is too aggressive. But it's the best going, because it's one that's carried out by reminders mailed to the member. If the member fails to respond, a warning letter goes out that says "You didn't respond. We're waiting for your visit, we're waiting for you to go to get your mammogram at no charge." We've picked up in our practice 2 early breast carcinomas because of that program. So there's a lot to be said for that pre-paid package that they're offering. It's publicity for them, too.

The withholding is a critical issue. It would stand out like a red flag on Dr. Standridge's survey of how practices are. Our practice has never, never received any of our withholding. We have a reputation in our community for referring early. It's our feeling that early referral, early intervention is more cost effective than later referral.

We feel for that reason that the amount of capitation isn't high enough for the primary care physician. I don't fault the idea of having that withhold as an incentive for me to be effective and efficient. It's tempting to blame the system for that. The system is quite decent.