Special Article

Survival of Family Medicine in a Corporate Health Care Environment

Lessons from the United Kingdom

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The preservation of small, independent family practices within a changed health care delivery environment is a goal worth pursuing. Properly organized, such practices would maintain the special fiduciary relationship between physicians and patients. Fundholding practices, which are a growing organizational form of general practice in the United Kingdom, are described as a model that could serve as the basis for an American alternative to corporate medicine.

Key words. Family practice; delivery of health care; physicians' practice patterns. (*J Fam Pract 1996; 42:409-416*)

The demise of health care reform legislation at the national level did not slow down the rapid changes in the organization of health care being driven by private market forces. These changes are typified by increased enrollment of individuals and families in managed care plans and consolidation of the managed care industry into smaller numbers of very large plans. Over 50 million Americans belonged to health maintenance organizations (HMOs) in 1994.[1]

The value of mergers and acquisitions in the managed care market was $20 billion in 1994, which, when combined with $22 billion in pharmaceutical deals, surpassed any other industry for 1994. Columbia-HCA, which recently joined with HealthTrust Inc, now ranks as the nation's 12th largest employer, with $15 billion in annual revenues.[2]

Can the traditional, relatively small, physician-owned family practice survive in this corporatization of American health care? Should it? The authors believe that a place should remain for such practices, based on arguments of ethics, quality of care, community health, and efficiency. This article includes a discussion of the reasons for preserving small family practices as an option, describes fundholding practices in the United Kingdom (UK) as a model worth considering for the United States, and offers an adaptation known as "physician health trusts" as a model.

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Ethics of Managed Care

In an ideal world, physicians and their patients would like to think that physicians place the interests and welfare of their patients over any self-interest. In this altruistic model, physicians act as fiduciaries, or trustees, for their patients' best interests, and are not subject to any external factors that might influence their decision-making.[3] Of course, no such world exists. Physicians are often faced with powerful personal financial incentives that have the potential to influence their decision-making. In fee-for-service medical plans, physicians earn more by doing more and charging more.[4] Insurance companies, in turn, pass the costs along to subscribers as higher premiums.

Health maintenance organizations (HMOs) reverse the incentives of fee-for-service. Since HMOs have a fixed budget regardless of the amount of services provided, the less done, the more profit. These incentives create an ethical danger that patients will be undertreated, espe-

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cially if the physician personally stands to lose money if the budget is exceeded, or earns a bonus if a surplus is generated.[5]

Although these personal incentives have existed for physicians in the past, the for-profit nature of large, corporate managed care organizations makes the potential for harm to patients all the greater. Nonphysician corporate managers may be more driven by the profit motive without sufficient regard for the effect on patient health, since they are knowledgeable about neither clinical medicine nor individual patients. At the corporate level, the potential for profits is enormous and compelling. US Healthcare, a managed care organization, had an operating profit margin of 19.9%, more than twice the industry average of 8.2%. Part of its financial success is due to its ability to limit expenditures, spending only 69.9 cents of each premium dollar on medical expenses.[6]

Paying physicians fixed salaries unrelated to the volume or cost of service would reduce purely financial incentives to overtreat or undertreat patients but carries with it other disadvantages. Under this arrangement, salaried physicians might become less responsive to the needs of their patients, less productive, and less concerned about the costs to society of the services they order. To some extent, these were the maladies that affected the National Health Service (NHS) in the United Kingdom (UK), which was criticized for being too provider-oriented and having no incentive to examine organizational effectiveness or efficiency.[7]

General practitioners (GPs) in the UK were not actually on a strict salary arrangement. General practitioners earned income through a more balanced variety of sources, and overall health care spending had been kept under control, but the system was criticized as unresponsive to consumer needs. These criticisms led to changes in the NHS that combined free-market concepts with fixed budgets for health services in the form of fundholding practices.

Fundholding Practices

The NHS came into being in the UK in July 1948. It established a central tax-financed organization whose main objective was, and still is, to provide a full range of health services free to all of the country's population. Despite this universal comprehensive health insurance, the British devoted proportionally less of their gross domestic product to health care than did the United States (7.1% vs 13.6%) in 1992.

The Secretary of State for Health assumes responsibility for formulation of health care policies, while the day-to-day operation of the system and funding rests with 14 regional health authorities, which, in turn, authorize 186 district health authorities to fund hospitals and to pay for primary health care through the family health services authorities (FHSAs).

The way in which primary health care services are organized and administered in the UK has been well described by Grumbach and Fry[8] and is summarized only briefly here. General practitioners are the sole primary care physicians in the UK. They function as independent contractors with the FHSAs, providing all necessary general medical services to their registered patients. General practitioners refer patients who need specialty care to specialists who work at district hospitals.

The one great weakness of the NHS was its lack of accountability. General practitioners and their patients were required to use the district hospital and its specialists. In 1991, the philosophy changed to adopt a more market-based approach by splitting the NHS into purchasers and providers. Groups of GPs with a registered list of 11,000 or more patients (now down to 5000) could choose to manage a fund that covers four areas of patient care. The fund covers 114 specific hospital treatments, mostly elective surgery, and most outpatient care, community service, drug costs, and practice staff costs.[9]

Groups that choose to manage these funds are called fundholding GPs. General practitioner fundholders are now able to influence how quickly and effectively their patients are treated and by whom. They may refer to any provider they wish, including hospitals that are privately funded, and, as the slogan for this new concept goes, the "money follows the patient." One of the authors (D.M.L.) manages a GP fundholding (GPFH) practice in Tetbury, England, which serves as the basis of the case study that follows.

The Tetbury Practice

The practice in Tetbury consists of four physician partners, a trainee doctor (comparable to a third-year family practice resident in the United States), four nurses, and 11 full-time and part-time office staff. The practice list of 7400 patients is drawn from the town and surrounding rural area and covers a wide range of socioeconomic groups. The practice can best be viewed as consisting of two distinct components: the partners' practice and the fundholding practice.

The partners' practice reflects the way all GPs operated before the 1991 changes, and the way many still do. The practice earns £75 ($116)* per annum for every

**Dollar equivalents are based on the exchange rate listed for February 20, 1996 in* The New York Times.

patient on the list. Each partner earns £27 ($42) per patient per annum (before taxes) based on a combination of capitation, attainment of practice targets, eg, rates of childhood immunization, cervical cytology, and well-child visits, and income for certain other services, eg, nighttime home visits, emergency treatments, and contraceptive and maternity services. The remaining £48 ($74) per patient per annum covers office expenses, staff salaries (70% of which is reimbursed by the NHS), and full NHS reimbursement for office rent and property taxes.

The fundholding component of the practice consists of a management allowance and the fund itself. Practices are allocated a management allowance of £35,000 ($54,075) with which to administer the fund. This pays the wages of the manager and two clerks who run the GPFH office and other administrative expenses. A maximum of £3718 ($5744) of the management allowance also may be used to hire a temporary physician service to free the partner primarily responsible for the GPFH from office practice one-half day each week to meet with the manager and to attend meetings.

The fund itself is negotiated annually by the practice and the FHSA. For the fiscal year 1994–95, the practice received £1,342,439 ($2,074,068), or £181.42 ($280.29) per registered patient. A little over one half of the fund is designated for specialist and hospital services (£734,267 [$1,134,443]). The remainder is used for prescribing (£526,481 [$813,413]) and staff salaries (£81,691 [$126,213]).

The fund covers 114 specified operative procedures; outpatient consultations; home visits by specialists (almost unheard of in the United States); mental health care, including alcohol and drug abuse services; diagnostic services; prescriptions; physical therapy; dietetics; podiatry; speech therapy; occupational therapy; audiology; and home health care. The NHS absorbs the balance of any treatment that exceeds £6000 ($9270).

The fund does not cover emergencies, obstetrics, dental care, or treatment for sexually transmitted diseases, all of which are provided by separate parts of the NHS. Nursing home care is another service not covered by the fund, but it is paid for by other government agencies. The fund does not cover alternative medicine, such as acupuncture and homeopathy.

Family health service authorities carefully and thoroughly assess practices before recommending them to become fundholding practices. The practice must have at least 5000 patients, and all the partners, one of whom must be designated to take a leading role, must be committed to the principle of fundholding. The practice must demonstrate that it has or will have the resources required to manage the fund effectively, efficiently, and economically. Suitable computer hardware and software must be in place to handle and report the necessary information.

After meeting the initial requirements, the practice must spend 1 year preparing for fundholding. Data collection represents a major portion of the effort during the preparatory year. The practice must demonstrate to the FHSA that it can effectively collect, analyze, and draw meaningful conclusions about activities that are likely to put pressure on the budget. The FHSA uses the data as the basis for establishing a budget for the practice.

Each practice must also create during the preparatory year a development plan that addresses waiting times and resources relationships. The practice will undertake discussions with providers regarding the type of medical services to be delivered, the nature of the contract, eg, fee-for-service or capitation, and quality issues. Quality issues represent the most important factor in determining referral arrangements. Most practices prefer to continue referrals to providers with whom they have good working relationships and confidence in their services, rather than changing to another provider solely on the basis of cost.

Once established, the GPFH sends approved invoices from providers to the FHSA for payment. The GPFH does not actually handle the money, which makes improper use of funds more difficult. At the end of each financial period, the fund accounts are carefully audited by government auditors. Any mismanagement of the fund can disqualify the practice from fundholding.

If a surplus remains in the fund at the end of the year, it must be used to improve patient care, but may not be used to financially reward the partners. Examples of appropriate uses include enlarging the practice premises, acquiring new diagnostic equipment, expanding the services provided, and donating funds to other NHS bodies for specified purposes to improve patient care. The FHSA must approve the use of any surplus.

If a GPFH incurs a deficit, agreement must be reached with the FHSA to make up the balance from the FHSA's reserve. The GPFH status may be withdrawn at the end of a year if mismanagement is shown.

In each of the first 2 years of fundholding, the Tetbury practice has realized a surplus. Waiting time for surgery has been virtually eliminated. The ability to purchase additional sessions has resulted in a reduction in waiting time for physiotherapy from about 1 month to a maximum of 5 days. The practice improved laboratory services by contracting with a new provider who, while more expensive, was able to tailor services to better fit the needs of the practice. The new laboratory picked up specimens more often, ran analyses sooner, and electronically transmitted the results directly to the practice's computer system. The practice contracted for dermatology, ophthalmology, and otorhinolaryngology services in the town

hospital, and enabled the hospital's operating theaters to reopen. By offering these services locally, the Tetbury GPFH practice reduced costs and otherwise long traveling times for patients who previously used the more distant district hospital for these services.

Fundholding has been in place in the UK for 4 years and now covers one half of the population.[10] Some have criticized fundholding for creating a two-tier system; yet the UK has always had a multitiered system, based on variables such as where the patient lived, what facilities were close by, the enthusiasm of the GP to provide services, and the relationship of the GP with specialist colleagues.

Another criticism leveled against fundholding is that of "queue jumping." Fundholding patients represent additional revenue to the providers to whom they are referred.[11] To satisfy the referring GPs and their patients with rapid attention, managers might insert such patients at the top of a waiting list. To prevent this occurrence, this scheduling practice is specifically prohibited by the rules governing contracts between fundholding practices and referral providers. Instead, managers provide rapid accommodation for fundholding referrals by arranging extra consultations or scheduling additional operating times. According to fundholding proponents, this approach has the dual benefit of allowing fundholding patients to be treated when they choose and speeding up the other NHS waiting times by increasing the overall capacity and productivity of the system.

Several studies have demonstrated a cost saving in prescribing practices among fundholders compared with traditional practices.[12,13] While published studies of other benefits are sparse, the early experience of fundholding seems to have shown, at least to some, that GPs can be effective purchasers of care.[14]

The response of fundholders themselves seems to have been very positive. They report that the greatest change has occurred in relationships with consultants and the least change in relationships with patients. Changes for the better include overcoming difficulties in arranging for pregnancy terminations, improving discharge summaries from hospital consultants, and improving communications with consultants on a variety of practice issues. One physician summed up the positive changes this way: "We've actually seen them [hospital consultants] for once; they've been out here visiting just to make sure that we are aware of their potential services."[15]

The purchasing power placed in the hands of GPs has made many providers apprehensive about the benefits of fundholding. One consultant expressed his reservations about fundholding, noting that the uncertainty of funding made planning more difficult for providers. On the other hand, the hospice program, which he headed, had just received £40,000 ($64,516) from a local fundholding practice. With this disclosure, he modified his previous caution to assert that he was all in favor of "enlightened" fundholders! (Randall Hayes, MD. Personal communication, June 21, 1995.)

Fundholding seems to have benefited the health care system of the UK by increasing accountability and responsiveness of providers to both their referring primary care physicians and their patients. Likewise, GPs appear to be more sensitive to the cost implications of their activities. The nature of the fundholding practice requires fundholders to meet regularly with the clinicians and managers who comprise their network of referral providers. These active and open channels of communication and the resulting interchange of ideas has the potential to promote continuous improvements in health service delivery.

In Tetbury, fundholding seems to have realized these potentials in the form of more health care services, better quality, more convenience, enhanced respect for GPs and their patients, and cost constraints. The modest additional administrative and management costs have been compensated by the annual surpluses and the reinvestment of those savings in expanded health care services for the community.

Physician Health Trusts

The physician health trust is a conceptual model that represents a potential version of the fundholding practice in the United States. Groups of four or more primary care physicians could apply to the state for designation as a physician health trust. State laws would require all employers to offer certified physician health trusts along with any other health plans available to workers. Premiums for all physician health trusts would be fixed at the median premium for that geographical area for comparable health plans. The enabling state laws would exempt physician health trusts from the traditional financial requirements applied to insurance companies and HMOs.

As in the UK, physicians would be paid a salary unaffected by the health care cost experience of the patient population. Physicians caring for 2000 patients would receive the average net salary before taxes for physicians in the US in 1993 (approximately $186,000). Physicians with fewer patients would receive a proportionately lower salary. The salaries of physicians who have more than 2000 patients enrolled in their practice would increase, but at a diminishing rate toward a salary maximum of 3000 registered patients, adjusted for age (Table 1).

Physicians would also receive fringe benefits equal to 35% of salary. The practice would be paid an overhead allowance based on a percentage of the base salary and

Table 1. Physician Salaries in a Proposed US Physician Health Trust

No. of Patients Enrolled	Annual Base Salary, $
800	74,400
1200	111,600
1600	148,800
2000	186,000
2400	218,387
2800	232,268
3200	234,119
3600	234,119

fringe benefits of the physicians. The state government would establish a trust fund with the remainder of the premiums paid by the enrolled patients. These trust funds would be used to pay for medical care other than that directly provided by the group practice. A reserve fund equal to 20% of the total would be set aside from the trust fund.

The physician health trust could offer benefits beyond the comprehensive plan, including health-related social services, such as respite care, as well as direct health care services, such as long-term care.

Table 2 illustrates how the premium income would be allocated in a typical practice of four physicians each having 1400 registered patients. The payment is based on premium estimates by the Health Care Financing Administration of $1933 for single individuals.[16]

Physician health trusts would likely band together to purchase stop-loss insurance to protect themselves against unusually expensive cases, eg, individual cases costing more than $250,000. Alternatively, the state government could provide this insurance either directly or as a purchasing agent for all physician health trusts in the state.

Any surplus funds in the trust fund would first be used to replenish any deficit in the reserve account from previous years. Any surplus beyond that could be applied to the reserve or donated to a nonprofit health care organization. The physicians would not benefit personally from the surplus. The opportunity to direct major philanthropy should be a sufficient incentive to keep the physicians mindful of costs, yet modest enough not to unduly influence clinical decisions.

Pitfalls and Potentials

The apparent success of fundholding in the UK does not guarantee similar results in the United States. Would physician health trusts provide sufficient incentives for physicians to practice cost-effectively? Can small practices adequately assume much risk? Could physician health trusts compete successfully with large managed care organizations? Would Americans prefer small practices over large networks? The authors believe the answer to each of these questions is yes.

Incentives for Value-Oriented Practice

Although the financial incentives for physician health trusts differ markedly from either fee-for-service or managed care, they do exist. Physician compensation grows as the patient list grows. Since the premium is fixed at the median premium for the region, recruitment of new patients and retention of old patients would be on the basis of quality, not price. The most visible measure of quality to the patients would be the breadth of services beyond traditional benefit packages. Benefit enhancement would be possible only when the practice consistently generates a surplus.

Unlike managed care plans in which physicians profit potentially at the expense of patients through undertreatment, physicians in the health trust system profit only when the patients profit by enhanced services and benefits, and thus join and stay with the practice: a "win-win" situation for both patients and providers. Under this system, physicians would have a powerful incentive to eliminate waste and marginally

Table 2. Hypothetical Example of Allocation of Payments by a Health Care Financing Administration to a Physician Health Trust

Total premium payment	($1,933×1400 subscribers per MD)×4 MDs=$10,824,800
Salaries	(1400/2000×$186,000=$130,200)×4 MDs=$520,800
Fringe (35%)	$520,800×0.35=$182,280
Overhead	$703,080×0.45=$316,386
Total practice cost	$1,019,466
Trust fund reserve	($10,824,800−$1,019,466)×20%=$1,961,067
Trust fund	$10,824,800−($1,019,466+$1,961,067)=$7,844,267
Total trust fund account	$9,805,334

beneficial practices in order to provide better value to their patients in the form of additional benefits and services. The incentive structure changes from one that promotes overtreatment (fee-for-service) or undertreatment (managed care) to one that promotes the greatest *value* for every dollar spent.

Spreading Risk

Although a practice of four physicians does seem small to be assuming risk for the health care of its patient population, the experience of fundholding practices in the UK allays that anxiety, as does the stop-loss provision and the 20% reserve. As family physicians know, rare things happen rarely. During the first 2 years of fundholding in Tetbury, the practice did not once exceed the £6,000 stop-loss. Admittedly, the cost of health care is lower in the UK, and some high-risk procedures, such as obstetrics, are excluded from the practice. Nevertheless, American family physicians in fundholding practices are likely to find themselves in an equally financially sound position.

The recent experience of a group of primary care physicians on Long Island, New York, demonstrated the financial feasibility of this approach. When state laws prohibited Blue Cross/Blue Shield from forming an HMO, a group of primary care physicians formed their own HMO, Community Health Plan, Inc, which was fully capitated by Blue Cross/Blue Shield. The insurance company only marketed the plan and collected the premiums. The plan enrolled about 28,000 patients and generated large surpluses, according to the executive director, Jack Resnick. He attributed the financial success to the natural conservative practice style of primary care physicians (Jack Resnick, MD. Personal interview, February 28, 1994). The Resnick HMO differs in two ways from the physician health trust model: the physicians personally profit, and the HMO must meet substantial capital reserve requirements. These hefty capital reserve requirements deter small practices from becoming HMOs themselves; however, the state would exempt physician health trusts from these requirements in recognition of the philanthropic nature of the trust.

Given the large reserves that can be generated by physician health trusts (nearly $2 million in the small practice illustrated in Table 2), the stop-loss insurance would likely be triggered at a much higher point than that for British fundholding practices. A trigger of $250,000 for a small practice would not be unreasonable. Practices could earmark a portion of their surpluses to increase the reserve, thus allowing higher stop-loss levels and lowering coinsurance premiums.

Successful Competition

Physician health trusts would be offered to employees along with other plans offered by employers. At its inception, the physician health trust practice would let its patients know about the option. At least initially, physician health trusts would be formed from existing practices rather than new entities. The authors believe that, as has been the experience in the UK, patients already in the practice will want to stay with the practice and will opt for the physician health trust plan through their employers.

The growth in HMOs took a similar path, beginning with the mandate that all federally certified HMOs had to be offered by midsized and larger employers along with their other health plans. A recent poll by Louis Harris and Associates showed that most people would like to have more information to help them choose hospitals, physicians, and health plans. Commenting on the results of the survey, Karen Davis, president of the Commonwealth Fund, observed that Americans like to have choices they can afford.[17]

The current debate over Medicare offers an excellent opportunity to test physician health trusts. Politicians from both parties believe that substantial savings could be realized in the Medicare program if beneficiaries were enrolled in managed care organizations. The elderly are very leery, however, about being coerced into such organizations. They loathe leaving their existing physicians and worry about financial incentives causing their managed care providers to undertreat them.

Physician health trusts could produce the same cost-effective practice as managed care organizations while allowing seniors to stay with their familiar and trusted primary care physicians. The practice would receive capitation payments equal to 95% of the age-adjusted average per capita cost for Medicare enrollees. Those capitation revenues would be distributed between the physicians and the trust fund in the same manner as previously described. The trust fund would be maintained by the Health Care Financing Administration.

Starting with the federal Medicare program offers several advantages. The success of physician health trusts could be evaluated without having to change state laws. Medicare beneficiaries who live in regions not served by large managed care organizations could enroll in physician health trusts. Also, the practices could gain experience with a portion of their patient population before extending physician health trusts to all.

Small Practices vs Big Networks

Given the rush toward bigness in health care, is the idea of preserving small practices just a quaint anachronism? Sentimentality is not the reason for advocating the preserva-

tion of small practices; hard-nosed business sense is. The flood of mergers and acquisitions in health care is fueled by excess cash generated by stock purchases of "hot" health care companies. United HealthCare is so cash-rich that it made its latest purchase of MetroHealth in cash, without the need to borrow.[18] It remains to be seen whether this merger mania will result in any tangible benefits to patients.

Beyond the health care sector and media sector, companies are beginning to realize that bigger is not necessarily better. The recent decision of AT&T to break itself into three companies is a case in point. Smaller units can make decisions faster, spend less time in internal meetings, and adapt more easily in a rapidly changing environment.

After decades of growth in bigger, more diversified department stores, Americans now seem to prefer "old-fashioned" specialty stores that provide personal service. If this is the preferred taste for retail shopping, such a preference should be even more pronounced in matters relating to personal health.

The argument for physician health trusts must not rely solely, or even primarily, on business analogies. The profession of medicine must rest on a different set of ethical principles from those that govern regular business practices. For a truly effective physician-patient relationship to exist, a bond of trust must exist. Patients must view their physicians as trusted fiduciaries who place the patient's best interests over their own financial self-interest. Relationships tainted by distrust and suspicion cannot possess the therapeutic power embodied in the traditional physician-patient dyad.

As many Americans are forced into large managed care organizations, replete with impenetrable rules, intrusive claims review practices, and impersonal bureaucracy, the authors predict that patients will long for the simplicity, security, and personal nature of a small family practice to meet their health care needs. Physician health trusts would put decisions on health care back where they should be: with physicians and patients who have the authority and resources to manage medical care within defined budgets but without the intrusion of third parties.

Conclusions

The health care systems of the United States and the UK are moving toward each other from opposite ends of a pole. The United States struggles to find a way to extend health care to all its citizens while restraining runaway costs and inappropriate utilization. The UK seeks ways to make its universal health care system more responsive to patients and more productive while maintaining its successful efforts at cost constraint.

Primary health care is at the heart of each nation's attempts to improve its system. Primary health care lowers the costs of providing medical care to a population by rationalizing the care and tailoring it to the individual. Fundholding practices by GPs in the UK empower those primary care physicians to arrange the best care for their patients within a defined budget.

In the United States, primary care physicians are simultaneously watching their importance grow while their autonomy erodes. Just as the value of the primary care physician as advocate, caregiver, and coordinator of care at long last is being realized, lavishly financed corporations threaten to undermine the traditional independent practice of primary care.

If the American people believe that small independent primary care practices should continue to exist as a social good, physician health trusts may be the means to accomplish that goal. Such a case can be made from an ethical perspective, viewing the physician-patient relationship as one in which the physician serves as the fiduciary whom the patient trusts to make vitally important decisions in the best interests of the patient. Neither the former unfettered fee-for-service system nor the growing for-profit managed care system offers adequate safeguards to protect that special relationship.

Physician health trusts could provide the right mix of productivity incentives along with sufficient safeguards to ensure the ascendancy of altruism over self-interest. Physician health trusts would attract graduates to primary care by promising financial security, respect from colleagues, and the opportunity to provide quality health care to their patients free from the intrusions of perverse financial incentives and third-party payers.

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