Low-Overhead Practice Models and the Uninsured:
Harnessing the Power of Small Scale to Address Large Unmet Health Needs

Steven D. Crane, MD

Despite a decade of extraordinary economic growth and low unemployment, fewer Americans had health insurance in 2000 than at the beginning of the decade. One third of working North Carolinians (2.5 million people) between the ages of 18 and 64 are not covered by health insurance.[1] Minorities are much less likely to have insurance; 40% of Hispanics and 20% of African Americans lack insurance compared to 12% of whites. Furthermore, lower-income Americans are more likely to be uninsured; 30% of those making less than $25,000/year, compared with 8% of those making more than $75,000, lack insurance. Insurance makes a difference. Those without insurance seek needed care less often, are less likely to receive preventive services, and have poorer health outcomes.[2] About 18,000 Americans die each year of treatable diseases because they don't have healthcare coverage.[3] Most of the uninsured are employed full-time, and nearly one fourth work for firms with more than 500 employees.[4] Two thirds have household incomes of $25,000 or more [140% of the federal poverty guidline (FPG)].

Private physicians provide 75% of ambulatory care for uninsured patients.[5] Given that substantial system-wide health reform is unlikely to occur in the foreseeable future, the private sector will likely remain an important part of the healthcare safety net. Nevertheless, financial pressures are eroding charity care in the private sector. Primary care physicians widely report that managed care/Medicare changes have substantially increased overhead in outpatient practices, reducing time with patients and increasing physician dissatisfaction.[6] The number of United States-trained medical students choosing careers in primary care has steadily declined for the last five years.[7] Although there are likely multiple reasons for this decline, the perception that primary care is a less satisfying medical career is probably an important one.

Examples of Low-Overhead Solo Practices

Gordon Moore, MD, has demonstrated that a primary care practice can dramatically lower costs by "going solo," hiring no staff, and using technology and lean systems to manage a practice's "non-physician" tasks.[8] This allows longer, more meaningful interactions with patients, improved ability to address their chronic needs, while maintaining a salary in excess of $150,000 and averaging only 12 patient visits per day (or about half the daily volume for most family physicians). Innovative use of electronic medical records, communication technology, and Advanced Access scheduling* allows patients unparalleled access to their primary care physician, improving the quality of their care, and enhancing professional satisfaction. Closer to home, Dr. Brian Forrest has demonstrated similar results from a practice opened in April 2002. Patients are charged a flat office visit of $45. Lab tests are charged based on cost and yield the practice a small net profit of $15 per test. The practice nets $165,000 per year with a practice volume of 15 patients a day/44 weeks a year. Both of these practice examples share a

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* Advanced Access scheduling is a patient-scheduling model that emphasizes the provider seeing patients on the same day the patient calls for an appointment.

Steven D. Crane, MD, is the Program Director for the Hendersonville Family Practice Residency Program. He can be reached at Steve.crane@pardeehospital.org or 741 6th Avenue West, Hendersonville, NC 29739. Telephone: 828-696-1255.

low-volume, low-overhead model approach, but differ in that Dr. Moore accepts insurance whereas Dr. Forrest accepts only cash payments for services and allows patients with insurance to file their own claims for reimbursement if they wish. Both practices are located in urban areas.

Dr. Kate Sloss of Bat Cave, North Carolina has established a high-volume, low-overhead model in an isolated rural community. Although she employs three staff members (to Moore's none and Forrest's one), her overhead is still substantially below Medical Group Management Association benchmarks[9] for family physicians and enables her to see 15% of her patients on a sliding-fee basis ($10 per visit) and a large proportion of Medicaid and Medicare patients, with less than 15% commercial or management care coverage. She achieves these cost reductions from a lower rent structure through a community church, very low capital costs through donated or used equipment and furniture, and administrative overhead that is paid through lab revenue from a local provider group with which she is affiliated.

Each of these practices shares some very important features. First, they are solo practices providing personalized service to patients with Advanced Access scheduling. Each reports high levels of patient satisfaction, due to Advanced Access scheduling, and higher physician satisfaction, because they are able to focus more of their attention on taking care of patients' needs and less on managing complex organizations. Second, precisely because these practices have lower overhead, they report profitability at volumes or in locations that more traditional practices would find difficult. Finally, although each practice approaches the revenue side of the practice differently, the revenue is sufficient, given the practice model, for the physician to enjoy a competitive net income.

Will Providers Who Use Low-Overhead Models Continue to Provide Quality Care to the Uninsured?

Low-overhead practice models could play an important role in addressing the failings and gaps in the present system of primary care for the uninsured. As noted above, two thirds of families without health insurance have incomes greater than $25,000 (or 140% above FPG) and potentially could pay the cost of primary care if it were more reasonably priced, as it may be through achieved low-overhead practices. Because one third of all adults aged 18 to 64 in North Carolina do not have health insurance, this population represents a great untapped market for primary care in nearly every community. Physicians choosing to establish these types of practices could choose to locate nearly anywhere and quickly become profitable.

While it may be inevitable that these types of practices will become more commonplace as experience with the model grows, it is not at all clear if the practices will serve the needs of the uninsured or if they will produce the type of quality and breadth of services called for by the Future of Family Medicine Project.[10] Practitioners in low-overhead practices may very well either continue to provide care to the insured population, enjoying higher incomes with less stressful work styles, or to those uninsured with higher incomes who can afford higher out-of-pocket fees for "concierge" type service.[11] It is also unclear if solo practitioners will perform any better with regard to quality, safety, or evidence-based practice standards than those in more traditional practice models. It is quite likely that without the peer oversight and role-modeling, which may occur in group practices, practitioners may perform less well in these areas.

Barriers to Implementing a Low-Overhead Model

Although this practice model may be very appealing, physicians will encounter many barriers to actually opening such a practice. First, as in any practice, there are a myriad of details and tasks that need to be successfully completed before opening the doors. These include developing a business plan, securing working capital, finding a location, negotiating a lease or building purchase agreement, finding equipment and supplies, setting up accounting and financial procedures, and developing an array of necessary forms, to name a few. Family physicians just graduating from residency, or even those who have previously practiced in a group where such details are managed by others, may lack the confidence, experience, or entrepreneurial spirit to start such a solo practice. Second, because this practice model is innovative, banks may be reluctant to extend business loans to someone wishing to start such a practice. Finally, although the idea of having more professional control may be appealing, many may fear becoming professionally isolated. Medical training is typically done in large organizations, and a physician's previous patient care experiences are likely always to have been part of a larger group.

For the low-overhead practice model to meet the needs of low-income patients or isolated communities, it will need to accommodate those who have public-funded insurance, such as Medicare and Medicaid. For instance, Dr. Forrest's practice accepts no insurance and charges a flat rate of $45 per visit. This may be both affordable and a bargain for moderate-income patients, but neither to low-income patients who have Medicaid or Medicare and no physician. Under present Medicare and Medicaid rules, Dr. Forrest couldn't easily begin taking such insurance and continue serving his uninsured clients at a lower rate. Sliding-fee scales for low-income patients and cash discounts may be acceptable ways to accommodate both payment systems into a low-overhead practice, but would probably require further clarification if this model is to become more widespread. Although accepting Medicare and Medicaid would add some complexity and cost to a low-overhead practice, it would nevertheless add some robustness to the model by allowing a more diverse and medically needy patient population.

Access to Specialty Care

Even if these practices could help improve access to primary care for a substantial portion of the uninsured population, lack of health insurance still limits access to more expensive specialty

or inpatient services. If a person requires expensive inpatient or specialty care to return to work (or to health) they face a "Sophie's Choice" of getting the care and facing financial ruin, or not getting the care and facing worse health. Strategies that just address the affordability of primary care neglect this critical aspect of access for the uninsured. Uninsured families are likely to remain one illness or injury away from financial ruin if they require such care in order to return to health. According to bankruptcy experts, medical bills contribute to about one-in-five personal bankruptcies, and the states with the highest filing rates tend to have larger-than-average populations of uninsured.[12]

Benefits in Creating Networks

A network of semi-autonomous, low-overhead practices specifically targeting high-need areas and populations could harness the promise of this low-overhead model in addressing the larger goals and needs of the healthcare system. A network could help reduce costs by allowing for group purchase arrangements, sharing of management expertise, and providing start-up know-how and capital. These highly innovative practitioners could also share their solutions to the daily practice tasks, thereby improving efficiency for all in a shorter time frame. A network could help provide professional support and accountability by reporting clinical outcomes for chronic conditions and preventive care, raising the general standard of care in such practices. The lessons learned from this practice model in improving access, patient and physician satisfaction, lowering costs, and clinical outcomes could lead to wider system improvements, if there was an efficient mechanism for monitoring and reporting these innovations.

A network of such practices potentially in partnership with third-party payers could also spur the development of an innovative insurance product that coupled high-deductible catastrophic coverage (generally available at about half the premium of traditional preferred provider organization policies) with a prepaid primary care allowance. Such a primary care prepayment structure of even $15 per month could allow these low-overhead practices to achieve similar revenue and utilization rates, but allow primary care to be even more accessible while giving working families substantial protection from ruinous medical costs. This insurance product could help small businesses extend employer-based coverage for primary care at a much lower cost than is presently available even through group purchase arrangements.

Improving access, reducing racial and economic disparities in health status, and improving patient outcomes should be high priorities of healthcare reform. Efforts to expand health coverage or expand subsidized healthcare centers are expensive and unlikely to be undertaken in a climate of other pressing national concerns. Although other individual practitioners may adopt a similar low-cost practice model, as demonstrated by the experience of Drs. Moore and Forrest, unless the model specifically targets underserved populations in the network context, health outcome improvements will be sporadic. And unless there is a mechanism to share the risk of catastrophic illness, the uninsured will remain excluded from the benefits of expensive care that can restore health and function.

Success of this type of practice could encourage the use of this model to serve unmet needs in many communities. Demonstrating that low cost and sustainability, coupled with accountability to achieve measurable outcomes, may hasten the development of such networks elsewhere using locally available resources. **NCMedJ**

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