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TRENDS & Ideas

PHYSICIANS

The Price of a Practice

The value of a physician practice is critical to physicians and to organizations purchasing these practices, as they try to agree on a competitive financial package. To find out the going rate for physician practices, healthcare providers can now look to *The 1995 Physician Practice Acquisition Resource Book*—developed by the Center for Healthcare Industry Performance Studies and Findley, Davies & Company—which offers data from 245 actual transactions involving more than 650 physicians.

Sim Gellman

As reported in *American Medical News*, the data show that the median purchase price per physician is highest for multispecialty and specialty practices; in fact, at $224,000 per physician, such practices are double the price of a family practice. The lowest paid practice, however, is pediatrics, at $78,000 per physician.

There appeared to be some trade-off between the price of the practice and the initial base salaries paid. For example, multispecialty practice physicians received the highest purchase prices per physician but among the lowest base salaries. However, in general, the two figures were consistent; for example, pediatrics and family practice had the lowest values paid per physician and among the lowest base salaries, whereas the opposite was true of ob-gyns.

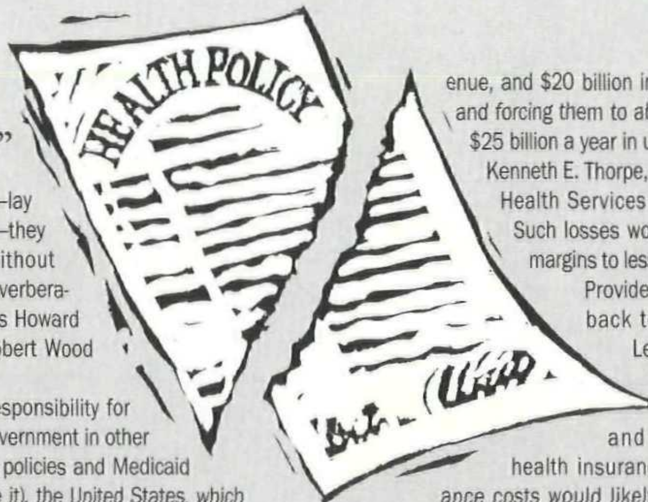
More than 80 percent of the doctors were eligible for bonuses in future years, and these physicians also received a median of $18,000 more in their base salaries compared with physicians not eligible for bonuses. The average maximum incentive was 20 percent of a physician's base salary. The key factor in determining incentive compensation was productivity, used by 86 percent of institutions.

The study also found:

- About 78 percent of all physicians were paid in full, in cash, at the time of the acquisition. The median value increased by about 20 percent when some of the payment was deferred.
- About 80 percent of the acquisitions had some type of noncompete clause in their contracts.
- Purchase prices varied by region, with those in the Northeast being lowest and those in the Near West, highest.
- The majority of practices being bought and sold are of primary care physicians.

DOWNSIZING

The Rising Costs of The "Medically Homeless"



As corporations of the nineties "restructure"—lay off employees to cut costs to increase profits—they also increase the number of Americans without health insurance. This will inevitably cause reverberations throughout the healthcare system, writes Howard Larkin in *Advances*, the newsletter of the Robert Wood Johnson Foundation.

U.S. employers have traditionally taken responsibility for their workers' healthcare, a role filled by the government in other countries. If companies continue their current policies and Medicaid growth halts (as some in Congress would have it), the United States, which now has nearly 40 million uninsured people, is likely to have 50 million to 67 million (24 percent of the population) in seven years, according to the Council on the Economic Impact of Health System Change (CEIHSC).

Even though the lower figure is more realistic, such a jump in the number of the uninsured would be disastrous for hospitals, annually costing them, by 2002, $20 billion in lost Medicaid revenue, $14.4 billion in Medicare revenue, and $20 billion in revenue from private payers—and forcing them to absorb as much as an additional $25 billion a year in uncompensated care costs, says Kenneth E. Thorpe, PhD, director of the Institute for Health Services Research, Tulane University. Such losses would shrink hospitals' operating margins to less than 1 percent.

Providers would then try to shift costs back to employers, according to a Lewin-VHI study, and employers would in turn shift them on to workers as forgone wages and higher premiums on their health insurance. And an increase in insurance costs would likely force many workers to drop their coverage altogether.

Uninsured workers would then join the unemployed in constituting what CEIHSC senior researcher David Shactman calls a new class of the "medically homeless." This class would further strain the healthcare system, adding new pressures to the downward spiral of corporations' support for health insurance.

INSURANCE

24-Hour Coverage Streamlines Workers' Comp Claims

Companies in four Californian counties are experimenting with "24-hour benefit plans," that is, consolidating healthcare services so that employees receive their group health benefits and care for work-related injuries from the same company, Geoffrey Leavenworth reports in *Business and Health*.

"Our employees feel more comfortable going to their regular provider for occupational care, and the doctors who treat occupational injuries have quick access to patient records," explains Jane E. Brady, human resources director for Mariani Packing Company, San Jose, CA. In addition, Brady says, capitated coverage for workers' comp claims has cost the company 26 percent less than fee-for-service charges for similar treatments. And, she believes, 24-hour coverage will help eliminate fraud and double-dipping, when employees collect benefits from group health and workers' comp for the same services.

Marcia J. Carruthers, director of disability management at HHRC, Inc., San Diego, points out that consolidation of group health and workers' comp programs might also prevent some of the misrepresentation and litigation over where an injury occurred.

Despite these pluses, no state has passed regulations enabling insurance companies to offer such coverage, and it is available only as part of the pilot program in California. But many partially integrated initiatives are already in place or in planning in other states. The most prevalent form is coverage that links group health and workers' comp policies—improving data processing and claims management although it does not cover nonoccupational disability. Other plans give employees a single access point for both systems but maintain distinct policies for each.

The barriers to more complete integration include the fact that group health and workers' comp coverage are usually provided by different insurance companies, which would see consolidation as a threat. Also, workers' comp is mandated by law and jealously guarded by unions, which may see reform as a diminution in benefits.

AGING

Old People Need Their Communities

Although developed societies help older people overcome their physical frailties through technology, they also tend to deprive elders of the support, respect, and meaningful roles furnished by more traditional cultures. So writes Jennie Keith in *Aging Today*, in an article adapted from a book called *The Aging Experience: Diversity and Commonality across Cultures*.

The book describes an anthropological study of aging in different parts of the world, including Swarthmore, PA; Clifden, Ireland; Hong Kong; and Botswana. The anthropologists found some notable variations:

- The Herero people of Botswana are, on one hand, probably the least technologically developed of the societies studied, and, on the other, the most supportive of their old people. Indeed, the Herero take great pride in the care they give their elders.
- The Irish value healthcare that can be provided in the home, a practice that tends to keep elderly people in the community, cared for by younger family members.
- The people of Hong Kong also prefer family care for the elderly, but they realize that this is not always possible. They therefore provide government-subsidized nursing homes for old people who have no children.
- Too often, the elderly of Swarthmore get the support they need from neither their children, their culture, nor their city government. Although Swarthmore is a college town, its zoning laws prevent old people from renting rooms to students, which means the elderly must eventually either live alone or abandon the city for nursing homes in the suburbs.

The main lesson to be drawn from these studies is that when societies separate their age groups, the elderly are the ones who get hurt, even if they are the beneficiaries of technological development.