DR. STAN KARDATZKE

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Dr. Fitzhugh Mullan,
interviewer

[Begin Tape 1, Side 1]

Mullan: The date is January 12, 1995. I'm with Dr. Stan Kardatzke. We're in his offices in the corporate headquarters of the Physicians Practices Corporation of America in Miami, Florida.

I appreciate very much you giving me the time to chat. I have read a little bit of biographical material, but if you'd give me just a kind of quick walk through your youth and what decided you to go into medicine, then where did you go to medical school.

Kardatzke: I wanted to be a doctor ever since I was a little kid, probably challenged by David Livingston, the famous missionary to Africa, and studied his life, and then I began to study everything in Africa. I wanted desperately to be a missionary to Africa and solve all the world's problems while hunting lion and elephant and rhinoceros. [Laughter]

Mullan: Your father was a minister?

Kardatzke: A clergyman. So I was exposed to that type of mission "save the world" concept. So I wanted to be a doctor

ever since I decided not to be Superman.

So then I went to college back in Indiana, where I majored in music and pre-med.

Mullan: Anderson?

Kardatzke: Anderson University. There I did my first career was in music, and I toured for three years, giving concerts everywhere. Then I went into medical school. The old adage was, my music professors thought I needed to do something honestly productive.

Mullan: Had you considered the ministry?

Kardatzke: No. I had a scholarship to seminary, but I really always wanted to be a physician. I would have enjoyed a year of theology, just understanding theology, but you probably don't get that as much in seminary as you do reading. I also could have gone for a Ph.D. in music, but I wisely decided as I've always told the story about my surgical professors, after watching me operate, said, "Maybe you ought to go back into music." So I had to become a family doc and a country doc and an entrepreneur and a tennis coach and a variety of other things.

Mullan: Where did you pick up the tennis?

Kardatzke: Just a hobby as a kid, so I developed tennis coaching

and coached a major university, the teams got several rankings in the top ten NCAA, and some members of the team and won a couple of national championships coaching. It was fun. I never could do that as an athlete. I wasn't that good of an athlete, but coaching is full of a lot of recruiting and inspirational stuff. So I've had a lot of fun on this path of being a doctor.

Mullan: When you considered medicine, would that equal family physician to you, or as you got into it, what did you expect you would be?

Kardatzke: Probably all along, I probably thought I wanted to be a family physician. Along the way I thought surgery would be fun and cardiology would be fun and OB would be fun, psychiatry would be fun. Those are the four or five specialties I looked at, but I said it's good to be a country doctor. You can do a little bit of all that if you're a country doctor. That's probably why I decided to be a family physician.

Mullan: Indiana was home or Kansas was home?

Kardatzke: Kansas was home, but I went to medical school in Indiana because I went to undergraduate there and I established residency there, was admitted there to medical school.

Mullan: When were you born?

Kardatzke: I was born in 1939, in April of '39.

Mullan: Then going through medical school in a time when the general practitioner was kind of a lower pew. It was before the family physician was born.

Kardatzke: Yes.

Mullan: What sort of encouragement or discouragement did you receive from peers, faculty, family?

Kardatzke: There was a general depreciation of the generalist. In fact, you're a little younger, we called them LMDs, local medical doctors, were kind of the dummies. That kind of made me angry. I identified all through medical school with the guys the medical schools were always criticizing, that he didn't discover the weird cancer or didn't recognize the rash was tuchigamuchi [phonetic] fever or whatever. And they were always criticizing him, and it made me angry, finally. This guy's out there busting his ass as a family doctor in a community I identified with the underdog. So that didn't discourage me. In fact, it made me probably attracted to family practice even more.

Mullan: When you graduated, you went for your internship at that point? Tell me about how you got into it and how you got into practice.

Kardatzke: I got out of medical school when I was just barely twenty-four, just had my twenty-fourth birthday in April, and started my internship with a general rotating internship, I looked at several specialties. In Kansas, family medicine was just getting started. Of course, as you probably recognize later on, a lot of founders of the American Academy came from Kansas. So the Land of the Wizard of Oz and Dorothy and tornadoes was really a bedrock for the beginning of family medicine. I started private practice out there, later on I became board certified twice.

So I think Kansas was one of the other reasons I was drawn to family practice, because that was a need specialty in Kansas. Although there was still some of the snootiness of the subspecialties and some physicians tried to discourage me in the internship, but the more they tried to discourage me, I was stubborn. So I wanted to do it.

Mullan: [unclear], on your own?

Kardatzke: My father had a large church in that area, so I started practicing in Wichita, Kansas, on the very western portion of the county, kind of a suburban practice, had some rural practice. So I started practice. My brother was in the Army and he'd just finished medical school, so he joined me a few months later. One of my partners in internship joined me a year later, so we had a group of three. Then we added other friends as they came through the program. Now I think there are twenty

or twenty-five physicians in the family practice group. That family practice group expanded and eventually I acquired other practices until we owned about 120 practices and it became a multi-specialty clinic from that group, heavily geared in primary care.

Mullan: Somewhere along the line you must have had had and recognized within yourself an entrepreneurial element [unclear], laying on of hands. Was that something [unclear] going in, or when did that occur?

Kardatzke: It came gradually. My father was also an entrepreneur. Being in the clergy, he made very little income, even though he had a M.A. and a D.D. degree. I think when he retired, he was making $5,000 a year. It wasn't quite like the TV evangelists. [Tape interruption.]

[Begin Tape 2, Side 1]

Mullan: We're picking up on a new tape with Dr. Kardatzke, and we'll count this as tape two. I had trouble with the last tape. Let's pick up, if we could, from entering practice following medical school, your decision to move to Wichita.

Kardatzke: I was educated at Indiana University, and Indiana University had a lot of subspecialty, even more than Kansas. But I decided I wanted to go to Kansas to do my internship and

private practice, and I became more and more convinced to go into family medicine. In fact, the more people discouraged me, the more I identified with the generalist, and I think probably part of that came out of my training in the church, because a generalist acts essentially like a minister. I mean, he knows everything about the family, he becomes part of the community, and he does a little of everything. I enjoyed that. I liked to do the psychiatry, I liked to deliver babies, I liked to do minor surgery. I enjoyed it all. So that pulled me to it.

My father had a marvelous entrepreneurial bent. He wanted to build a nursing home, because the nursing home industry at that time was poorly developed and were located in old houses. There were no nursing homes, no ventilation, so the urine and fecal smell was always there.

Mullan: Was this before you'd gone to medical school?

Kardatzke: This was right afterwards. He decided he wanted to do that. The church wouldn't do it, so he decided to raise some funds, so my brother and I would go out to the bank and we borrowed whatever we could borrow, just because we're doctors. So they loaned us $10,000 apiece, so Dad, my brother and I took out a huge capital of $30,000, got a few other investors, and raised about $60,000 or $70,000 and built a nursing home, which became very successful.

My dad began to run it. When he retired from the ministry, he took over the CEO of the nursing home.

Mullan: That was in the Wichita community?

Kardatzke: Yes, right next to our office. So that grew rapidly and became then the largest nursing home in the state. So we took care of the people. It became like part of his church. It was all related to this cross-culture of church and medicine and family entrepreneurship. We developed a small chain of nursing homes, so that pushed me into the entrepreneurial bent.

Then about four or five years later, in the late sixties, I was having difficulty with my employees' health insurance. With Blue Cross, the premiums were skyrocketing, to me. They were going up 20 to 30 percent per year. The premium was only $25 a month, but that's what they were inflating at, and for a very young guy and heavily in debt--I owed $20,000 to the bank, and so I wanted to do something to try to help solve the crisis of health inflation.

When I went to the hospitals, I was having trouble getting patients admitted to the hospital. The hospitals were too crowded back then. I, as a family physician, discovered there was a bias against me admitting, so when I would admit a fifty-year-old guy with a chest pain, (they didn't have a medical director of the hospital), the general counsel called me and said, "Doctor, we're too crowded on beds. All admissions have to come through me."

Mullan: The general counsel?

Kardatzke: The general counsel, because of medical legal risk. I said, "What in the world are you, an attorney, telling me?"

"Well, does this patient really need to go to the intensive care unit?"

I said, "Sir, he's fifty-four years old, his blood pressure is 160 over 100, and he's got severe subternal chest pain with ST changes on his EKG. He's going to be in the intensive care."

"Well, we don't have room for him."

I said, "Hook him up to a monitor right next door to it." They'd put them in the hall, because the hospitals were too crowded.

At the same time, I went around and took a census and found out that 80 percent of patients in the hospital were there for ambulatory tests. I was very angry. My health insurance premiums were going up 20 to 30 percent per year, I couldn't admit critically ill people because ambulatory patients were taking up the beds. I was very angry. And besides, because I wasn't a "subspecialist," they wouldn't listen to my request to admit a patient.

Mullan: And the same ambulatory patients taking up the beds were people who were being admitted for what could have been ambulatory workups, but their insurance covered them only if they're in-house.

Kardatzke: Exactly. That's the way the old system was. They had to be admitted. So I was really angry.

So I went out to California and to Oregon, checked out Kaiser, found out that they were charging a dollar per office calls, and they were growing like mad. I was charging $4 for office calls and I was losing money. I said, "How in the world can they do that?" And I began to study the whole precept of prepaid medicine.

Mullan: This was your first exposure to managed care?

Kardatzke: Pre-pay. Right.

Mullan: This would have been 1970?

Kardatzke: No, late sixties. So I developed a very primitive business plan. I just said if 80 percent of the admissions are unnecessary and their costs are that, then 80 percent of the hospital costs can probably be reduced. If I could reduce 80 percent of the hospital cost and at the same time physician costs would go up some, because you're going to do more at the ambulatory level, there ought to be a net savings of 40 to 50 percent. I said, "All we have to do is let physicians know this, let the insurance companies know it, and let's split that savings equally between physicians, insurance company, and patients. Hospitals are too crowded anyway."

I tried to get Mutual of Omaha, Bankers, Life and several other insurance companies to help me. They wouldn't have anything to do with it, so I went to Blue Cross/Blue Shield of

Kansas, and they found it an interesting experiment. So we started what was called the Experimental Plan. I believe it was the first time Blue Cross tried the HMO concept. So we started this Experimental Plan and certainly we reduced hospital bed days from 1,200 per 1,000 to under 400, and this was just using our common knowledge. We just told our patients "you will have all your X-rays and tests done free." That's all we did. So we started doing more tests in our office, and we figured we saved Blue Cross in that experiment millions of dollars. We had it all calculated at that point.

When it came time for them to split the savings, one-third of the docs, one-third of the insurance company, one-third of the patients, they kept all. They claimed after the experiment there was no legal way for them to share the savings. So you can imagine I was very angry again at this system.

So after five years and saving them an estimated $10 million, we were pretty frustrated with lack of cooperation, so I got out of it and began to coach tennis, do more music.

Mullan: The "we" at this point was this expanded group practice that you developed?

Kardatzke: About five physicians now. We were growing that practice and very busy. I was seeing thirty-five to forty patients a day, and I was also coaching Little League and coaching the university and teaching at the medical school.

Mullan: So you got out altogether?

Kardatzke: Got out.

Mullan: Did you sell the practice?

Kardatzke: No, no, I just ran the practice. I was doing my practice, expanding the practice, very busy in that.

Mullan: But you got out of the Experimental Plan.

Kardatzke: Yes, the Experimental Plan. Then a few years later a good friend of mine, he had started a similar program. He had followed my program and started a similar one, found the same problem with Blue Cross. They ended up not doing what they said they were going to do, and it was, again, successful. So he said, "Let's start a private one." That was back in 1973. Do you remember when the Roy-Rogers HMO Law was passed? The OB physician, Dr. Bill Roy from Kansas--

Mullan: What was the Roy-Rogers HMO Law?

Kardatzke: That was the one that began the initial funding and created the--the Office of Managed Care.

Mullan: This was a federal law?

Kardatzke: Right. They called it OHMD back then.

Mullan: Why Roy-Rogers?

Kardatzke: The law was called the Roy-Rogers because there was a Dr. Bill Roy, who was a congressman from Topeka, an obstetrician, who founded the law with a congressman by the name of Rogers, so they called it the "cowboy legislation," the Roy-Rogers Law.

Mullan: Paul Rogers and Bill Roy.

Kardatzke: That's it. So I began to relate to Bill Roy we got involved with him a little bit, and we got this thing going. We received an initial grant, a few hundred thousand dollars, and we began developing it and we began growing. After we were doing this for about two or three years, we decided to convert it to for-profit, so I went out and raised several million dollars, paid off the federal debt. We were the only HMO, back then, that ever paid off any grants, and they said that was a record, because everybody else always went under or never paid them off.

So we paid off all the federal monies, took it private, and grew it for several years. Again, our bed days were gradually going under 300. We had some big fights with the medical society. I was investigated by the medical society for communist plot--that's the term that was used from time to time, was a communist/socialistic plot. I said, "Why is it communistic that we're paying doctors two weeks earlier rather than six weeks

later? I don't understand that." But was required to appear before the Ethics Committee every two weeks for six months, explaining this.

Mullan: The state medical association?

Kardatzke: The County Medical Society. Explaining this, what they thought was a weird Marxist plot.

Then when we started making money and we were able to leverage the hospital and get discounts, we capitated most physicians, not at discount, we just capitated them, and everybody was doing well with capitation. We were able to leverage some hospitals by shifting volume into them and got better discount.

Mullan: Was this primary care only, or you were doing all services?

Kardatzke: We capitated any service we could. We capitated surgery. OB, we paid fee for service. We capitated primary care, then put them on a risk pool. This is before it was really thought of. No one had really thought of risk pools yet. It was very successful.

We started seeing some problems in the latter stages of its early development with primary care physicians being at too much risk, and we started seeing them complaining to their patients, "You're costing me so much money when you get cancer or this

heart disease." So we then changed our whole policy. We said we could not put primary care physicians at full risk, because a lot of them didn't have the financial wherewithal, nor the ability to avoid the conflict. So we started putting them only at risk for their services and capitating subspecialists and taking the risk of the hospital, and that was very successful.

We eventually sold that plan to HCA. That plan became, later on, the central region for Equicor. Paul Elwood was working with Equicor. But later Equicore became simply another Equitable. It lost its managed care concept. Signa bought it and, of course, that's where it is today, in Signa.

Mullan: What year was it that you sold it?

Kardatzke: Sold it back in 1985.

Mullan: So it was between '69 and '85 that you undertook these sequential experiments in managed care.

Kardatzke: That's correct.

Mullan: With some down time in the mid-seventies?

Kardatzke: That's correct, because I was so irritated, just going back to practicing medicine and doing the teaching and the coaching and community-based things like that.

Mullan: That brings us to '85.

Kardatzke: Then in '85, when I sold it, I felt that quality issues were going to now emerge as being equal to cost issue, and market really didn't believe that then. They thought that cost was going to be the main issue. So I started another company. I wanted to be a proactive physician company. What I wanted to create was a physician company, not an HMO company, where we would create perhaps 20 percent of the family docs in a community would become one clinic without walls.

Back in those days, multispecialty clinics were controlled by subspecialists, and they hired family docs as necessary "evils," because they brought in patients. So we wanted to create a family practice, clinic, who would then hire its subspecialty physicians. We'd make money off of them instead of having them make money off of us.

Secondly, we thought about building our own hospital. We could fill it and make money that way. But we elected, instead, to get this group of quality and cost-effective family docs.

Mullan: You're still in Topeka?

Kardatzke: Wichita. We elected--

Mullan: And "we" is the group?

Kardatzke: Our group of physicians.

Mullan: Your same group?

Kardatzke: Right. So we went out, and at first we charged fees to become an association. We charged fees to all the doctors, big fees, to form this association. The goal was to become a clinic without walls statewide. We'd be able to go to Blue Cross and offer them, "We'll take 85 percent of revenue and we'll manage your health care dollars, but we're going to share the savings with the docs." We would have done that with Blue Cross, we would have done it with Aetna and everybody.

At that time, the insurers were terrified of us. No one would contract with us, because they saw us as a union. So we decided we had to get back in the HMO business. We had purchased 120 Physicians Practices. We became a super group.

Mullan: Tell me the distinction between being a physician group and being in the HMO business. Physician group, you're responsible just for the physicians that you bring together?

Kardatzke: That's correct.

Mullan: And being an HMO, then you're--

Kardatzke: Responsible for the insured product, working with the insurance department, being HCFA-approved, all this, and also taking the risk for the hospital, the marketing, and everything else. We didn't want to do that.

Mullan: So, the provider and you go beyond the clinical concept of being a provider to being the provider and a more--

Kardatzke: We found out that since insurer companies wanted to cut us out, and we also found that hospitals saw us as getting too strong, so they wanted to cut us out, but we decided we had to become our own insurance company, so at that time we raised capital to buy some practices, we also raised enough to buy an HMO in Texas that was failing, founded by the medical society for the wrong reasons. That is to keep HMOs out. It was losing a million a month. We were fortunate to turn that around through the same things we had learned. We bought one in Sacramento, California, did the same thing. Then pretty soon we got started in Florida; we bought three HMOs that were bankrupt down here. So we were called "turkey hunters." We would always buy bankrupt HMOs and turn them around. That was how we got our start in the mid- and late eighties.

Mullan: At this point, you personally were pretty much exclusively involved in the management side of things?

Kardatzke: Yes.

Mullan: When did you stop practicing?

Kardatzke: Stopped practicing in '85. I had a coronary and bypass when I was forty, so I said, "I can't keep doing tennis

coaching and running the practice and teaching at medical school and singing concerts. I've got to focus." So I just focused on this. The hours were better, stress was probably even more, but I didn't have to get up at night, so I gave up the OB and I transferred about twenty-five "thank yous" a day from patients for twenty-five gripes and complaints from physicians. But nevertheless, it's been an interesting career.

Mullan: You were still living in Wichita at that point?

Kardatzke: Yes.

Mullan: As you began to aggregate your turkeys and turn them around, what decided you to--was it a direct line to moving here? How did that come about?

Kardatzke: We bought three in a row, and they were in trouble and their revenues were very high, and they were losing so much money, and the opportunity in Florida was so great because there was more fraud in Florida, the cost per capita was the highest in the world, so we said, "Here's the opportunity." So we moved down, and the move was good. It was good for us.

Mullan: You have, I gather, consolidated principally here, although you have a Texas--

Kardatzke: We have a Texas company, one of the larger HMOs in

Texas. We have 250,000 members in Texas. We have 250,000 members in Puerto Rico. We have in the state of Florida about 400,000. We've got 50,000 spread out in Georgia and Alabama. Then we have a workmen's compensation company in about fifteen states in the Southeast, where we also manage workmen's compensation. We also have clinics and manage physician practices. We've been buying clinics and operating physician practices.

Mullan: I gather the focus of at least PCA Florida, if not all, is very heavily Medicaid and Medicare?

Kardatzke: Nationwide, our mix is about 50 percent of our revenues come from government sources, federal, defense, Medicaid, and about 50 percent comes from the commercial. Pretty similar to the national health care expenditures. As you probably know, about half a trillion comes from private side and about half a trillion comes from government.

Mullan: But in terms of the profile of managed care companies to date, until the last year or so, I would be correct, I believe, in saying--

Kardatzke: Eighty percent or so was commercial.

Mullan: Medicaid was small, Medicare was small?

Kardatzke: That's correct.

Mullan: So you're ahead of the market in that sense.

Kardatzke: Right.

Mullan: Is that strategically designed by you, and if so, why?

Kardatzke: I would like to say it was strategic, but most of our successes were like other opportunities you fall into it. It's an accident that happens and then you scramble to try to make it good. So it wasn't that I was smart, I was just motivated by opportunity.

Mullan: I gather it's been successful. Particularly because managed Medicare, managed Medicaid have become such hot policy issues and even ethical issues, being out in front as you've been, having more experience with this, what are your observations about that, both from a business point of view, as well as from a medical point of view?

Kardatzke: Government, we found, will make the changes faster, because as a sole-source provider, we figured three years ago they would have to make the changes. In the book I wrote, I stated that our federal inflation and our foreign trade deficits are somewhat related to our health care overexpenditures. So we predicted that government would be the fastest to change.

Although they had the lowest HMO penetration rates, we also said within a few years they would be the fastest because they had the highest incentives to reduce costs for taxpayers.

Mullan: They'd have to reach for it.

Kardatzke: They'd have to reach. So that's why we got into that.

Mullan: For a long time there were many obstacles in the way of managed Medicaid, in particular, in the belief that if one ran a managed Medicaid practice, it would be cut-rate medicine and the population would be at inordinate risk. I believe the federal guidelines called for you had to have a mixed practice and could only have a certain percent.

Kardatzke: Correct.

Mullan: Those prohibitions have fallen over recent years. Are those issues? If you have an exclusively or largely Medicaid practice in a managed setting, with all of the limitations in federal funding such as they exist, does that create a second-rate kind of situation?

Kardatzke: We found just the opposite. When we first came, that was our concern, and also Wall Street was very concerned of what we were doing. We were the first company to really get into

Medicaid, and many thought Medicaid was going to pollute our commercial business and that we'd lose membership. Also how could you take care of this patient population whose costs had been inflating four times the national average of the CPI?

When we got in, we found our costs were very high and this company that we bought was losing money in every way, but we did a little survey. We found out at the clinic sites, where we were taking care of Medicaid population, that the average number of visits we were seeing at that site was 5.8 visit per person per year, and that was four years ago, five years ago. At that time, nationwide, the average was about 3.8. So the board and Wall Street was telling me, "Don't get into that business. You see they're losing millions in that business. At the same time, your physician visits are 50 percent higher."

So I was warned not to get into it. But I had a deeper belief it would work. We also saw that immunization rates in Medicaid populations were running 30, 35 percent. We saw that prenatal care didn't exist much in that population. Many of the Medicaid women presented to the emergency room or in the last trimester--in fact, I've delivered them in the emergency room, never having seen a physician, didn't even know they were pregnant.

Mullan: I read that anecdote in your book.

Kardatzke: And the reason why is they couldn't get in to a primary care doc because there were not enough primary care

doctors and they were underpaid. The primary care doctor didn't want any more Medicaid. He's already inundated with commercial business. So therefore, these women couldn't see OBs because the OB had a white-collar practice, and so therefore they just didn't get prenatal care. We now know that that lack of prenatal care is going to lead to complications which are very costly.

Well, when we got into it, we bought the plan, we began to expand this Medicaid business in our own clinics, we found that the patient population that was experiencing 5.8 visits per person per year, 50 percent or so of the national average. However, conversely, the per capital medical costs were running 20 percent lower than the population around it. The reason the health plan was losing money wasn't because of frequent primary care visits. We found other reasons they were losing money. A lot of it was going out the back door in the back pockets of certain people--fraud and mismanagement.

Mullan: They were being hospitalized less? That difference between the double the national average of ambulatory visits, but 20 percent less in terms of overall cost.

Kardatzke: Right. You found out that people, when they got their care at the ambulatory level and the clinics were open twenty-four hours a day, didn't have to go to the emergency room. The emergency visits were less. Your admissions for emergencies was less. You were interdicting otitis media, prenatal care at earlier stages. So instead of having otitis media go into

pneumonia or a loss of hearing or meningitis, you could interfere medically earlier because these Medicaid people now had a clinic. They had a medical facility where they didn't have to wait for eight hours and they didn't have to sit, second class, behind knife wounds and gunshots. They could get in to see a primary care physician, their own doctor.

We found in these clinics some unique things that are unique to the Cuban community here. They had hairdressers in clinics, massagers, piano players. They would serve donuts, coffee to their patients. At first I wanted to stop that. Why do you serve donuts to a diabetic population? But it brought them in. It created a culture. They would do their hair and nails. No one minded waiting. They'd much rather wait here where they were "loved" than sit and wait in the emergency room in line behind dangerous incidents that occurred. So we began to better understand the culture.

Frankly, it went back to the whole primary care/family doctor concept, but instead of being one doctor, a clinic became their primary care center, and in the clinic there might be five generalists, a couple of pediatricians, and one cardiologist and a surgeon, and so the clinic became their medical resource night and day, and they would go there. It's much easier to see a primary care doctor for an evaluation, to say, "Fine, take this medicine and see me in a couple of weeks," than it was to wait six to eight weeks and then go see a subspecialist or go to the emergency room and then they order an MRI because the emergency doctor didn't know Hilda's always worried, see her next week, and

maybe save $1,000.

Mullan: These are staff-run clinics of which PCA owns some--

Kardatzke: Yes.

Mullan: In addition, you have IPA physicians as well.

Kardatzke: That's correct.

Mullan: And the Medicaid practice largely in the staff-run?

Kardatzke: There's a higher percentage of the Medicaid practice in our clinics, but, still, the bulk of all populations are taking care of the network. We have about a million patients now, and we have about 100,000 taking care of our clinics, but our clinic, about 50 percent of its patient volume is Medicaid.

Mullan: To develop a little further the intersection between primary care and managed care now twenty, thirty years later, as you bought the practices, particularly here in Florida, and began to expand them, particularly with an eye toward the Medicaid population--we didn't talk about it, but I guess Medicare as well--what was the situation with the availability, quality, and attitude of the primary care medical community? Did it exist? Was it sufficient, etc.?

Kardatzke: In this market?

Mullan: Yes.

Kardatzke: Primary care in this market was not sufficient. Primary care in the south Florida market five years ago was--primarily that there were some good family physicians and good pediatricians. However, they were terribly inundated, if they were American-trained. So the bulk of these staff-[unclear] clinics that we purchased were foreign-trained physicians, many of which could not speak English, were not board-certifiable. They were true GPs trained in Cuba or Latin America thirty years ago. So their level of care was not sufficient for what we wanted, so we gradually had to retrain, replace. Then we put a new record system in, because the records were in Spanish. They didn't follow problem-oriented practices or record-keeping systems, and it was not organized in a way that certainly we wanted to organize it.

There were no physician profiles. So our company developed the concept of grading physicians through report cards. We developed that about eight, nine years ago, a profile by a variety of things, not quite as sophisticated as what we have today, but, nevertheless, it was our attempt to have physicians be graded by their peers by some form of objective criteria.

Mullan: In terms of recruiting and availability, what was it like then and what is it like now? There's a raging debate, as

you're aware. There was a general consensus that we had too few primary care physicians. Now people are saying we have enough. True or not true? How has that developed?

Kardatzke: Well, although you have a lot of primary care physicians, board-certifiable ones, are in a shortage today. I think the ratio needs to be perhaps 60/40 primary care to subspecialty.

Mullan: In terms of what we're graduating.

Kardatzke: Yes. And I think we need to change that. I think there are two or three ways of solving health economic crisis in this country. One theory is on the demand side and the other theory is to control the supply of providers. I think certainly to have patients paying a portion of the bill when they see subspecialists is one way, to pay higher co-pays for subspecialty. I think the simplest way is to train more generalists, pay them more, train fewer subspecialist physicians and pay them a little less so that we equalize that balance, and then the subspecialty physician, instead of not having enough to do and so he drums up extra procedures, he will do only what's really necessary. And the generalist, instead of being so inundated that he has to refer everything out, he'll be able to be more of a true generalist and do a few more of the simple things that keep his relationship with his patients. We think that relationship in itself is cost effective.

Mullan: So as I gather, to summarize this issue, you see the market both in terms of your business as well as south Florida in general, as still able to absorb more properly trained or fully trained generalists. It's not closing down.

Kardatzke: I think the old school GPs in south Florida are leaving practice or retiring, and I think they will be replaced by small-group practice. We think the most efficient way to practice is three to five generalists in a location in a 3,000 to 4,000 to 5,000 square foot facility, with an X-ray and with their blood-letting service, and extended hours. That is the model I think can be used everywhere in the world, that model, and we're trying to promote that.

Mullan: What are you seeing on the specialty side? Is the glut developing, both in terms of your practices as well as the market in general?

Kardatzke: We think that's happening, and we think the glut will follow economic trends. In Florida, physicians' subspecialty income has gone down 11 percent last year, and they were crying in the press, yet their incomes are still average almost double what the generalist is, and they've never cried for the generalist in my thirty years. Never have cried for him. Of course, the AMA [American Medical Association] is still primarily run by the subspecialty interests, so they're mounting all kinds of campaigns for patient choice, they call it. What it really

is, is price fixing. It's really a way to price fix. It's a way to keep managed care from narrowing the panel of the subspecialty physicians, so we can control costs and also can control outcomes better.

So we see that as the glut is there, and we think it will take ten to fifteen years to really bring that balance about. What I would like to see is 60/40, where I think right now it's probably the other direction, or 40/60.

Mullan: Let me ask a couple of the tough questions that are sort of the brickbats thrown at managed care in general. The first is profiteering, that many managed care entities and the various corporate forms they take are essentially cutting back on what goes into patient care, but, by and large, the savings are being pocketed by investors and not going to buying down the national expenditure as a whole. True, untrue? And how does it work here?

Kardatzke: I think in general it's untrue. Most of the managed care organizations try to shoot for somewhere between a 4 to 5 percent profit margin, the same as the insurance companies do. They've got to have a profit margin. The state law in Florida has to be minimal of 2 percent or you're out of compliance. Very few can profit anymore than 3-5 percent because of competition. Our margins have gone way down, and we'd love to have a 3 to 5 percent profit margin. Now, that's not excessive profiteering, I believe that very few industries can operate on a 3 to 5 percent

profit margin. I don't call that excessive profiteering at all.

If you talk about profiteering, I think we have to look at certain subspecialty physicians that make $1 million, $2 million a year, and those are the physicians crying the loudest about the profiteering in the managed care industry. I don't think you find too many generalists crying about the "profiteering" in the managed care industry, because they've been doing better. In better, the generalist does better in managed care than he or she does in the fee-for-service system, and they're the biggest supporters of managed care.

I think some of the subspecialty physicians are crying "profiteering." They don't want that 3 to 5 percent profit because that 3 to 5 percent profit also means there are systems that eliminate duplication and unnecessary procedures, plus they also promote price cost effectiveness, which has never occurred on the subspecialty side. On the fee-for-service side, nobody ever asks the surgeon or the cardiologist, "What are you going to charge me?" The managed care organizations do that, and I think they don't like that. I don't blame them, but that's what the issue is. So excessive profiteering is taken care of by the marketplace through managed care.

Mullan: What about, and this pertains particularly to the Medicare practice, the ugly and simplistic term is cherry-picking, but the failure to risk adjust and the likelihood that healthy elderly would opt into managed care, leaving the sicker elderly on the indemnity standard system? Is that a shortfall of

managed Medicare, and how do you address that?

Kardatzke: I think there's been a little bit of that, not a whole lot. In our particular company, we would love to have the price adjusted by risk, because we're getting adversely selected for a variety of reasons. We can prove it by bed-day analysis. We support having a risk adjusted by diagnosis or by health of the consumer. We think that would be very fair, and I would support that. The problem is, technologically they've not been able to have data to do that yet, but I would very much support that.

It's my strong conviction that whichever patient population, exists, if properly managed for outcomes and cost, it will achieve better results than a population that is not managed for outcomes and cost, compared with the fee-for-service indemnity side, is not managed. It's managed to get the most money out of it. That's the whole incentive. The only group that protects quality outcomes on the FFS side are the lawyers, and we physicians don't want that, but that's been our only watchdog, have been the attorneys. They're not the ones who should watch us, and yet that's what the indemnity system has created. Managed care does have NQAA (National Association for Quality Assurance and other organizations that are looking for outcomes and costs for populations. Fee-for-service Medicare only funds care of episodic illness.

Mullan: But the issue of the elderly, you suggested that you

were actually adversely selected. Does that mean that sicker elderly are opting for a managed care package?

Kardatzke: Oh, yes.

Mullan: That's counter-intuitive, or it's contrary to what everybody's saying they're doing or would do.

Kardatzke: When the elderly is on a budget crunch--and remember, in Florida not very many elderly are raised in Florida and convert to managed care. They come down to retire here in Florida because it's cheaper to live. The winters are better. Now, when they come down to south Florida, they don't know any doctors, so they don't have a relationship to break, so the sicker ones are going to be the ones that tend to join because they have higher out-of-pocket costs. So we think, at least in our plan, we're seeing our bed days to being higher in Florida than they are in Texas in our Medicare population. So we think anyone who has an illness, if they're on limited budget, they want to find the best way to take care of that illness, and since they also know that the federal government is looking over the doctor's shoulders in a certain way, some way, they feel there's a certain amount of quality.

Mullan: In terms of the way it works in Florida, or I suppose is national--and excuse my ignorance on this--is it advantageous to the Medicare-eligible individual to go with a managed care

arrangement as opposed to a standard Medicare indemnity arrangement?

Kardatzke: It certainly is. On a cost basis, he gets more benefits. His drug benefit is free. He also doesn't have to pay out-of-pocket. There's no deductible. When he goes to the hospital, his out-of-pocket expenses are minimal with an HMO, where they could amount to several thousands of dollars a year if he has any kind of illness whatsoever.

Mullan: Is that Florida or is that national?

Kardatzke: That's national. I don't think it's any different in Florida. The costs are greater in Florida, so therefore his co-insurance amount is going to be greater.

Mullan: A final question and then some wrap-up things. A final question on these sort of standard charges. The universality issue. Obviously where people are under the roof of a corporate or managed care structure, they're in out of the rain. As I'm sure you've heard, as I've heard often, we're getting reform without government intervention because look at all the changes that are taking place, and yet most of the changes have done little to bring in either the uninsured patient or, in some cases, even the marginally insured. How do you respond to the charge logged by some that a given enterprise, any given company, may do all right in terms of prevention, all right in terms of

primary care, all right in specialty care, but, after all, that is not a solution to our national problem in which 15 percent of our population doesn't have coverage?

Kardatzke: I agree.

Mullan: You've written about it, I know.

Kardatzke: It is a partial solution. The problem with the uninsured is the uninsured can't afford the premiums, number one, because the premiums have been escalating at three times the rate of growth of their salary. That's the number-one problem. You've got to slow down the health care spending, and managed care is the only organization to have done that. There have been several studies to show that if there's an HMO in the community, the overall fee-for-service costs go down because they make everything more cost-effective--it's whatever you call it, the osmosis effect of everyone has to compete with that system.

Managed care has been wonderful for America. There have been some antidotal problems with it and they're correcting it, but I think in general it's been very, very good.

Mullan: Two questions about the future. What do you see as the future of the primary care physician? There are those who argue that, ironically, the primary care physician has come to the fore, as we talked about, on the wave of managed care in particular, and yet the population that now knows the term at

least more is sort of saying, "That's the guy (or the gal) that stands between me and--"

Kardatzke: The gate-keeper.

Mullan: He's the gate-keeper. And there are those who say, well, with the explosion of medical knowledge, the primary care concept, the generalist concept, isn't going to make it because nobody can know all that, and ultimately the future belongs to specialists; we're going to have to specialize. True, not true? What do you see as the future?

Kardatzke: I think the generalist will be here forever. You and I are physicians. If we choose a subspecialist, if we're in an area, we know them. But if we don't, if you're ill, you'll call a friend. You'll call an internist in the area who you know when you're sick, or your wife will call an internist or GYN when she's sick. That will be the source of their primary care. We need an interpreter between the high-tech side and the touch side of health care, because the bulk of the culture are not medically sophisticated, so we need that. I think that need is going to be there for a long time.

I do think the successful primary care physicians are going to be small groups, they're going to have wonderful MIS systems, they're going to know their patients. If I was doing it now, I would do what Pizza Hut does. You know, when you call into Pizza Hut now, you call in, they say, "Hello, Dr. Kardatzke." They

know because their screen tells them by the phone number who your name is and your address, and also the last pizza that you ordered.

Now, if Pizza Hut can do that, can't we do that in our office, have our office secretary say, "Oh, hello. Is this Thelma? By the way, how's Sally doing? She was in last week." The screen ought to tell her that. And that's what we ought to do in primary care, because what we can really sell is ourselves as opposed to the procedure we're going to do to somebody. I think we in primary care, if we are out there to serve and we use high tech as a tool to help serve better, we're going to be very successful.

Mullan: And you think it is viable that an individual can garner and maintain a broad enough base of knowledge to be that both gate-keeper and high touch counselor?

Kardatzke: I don't like the gatekeeper concept--I hate that concept and I think we ought to call primary care physician the usher. An usher is somebody that guides them to their place in health care, not someone that prevents them from getting there. I think in managed care we need to use primary care physicians as ushers, as guides, not as those that guard the gate to care. No one calls a guide when you're hunting in Alaska somebody who prevents you from hunting; they prevent you from getting killed. And I think primary care docs can prevent people from getting in the wrong hands of wrong people who are not ethical, and they can

also prevent--it's been shown, 50 percent of procedures which need not be done.

I think primary care physicians protect people, and I think if we carry that mentality and that mission and because of accessibility and a personal relationship and using high tech to help us serve better, primary care physicians are going to have a wonderful career.

Mullan: Just to touch on the question of a primary care doc, you have a new linkage with the University of Miami. You're on the health [unclear].

Kardatzke: Right.

Mullan: Give me just a word about that.

Kardatzke: That's kind of a unique arrangement where we use the medical school as the medical group, the medical center, which is a different corporate structure under a system of hospitals, as the hospital side, and we're the managed care organization. We each take a percentage of the premium dollar, and that percentage varies by utilization. So if utilization is better, the doctors and we get more. If the utilization is worse, the hospital gets a little more. But no one profits by excessive utilization. The hospital doesn't need either. So we all do better, utilization is better controlled, and we can have better health outcomes.

Of course, the medical school has never been the promoter of

basic primary care services. They're learning to, and they know this has to change.

Mullan: Is there a teaching component to this?

Kardatzke: Yes, there will be a teaching component. We'll all be on the faculty and our medical director, Mark Rivo, Dr. Johnson, will be on the faculty, teaching the physicians how to do a better job at educating the primary care physicians, how to interrelate with the primary care physicians.

Mullan: Is that important to you, or, to put it bluntly, is that window-dressing? Is that prestige for the company?

Kardatzke: We like the prestige, but in developing a model for the next century, nothing I would love better than to have the subspecialty physicians in any organization be the educators for the primary care physicians in that particular subspecialty. I'd love the urologist saying, "Here are the three most important conditions for primary care physicians to handle effectively.

[Begin Tape 2, Side 2]

Kardatzke: So that wouldn't be window-dressing. The urologist could tell the generalists "Do the PS for prostate cancer." A finger is not as good for the primary care; it just doesn't find much cancer. The gastroenterologist may say one or two things.

And every year they give the two or three bullets that we as primary care physicians need to improve in primary care. That helps us to know what's really important. And the second thing is when I, as a family doc, get a patient with Crone's Disease [phonetic], I want that subspecialty to educate me how to manage him or her, so I know when to refer, I'm still going to hold that patient's hand. When they get real sick, I'm going to hospitalize them and have the subspecialist take care of them, but they're still coming to me. I'm still their doctor. And I think that's what leads to cost effectiveness.

Mullan: You see a closer marriage between University of Miami and you, between academic medicine and managed care? It's a weird dance going on now, as far as I can tell, but do you see it prospering?

Kardatzke: I think it will prosper. I think the private sector is going to pick up the slack where government is going to quit funding, some medical schools. I think medical schools have to be market-driven; they can't just be academic-driven anymore. The government is not going to support it. There's been a lot of redundancy in that. I think the need to be market-driven is going to change that, and I think that's going to drive medical schools to be more primary care oriented, getting into managed care.

Mullan: A final question. The future of the system. Do you see

managed care being the *modus operandi* for the country, or an important contributor with a large indemnity market remaining there, or what?

Kardatzke: I think the indemnity market will continually fade until where it's no more than 10 or 15 percent of the market. I think managed care will come in a variety of methods. I think the solid HMOs are going to prove the best outcomes. They're going to have less choice of subspecialists, but the best clinical outcomes and costs.

Mullan: You said the solid HMO. You mean business solid, talking staff and IPA?

Kardatzke: I'm talking about the traditional HMOs, staff model, and IPAs, are going to have the best outcomes and the lowest cost. The PPO concepts, the point-of-service products, are going to fill in the gap. They're going to replace the indemnity FFS system. There the patients are going to pay a higher dollar for that choice, they're not going to have quite the same outcome, but those patients are going to be more medically sophisticated and they're going to be willing to pay that higher dollar. Then I think 5 or 10 percent eventually are going to be in the indemnity FFS system; those are going to be the wealthy people. Physicians may stay in indemnity themselves. They're going to pay the highest dollar, they have the ability to pay it, they don't care about the extra few hundred dollars a month for their

family, but they want choice, and because they're sophisticated, they can handle the indemnity side.

Mullan: The uninsured, the poor, will they ever get into the system, and how?

Kardatzke: The only way I see that happening is through a mandate, because I think so many people will not plan for the future. I did like Rockefeller's concept of pay or play. I thought that was a good one. A lot of people say that's a tax, but many people, if they don't have health insurance, they don't want to pay for health care until it's necessary. Then when it is necessary, they can't afford it because they haven't saved for it, so it causes cost shifting to the insured.

I think there will have to be some form of pay or play government action in the future, because I don't think some people are going to voluntarily pay if they are healthy today. They think "why do I want to pay the insurance?" So I think that's a weakness, and I think that's where legislation is going to have to come in. Even though I tend to be a conservative Republican, I tend to think you'll have to provide an incentive for people to pre-pay for health care, because we're not that disciplined as a culture.

Mullan: Will we end up with an automarket, four or five major purveyors in health care, the big five or the big seven, or will it be a much wider and more variegate structure?

Kardatzke: I think it will be both. I think the big providers, within five or six years, there are going to be seven or eight big national companies, we'll be a portion of one of those big ones. Then I think there's always going to be a lot of regional players, and some not-for-profits, that are going to hang on for as long as they can, and they'll meet a niche. This culture is so entrepreneurial that I think there are going to be a lot of other people always competing with the big guys. They're going to sneak in, in special niche markets, and do a good job.

Mullan: Good. Anything else you'd like to add?

Kardatzke: I think you've hit a lot of it. I think we tried to touch on what we really believe, that if you enhance the relationship between a person's personal physician and themselves, we have evidence now, by the study I showed you, by the number of visits and by whatever you measure that enhanced relationship, you will get two things: you're going to get improved health outcomes that are measurable and we think you're also going to measure decreased cost. We think management of health resources is just like management of wildlife resources. I love to hunt and fish. You want to manage it. The management of dollars, management of oil, I would like all resources result in improved outcomes for society.

Mullan: The 60/40 that you've cited a couple of times, you think when this all shakes out that that ought to be, or might be, the

profile, of primary care, especially here in practice?

Kardatzke: That's what I think. And I think we may add in obstetricians, internists, to pediatricians and family physicians. I think the primary care pool is going to take care of people first line, and I think that needs to be about 60 percent of the physician pools requirement for the best outcomes.

Mullan: Good. Thank you. It's been terrific.

Kardatzke: I'm sorry I have to leave so soon.

[End of interview]