DPC ALLIANCE

STATE OF DIRECT PRIMARY CARE

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Introduction

Direct Primary Care (DPC) has emerged as a compelling alternative model to traditional fee-for-service medicine, driven largely by patient and clinician demand for simplified, transparent, and personalized healthcare. Despite widespread anecdotal discussions surrounding DPC's rapid growth, robust, comprehensive data remains scarce. Prior to this study, the last major investigation into the distribution and costs of DPC practices was published over a decade ago (Eskew PM, Klink K. J Am Board Fam Med, 2015).

Current estimates suggest a significant expansion of DPC, with Hint Health projecting over 3,600 distinct practices, both physician and non-physician owned, nationwide as of Q1 2025, reflecting an impressive annual growth rate exceeding 19% since 2022. Despite this growth, existing literature inadequately addresses crucial aspects of DPC operations, including the relationship between clinician characteristics, patient capacity, and membership costs. As of this writing, a PubMed query yielded only 78 publications on DPC, many of which lack comprehensive analysis of the U.S. landscape.

Several factors contribute to this data paucity: DPC clinicians intentionally operate outside traditional insurance billing frameworks, limiting visibility within conventional research methodologies reliant on insurance claims. Additionally, many DPC physicians have limited available time or may not prioritize survey participation, especially when approached by organizations with which they are not affiliated.

Recognizing this gap, we conducted the largest and most robust survey of DPC practices to date. For the purposes of this analysis, a DPC practice is defined as a primary care practice that, at least in part, (1) charges a fixed, periodic fee and (2) does not bill insurance for clinical services rendered. The insights from this comprehensive survey aim to establish a clear, data-driven understanding of the evolving DPC landscape.

Methods

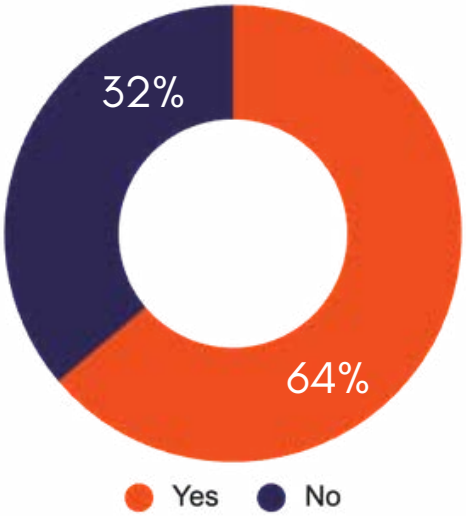
A novel survey, targeting physicians only, was constructed by the Membership Insights committee of the Direct Primary Care Alliance, a non-profit membership organization of DPC physicians. Survey responses were collected via Google Forms.

The survey was distributed via email to all members of the DPC Alliance on October 8, 2024, and through various DPC-specific Facebook groups between October 9 and November 7, 2024, with Facebook reminders sent on five separate occasions. DPC physicians were encouraged to forward the survey to their friends and colleagues in the DPC community. Hint Health also sent out a notification through their platform, and DPC networks emailed their affiliate practices.

Following a preliminary evaluation of geographic response distribution, targeted emails were sent to DPC clinicians, identified through the DPC Frontier mapper, in regions with lower response rates.

Results

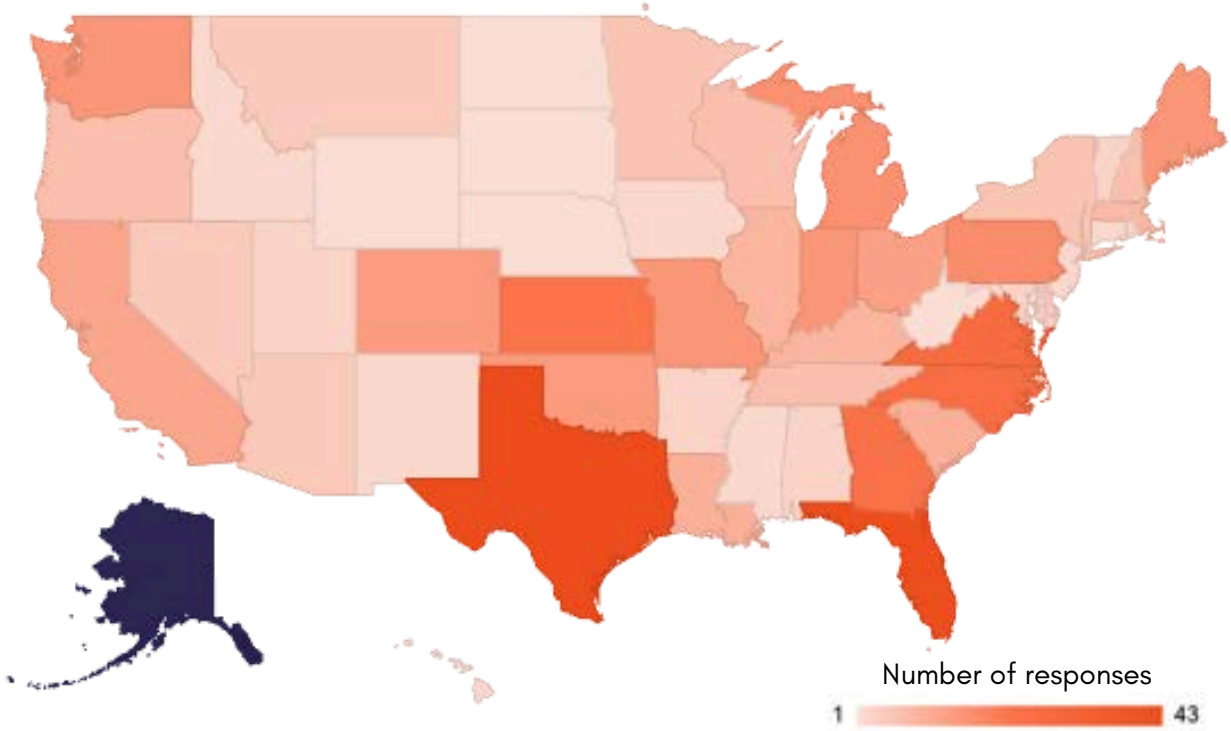
DPC Alliance Member



We received 465 unique responses, which according to Hint Health's estimate of approximately 3,600 DPC practices nationwide, both physician and non-physician led practices, represents over 13% of all physician-owned DPC practices.

Current DPC Alliance membership includes over 700 practices; notably, only 63.8% of respondents were members, indicating substantial participation from outside the DPC Alliance.

Location



Top 10 States

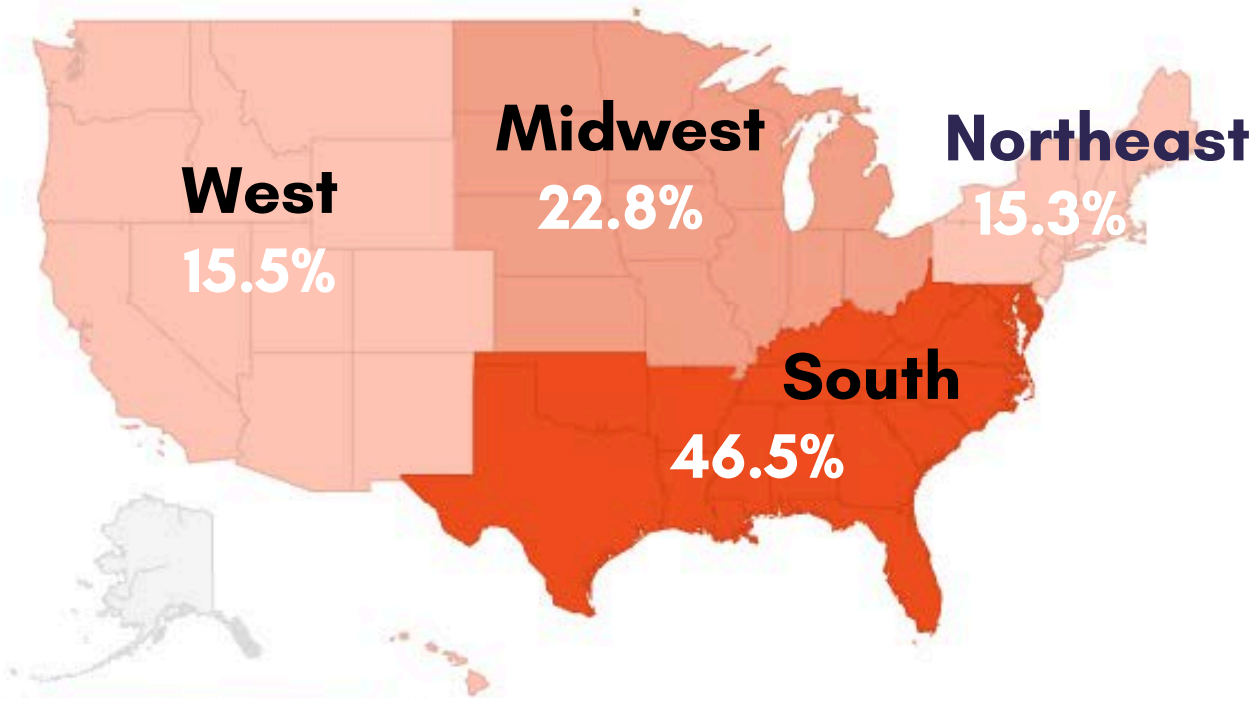
1. Texas*: 43
2. Florida*: 42
3. Virginia: 26
4. North Carolina: 25
5. Georgia*: 23
6. Kansas*: 22
7. Pennsylvania: 17
8. Michigan: 16
9. IN, ME, MO, WA (tie): 15
10. CO, OK (tie): 14

*States without Medicaid expansion

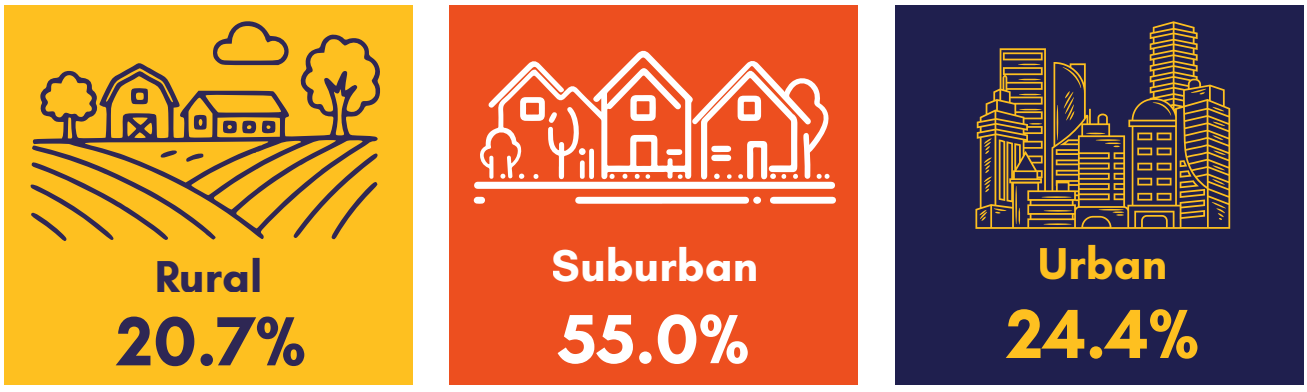
The geographic distribution of DPC practices spans nearly every state, with Alaska being the only exception. Interestingly, three of the top five states with the highest concentration of DPC practices are states that have not expanded Medicaid under the Affordable Care Act.

While the overall distribution of DPC generally aligns with population density nationwide, there are notable exceptions: Kansas, for instance, has a disproportionately higher number of practices compared to its general population. Conversely, states with major metropolitan areas tend to have fewer DPC practices relative to their population size, suggesting unique regional factors influencing DPC growth.

Location cont.



Consistent with the state-level distribution, the regional data shows that DPC practices are most concentrated in the South. The Midwest represents the second-largest share, while the West and Northeast are nearly equal. This reinforces the broader pattern that DPC growth is not evenly distributed across the country, with Southern states playing an outsized role in the current DPC landscape.

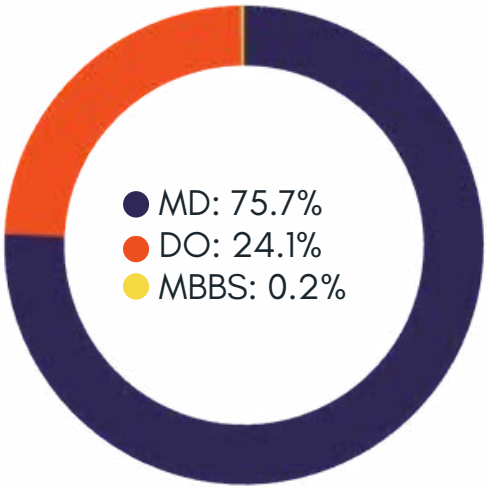


Regarding practice setting, most DPC practices are located in suburban communities. This finding likely reflects where physician entrepreneurship, patient affordability, and demand for alternative primary care models most frequently intersect.

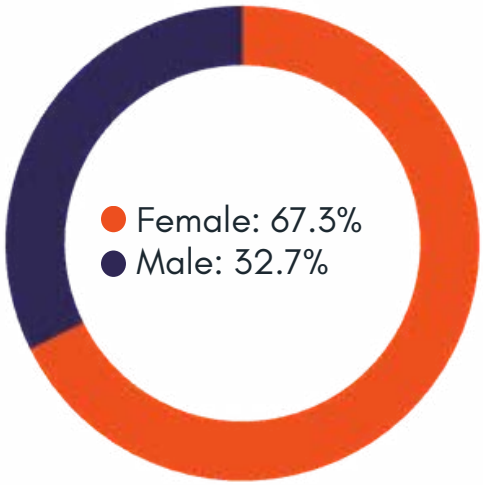
Demographics

The survey reveals distinct demographic patterns within the DPC physician community. While most respondents are MDs, osteopathic physicians (DOs) represent a substantial portion of the sample. Women comprise the majority of surveyed physicians, significantly outnumbering their male counterparts. Family medicine (FM) dominates as the primary specialty, with internal medicine (IM) and pediatrics (Peds) following as the next most common fields. The survey also captured smaller numbers of physicians, such as Internal Medicine-Pediatrics, reinforcing family medicine's predominant position in DPC practice.

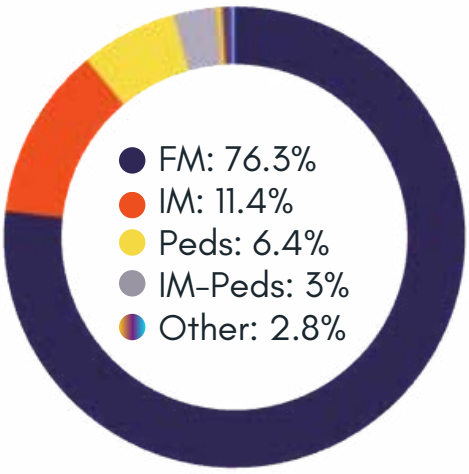
Medical Degree



Gender



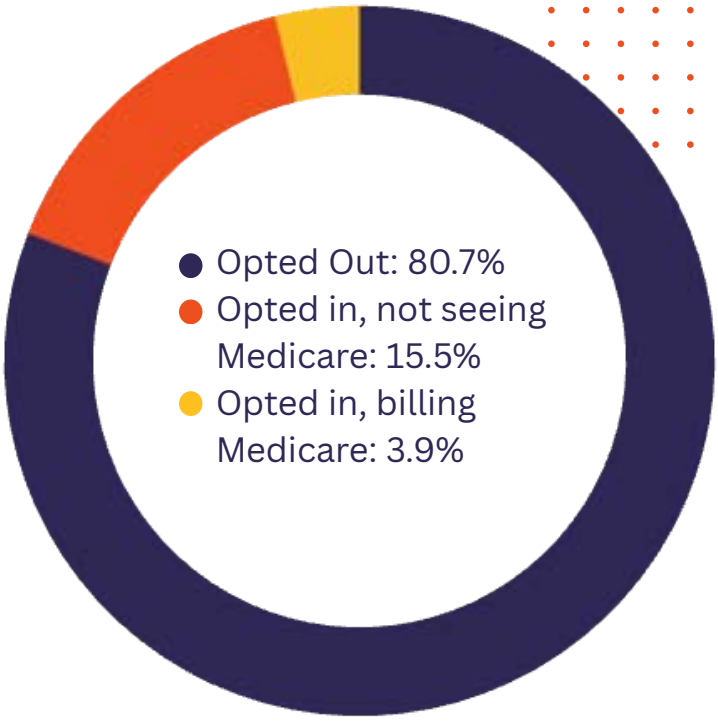
Specialty

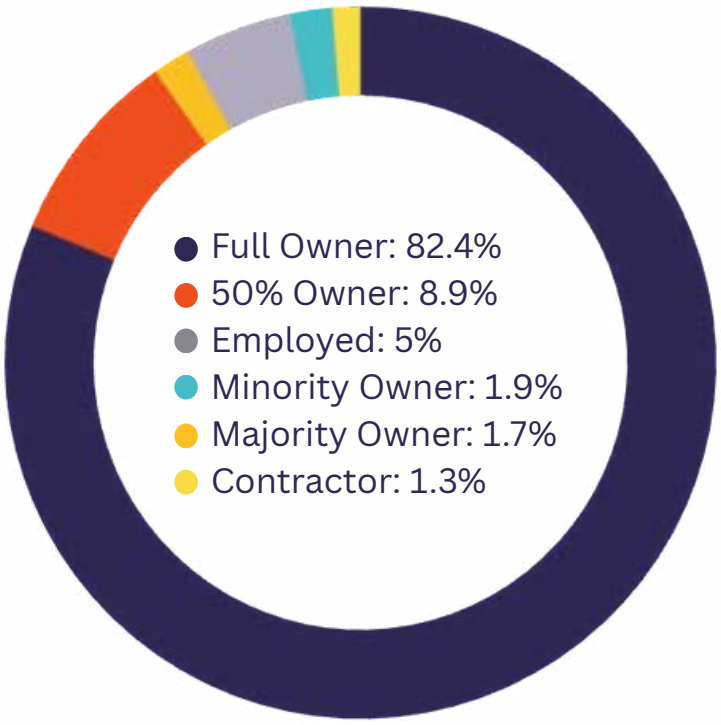


Demographics cont.

The vast majority of physicians have opted out of Medicare entirely, allowing them to practice independently of its billing requirements. A smaller group have opted in but do not see Medicare patients, while an even smaller minority remain hybrid by billing Medicare for eligible patients. This underscores a significant startup challenge in DPC: physicians who moonlight while building their panels cannot opt out of Medicare, forcing a choice between excluding Medicare patients or operating a hybrid model, which can complicate the DPC experience.

Medicare Status





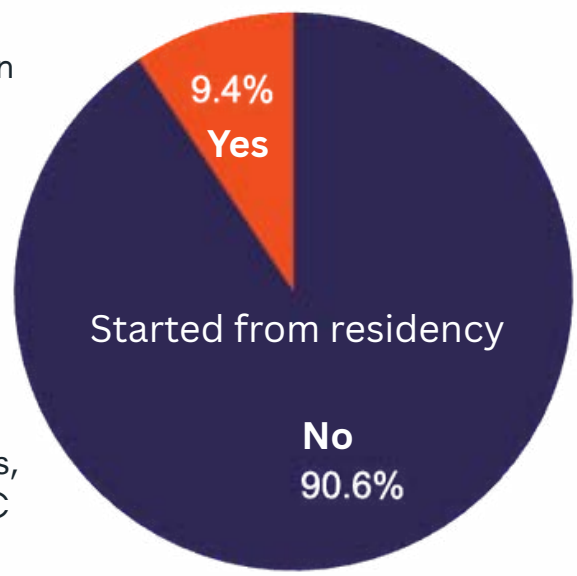
Ownership

Regarding practice ownership, the data shows strong entrepreneurial independence, with most respondents holding full ownership of their practices. Partnership arrangements are less common, including both equal partnerships and majority stakes, while some physicians work as employees or hold minority ownership positions. A small number operate under contracted arrangements. This ownership pattern reflects DPC's appeal to physicians seeking autonomy and direct control over their practice models.

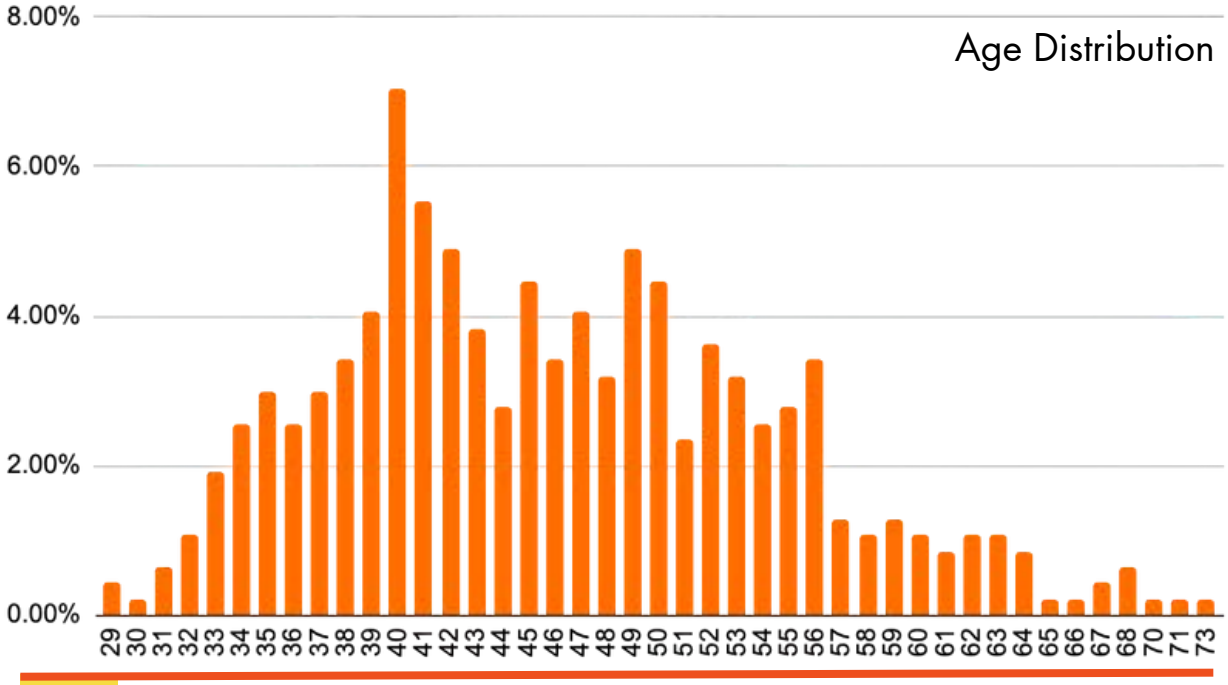
Age in DPC

The age distribution of physicians practicing Direct Primary Care reflects the model's evolution from a niche concept to a mainstream alternative.

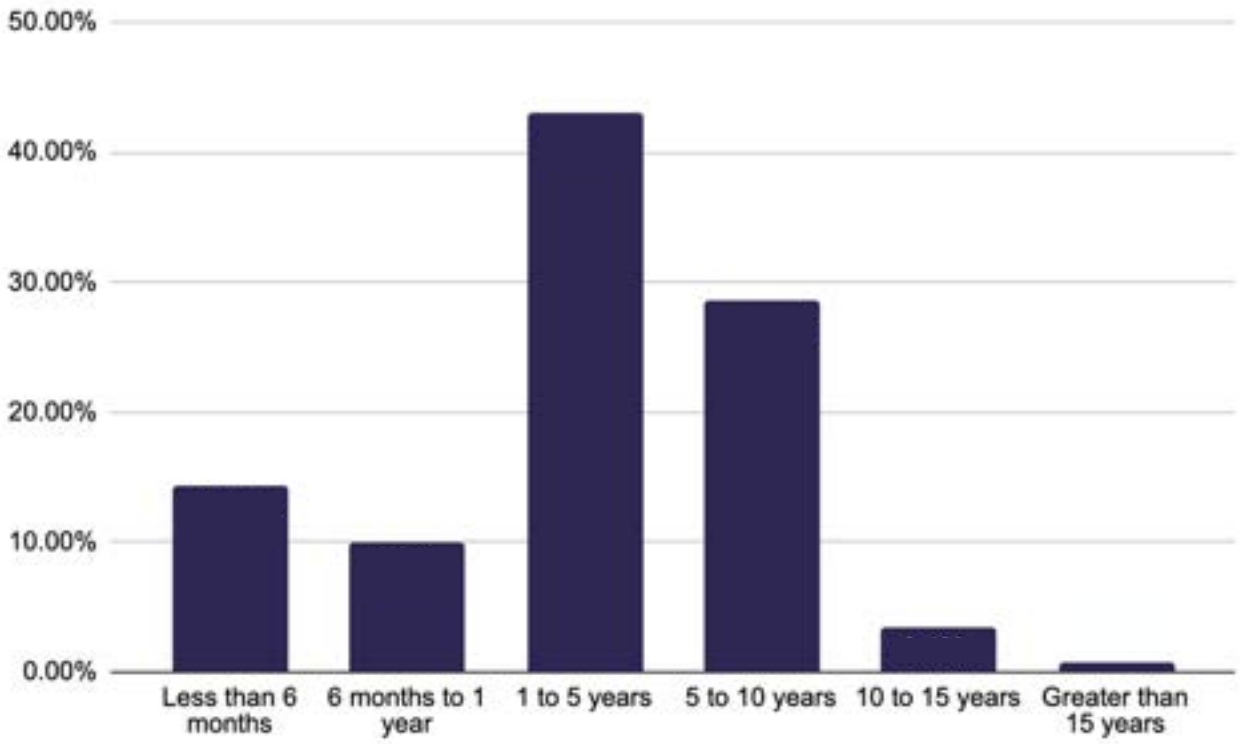
Respondents showed a mean age of 46 years with a median of 45 years. The distribution exhibited a right skew with a mode of 40 years, representing 7% of respondents, suggesting a concentration of physicians at a critical career inflection point. Ages ranged from 29 to 73 years, with nearly 10% of respondents starting their DPC straight out of residency.



This age profile aligns closely with DPC's historical trajectory: while the model emerged in the late 1990s, its significant growth occurred over the past decade, coinciding with the career stage when many current practitioners were seeking alternatives to traditional fee-for-service medicine. The substantial representation of younger physicians entering DPC immediately after training indicates the model's growing acceptance among newly minted doctors who view it as a viable primary career path rather than solely as an escape from burnout in traditional practice settings.



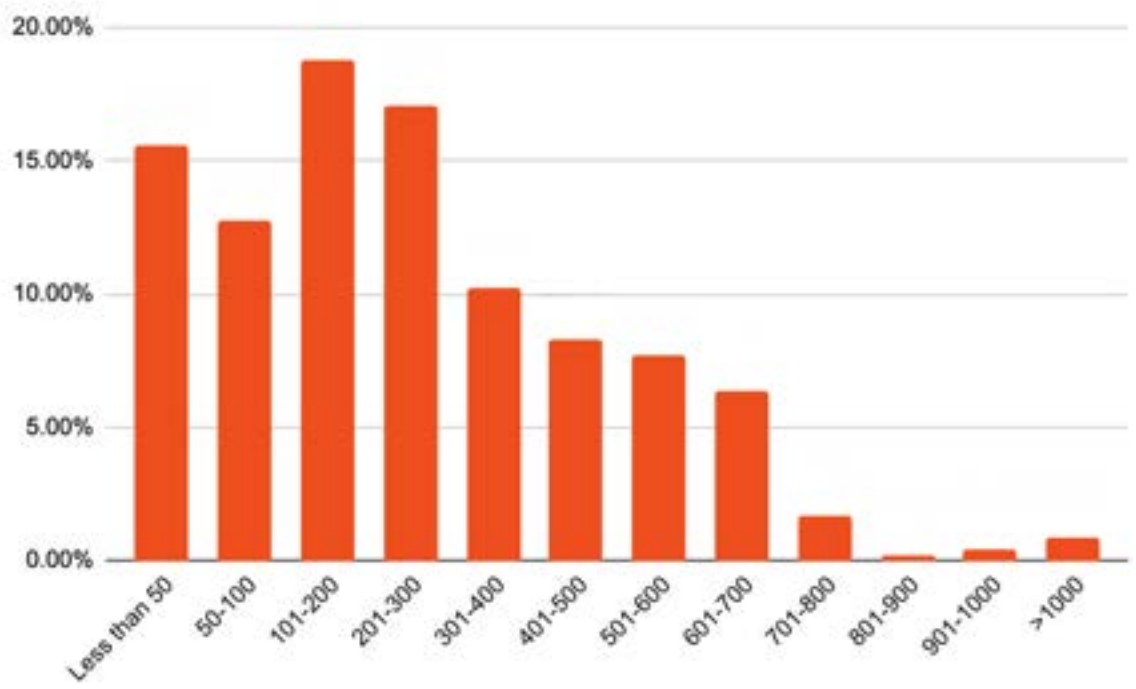
Practice Age



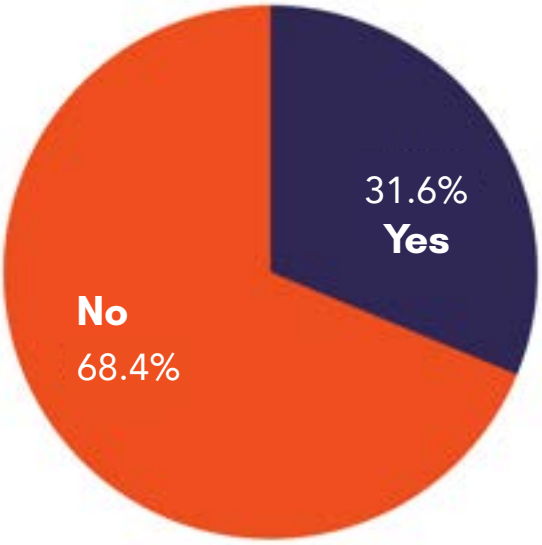
The age distribution of DPC practices reveals both the model's sustained momentum and recent surge in growth. Practices less than six months old were separated out to indirectly capture the pace of new adoption, offering a real-time glimpse into how quickly new clinics are opening. Combined with those open less than a year, this group represents a significant portion of the sample, underscoring continued expansion. Most practices fall within the one to five year range, aligning with the broader rise of DPC in the past decade.

A small number have been open for over ten years, true pioneers who helped shape the model early on. Their lower representation may reflect retirement, transitions out of practice, or limited engagement with the online networks through which the survey was distributed. Practice age of this survey sample is a key consideration when interpreting other data points, such as patient panel size.

Panel Size



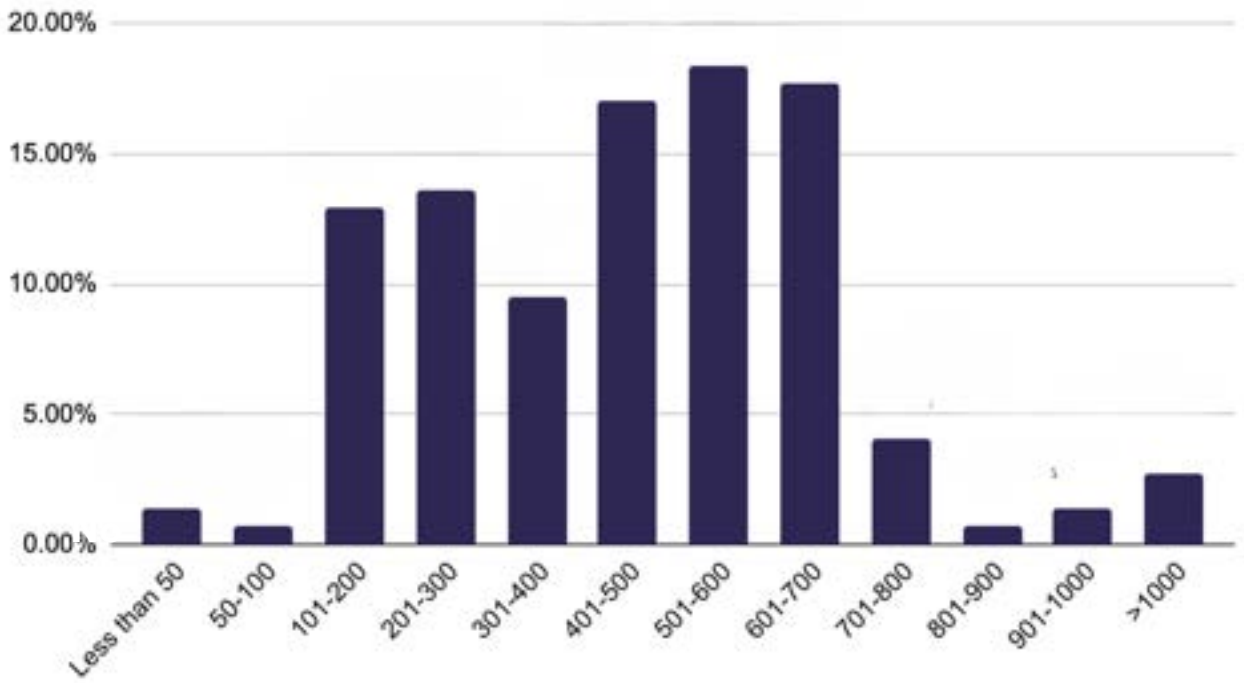
Is your panel full?



Patient panel sizes among DPC physicians vary widely, with the majority of respondents managing panels well below the often-cited word-of-mouth benchmark of 600 patients. In fact, only a small fraction report panels exceeding that number. This discrepancy likely reflects the relative youth of many practices, as noted in the previous section. Supporting this, nearly 70% of respondents reported that their panels are not yet full. While the survey did not define what constitutes a "full" panel, leaving it to physician interpretation, the data suggest that many practices are still in growth mode. As a result, the average panel size may be skewed lower than what might be seen in more mature practices

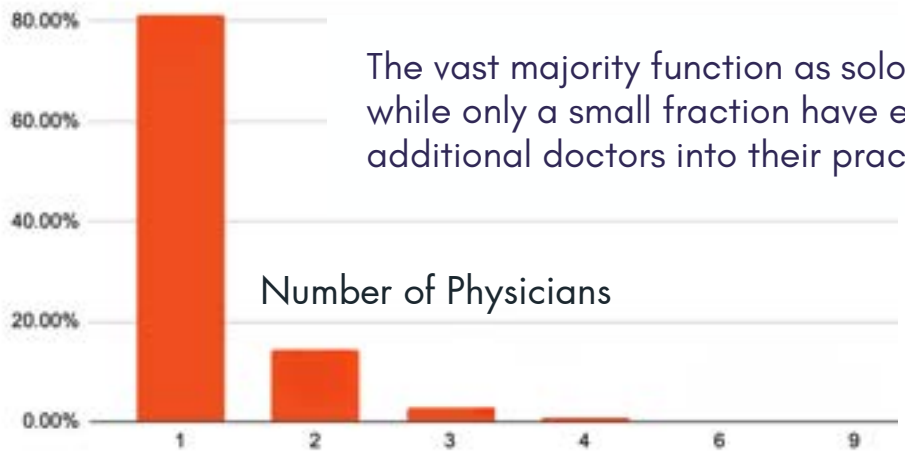
Mature Panel Size

When isolating only those physicians who reported having a full panel, the data shifts notably, offering a clearer picture of capacity among mature or stable DPC practices. In this group, panel sizes cluster more closely around the 400-700 range, aligning more closely with the commonly cited 600-patient benchmark. However, a small number of physicians reported full panels under 200, which may reflect those working part-time, balancing side gigs, or focusing more on administrative, leadership, or non-clinical roles within their practices. This variation highlights the flexibility of the DPC model, where "full" is defined not by a standardized number, but by each physician's unique goals, availability, and practice design.



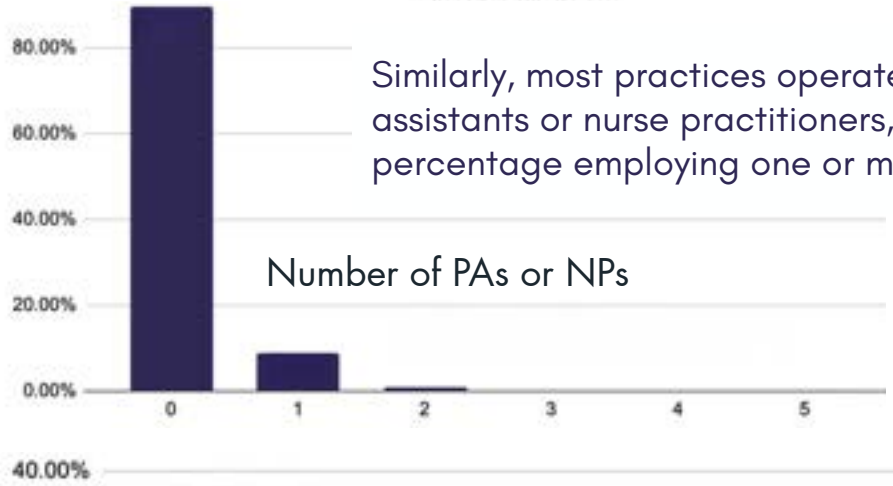
Staffing

Given that the overwhelming majority of respondents (89.3%) operate single-location practices, the staffing analysis on this page focuses only on these practices.



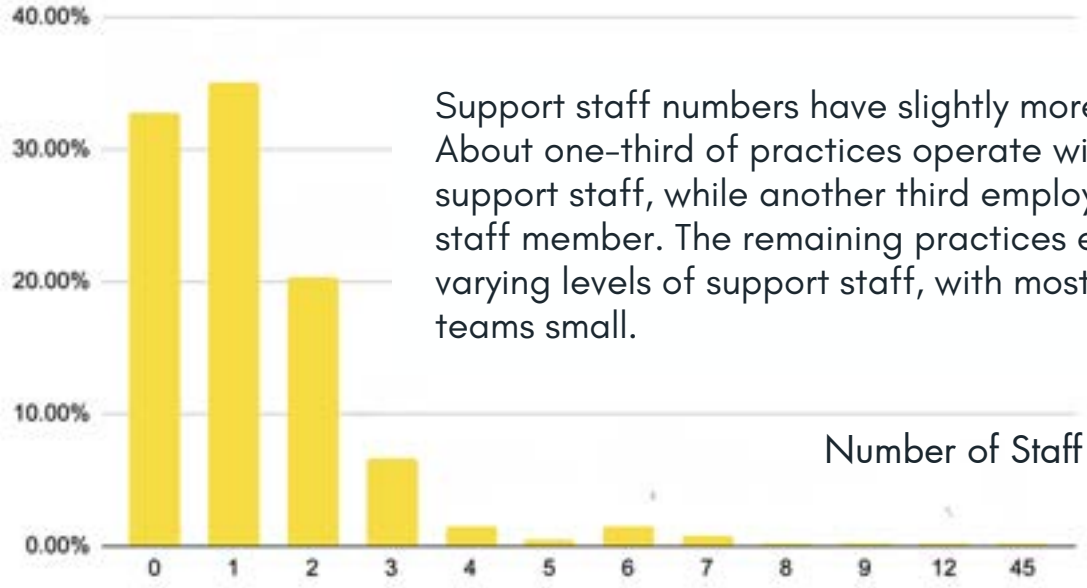
The vast majority function as solo physician practices, while only a small fraction have expanded to incorporate additional doctors into their practice structure.

Number of Physicians



Similarly, most practices operate without physician assistants or nurse practitioners, with only a small percentage employing one or more mid-level providers.

Number of PAs or NPs



Support staff numbers have slightly more variation. About one-third of practices operate without any support staff, while another third employ just one staff member. The remaining practices employ varying levels of support staff, with most keeping teams small.

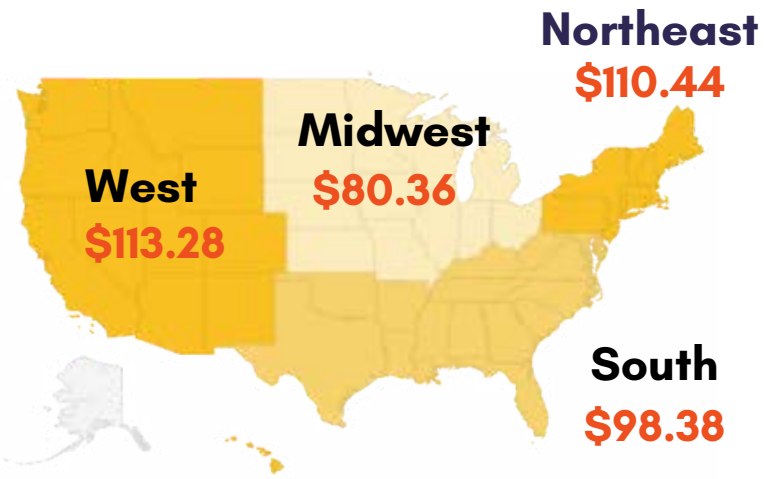
Number of Staff

Pricing Tiers

Historically, tiering based on age has been the default, which is reflected as the most prevalent type at 76.4% of practices. No tiering came a distant second at 15.1%. Family tiering was defined as price per member changing based on number of family members who joined together. This represented only 8.5% of practices and is one of the newer tier strategies that has emerged.

Pricing by Location

All prices are per member per month



Compared with the Northeast, monthly prices were significantly lower in the Midwest and South. Prices in the West were about the same as the Northeast.

Rural practices charged significantly less than urban practices. Suburban prices were not statistically different from urban practices.

Rural
$81.56

Suburban
$99.78

Urban
$110.00

Pricing by Practice Attribute

Panel size (% of respondents)

Practices with smaller panels tend to report higher pricing, while ones with larger panels appear to charge less. This may reflect a natural supply-demand effect or represent older practices not raising prices over time and/or the location of older practices compared to younger ones.

Price based on practice age shows less consistency than panel size. All the other factors seem to have more expected pricing.

Practice Age (% of respondents)

Across all categories, the national average per member per month price for DPC practices was $98.64. Panels of greater than 500 was the lowest priced group, and the West region was the highest.

Overall Average

$98.46

Acknowledgements

The collection of this data was a collective effort by the entire DPC community. The report would not have received nearly as many responses without the entire community sharing the survey with friends and colleagues. A sincere thank you goes out to everyone who participated. This level of collective engagement is what makes this report especially meaningful.

This report was written and illustrated by Kenneth Qiu, MD, who served as Chair of the Member Insights Committee of the DPC Alliance at the time the survey was collected. The Member Insights Committee included Rebekah Bernard, MD and Emily O'Rourke, MD who helped craft and distribute the survey, evaluate the data, provide insights, and proofread the final report.

Special thanks to Rebecca Etz, PhD, for helping review and validate the survey questions; Alison Huffstetler, MD, for leading the data evaluation effort; and Shikha Chandarana, PhD, MS, for performing the statistical analysis.

About the DPC Alliance

The Direct Primary Care Alliance is a national membership organization dedicated to advancing Direct Primary Care and supporting the physicians, practices, and advocates working to strengthen this patient-centered model. Through education, resources, advocacy, networking, leadership development, and partnerships, the DPCA helps DPC practices grow and thrive outside the traditional insurance-based billing system. At its core, the Alliance supports a grassroots movement focused on restoring the patient-physician relationship through transparent, affordable, and accessible primary care.

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