President Obama, ask the patient what they need!

04/20/09
For The Manhattan Institute Medical Progess Today
By Dr. Vic Wood of Primary Care One

My dad was an old time family doctor. As a child he took me on house calls with him. He always made time for house calls no matter how busy his day was. I never heard him complain once about doing them. They took place late in the evening on weekdays or early in the morning on weekends. It was an enriching experience for both patient and doctor. Jokes were always told. Injections were frequently administered. And patients generally received a parting prescription.

The patients welcomed us into their home as "family". They paid a few dollars; plenty to make it worth the visit for my dad. My dad didn't complain that payment was not enough. Patients didn't complain that the cost was too high. When a patient needed care that was more sophisticated, he or she was admitted to the hospital.

When his patients were hospitalized, I remember almost everyone had insurance to cover them. If they didn't, their stay was not an automatic path toward bankruptcy. This was the state of medicine before the insurance industry turned course to profit from both hospital stays and primary care.

The insurance industry moved to consume healthcare in the 1970s. They systematically worked to enact state laws to protect their product from the real free market competition, doctors. Today, doctors perceive the insurance industry to be a Tower of Babel mired in bureaucracy, no different than any other bureaucratic behemoth such as the government. As far as the doctor is concerned, both stand between the doctor and the patient.

The insurance industry helped enact laws that severely restricted access to anyone who did not participate in the insurance model. In my state, West Virginia, restrictions to care that dictate the kinds of services doctors can offer to patients are embodied in Chapter 33 of the state code. I cannot believe our public servants intended to restrict care. But that is what happened.

Insurance is designed to pool risk. By design, many must pay in while only a few receive the benefits. Accordingly, we have car insurance for major collisions; but we do not have car insurance for routine maintenance such as changing your oil or buying gasoline. The insurance model unraveled when it expanded beyond catastrophic care in the hospital and entered the physician's exam room.

Now, insurance covers routine costs that used to be paid out of pocket. This turns insurance into prepaid health care, a radically different proposition. How then could the insurance industry maintain any profits? Simple: increase premiums and decrease reimbursements to physicians. This works for a while. But, when insurers raise rates, the insurance pool contracts as younger and healthier people drop out. Also, many med school students are

avoiding primary care in favor of more lucrative specialties; some current primary care docs are retiring early in protest of the low rates and red tape from insurers. The family medicine my father practiced is a dying profession.

How does health care reform fit into the equation? Even if the federal government decides to embrace universal coverage through an individual insurance mandate and extensive subsidies, the current model is fatally flawed. By covering too much, insurance promotes a vicious cycle of rising costs and a declining base of paying customers in private insurance markets. Medicare and Medicaid, the public insurance programs for elderly and poor, are no different: ever more doctors are refusing to accept these patients, leading to insurance but no health care access.

In 2003 I had had enough even though I had only been practicing medicine for 15 years. I had seen the third party payers go from fee for service, to HMO, to capitation, and now back to a hybrid fee for service/HMO model where a code dictates what you are paid no matter what you charge.

Today, health care is the only industry where you are not paid "market rates". The system ignores your costs, such as utilities, payroll, and administrative costs, details that have only gone in one direction-up. The doctor who gets it wrong more often than right gets paid more than the doctor who gets it right the first time.

To compensate for lower reimbursements, doctors must turn each office visit into an ATM machine. The system offers completely perverse incentives. I was saddened when I saw my patients' health deteriorate precisely because of insurance rules and pre-authorizations delays. I became angry when patients who had chronic disease couldn't access care because they couldn't afford any insurance product. I became disgusted when I learned my patient, hospitalized in the ICU, was told that he had 2 days to get to an "insurance approved" hospital or he would have to pay the enormous bill himself. He died the next day.

As a provider, if you refuse to stomach the discounts demanded by insurers, you are dropped from the network. In many areas the insurance carrier might cover as much as 50% of your patient population, so that's not an effective option. In my area, the only HMO and largest insurer has a rule: Quit once and then you are excluded from their plan. Forever.

In 2003 I decided it was my responsibility to not only give care to my patients but to provide them access to care. I developed a system designed to give the patient access where and when they needed it most. A system that, for one monthly fee, gave them unlimited access to my clinic. For that same monthly fee they would also receive their labs, X-rays and generic medications for acute problems. One price: $83 a month for an individual and $125 a month for a family. Extended hours during week days and 8 hours on both Saturday and Sunday keep them out of the emergency department. A twenty-four hour call schedule gave the patients guidance, from a provider, for their healthcare needs. I was not trying to be an insurance company or a hospital. I was trying to do my job. Just like my father did.

When I started Primary Care One, I found patients who were craving affordable access. Patients who thought that they were never going to be able to afford regular care because of their chronic disease. The insurance companies had locked them out of the doctors' office because of their "pre-existing conditions". The bulk of the patients were the working poor, averaging 42 years old. One third of the patients had chronic disease.

The insurance industry did not like me "selling insurance". The insurance commissioner said I was violating criminal statutes and could be imprisoned. After thousands of dollars and as many hours in the state legislature, I prevailed. Now hundreds of patients have access to my system, Primary Care One, for the same monthly price regardless of pre-existing conditions. Yes, my system does not address transplants or chemotherapy. That is what real insurance was designed to address.

What have I learned? Patients are happy with the Primary Care arrangement. They receive the care they need before conditions progress into an emergency room visit. Patients have peace of mind knowing they will not be bankrupted by their primary care needs. I am also happier. My patients stay healthier. I have the luxury of spending more time with my patients; the incentive being to get it right as much as possible the first time. And I require fewer staff doing battle with insurance carriers to process claims.

The healthcare "debate" thus far has consisted of third party payers insurers or the government telling patients and doctors what they will pay for. The patients' voice is absent and the doctor's voice is being drowned out by price controls and red tape.

I hope that instead of working to provide "insurance" for everyone, the Obama administration will focus on the real challenge access to health care. This can be achieved by returning insurance to a vehicle for catastrophic care, and letting doctors and patients work out their own payment arrangements for better primary care.