

Scenario #5 – Dr. Martha Middleton, Family Physician

Dr. Middleton is in her sixth year of private practice, has \$160,000 of debt left to pay off from medical training. She works four days a week in a practice with a group of 5 other family physicians. They each earn @ \$80,000/year. She has 1 child, age 3 at home with a nanny. Martha's husband works in new construction, but since the housing market slump has been going farther away from home to find work.

She and her colleagues are assessing how many Medicare and Medicaid patients they can afford to carry on their books due to the low reimbursement rates for each category. With fewer family physicians willing to take Medicare patients in their community, they are under a great deal of personal and ethical pressure to see more of the elderly. In order to make the financial numbers work, they must see a maximum number of patients with private insurance each day in the shortest amount of time. The brevity of contact is counter to their original reasons for going into family practice—starting out with young families and seeing them into their old age. The number of staff needed to handle the billing and paper work has increased as well.

Dr. Middleton is politically active and wants to see as many uninsured patients as possible, but when she averages out the reimbursement, she often receives reimbursement that is 50% or less of cost. The doctors are also faced with the developing trend of patients wanting referrals to specialists for conditions that they feel they are more than qualified to treat. They believe that this is the result of insurance companies selling “no need for a referral to see a specialist” programs in order to attract members.

Medical System Frustrates Doctors Too

From Health Systems Unmasked (Internet site) November 13, 2007
by Jacqueline L. Jones

There was a time when I hated mainstream medical professionals. Wouldn't YOU get a little surly after repeatedly hearing that you were a hypochondriac in spite of the fact that you had a persistent fever of 104 degrees, your ankles were so swollen you couldn't walk, and you couldn't lift your hands over your head or do dishes? How could you avoid feeling a little smug when you fixed much of the problem without them, and most of them didn't know enough to know anything was wrong?

My attitude is beginning to change thanks to the book *How Doctors Think*. Dr. Jerome Groopman, the book's author and a medical researcher, Harvard professor, and journalist, says that though some insensitive physicians make snap decision that harm patients, most started off as caring professionals and have become jaded by dealing with the system.

Insane restrictions from insurers and equally insane control by pharmaceutical companies along with time restrictions dictated by practice managers have created a prescription for disaster. Unfortunately, insensitivity

only adds to the problem, but I can't say I'd have a different attitude under the circumstances. I hate to say it, but I'm beginning to empathize with them.

Disease Care Wastes Money and Lives

From Health Systems Unmasked (Internet site) November 13, 2007
by Jacqueline L. Jones

We buried my aunt last Saturday as another group of relatives gathered in a different city to bury her best friend, a cousin, at the same hour. They were two victims of chronic illness, and both had access to medical care. My aunt received treatment at one of the best medical centers in the country. I don't know the specifics of the cousin's care.

Chronic illness often affects several parts of the body. My aunt's case was no exception. As each body system manifested its own crisis, the attending physician of the moment sent her to a hospital specializing in that area. I lost count of how many transfers she endured. Surely travel fatigue hastened her death.

This saga highlights the real health care debate in this country. While we read stories of people who lack access to care, my aunt had access to care that did not serve her needs, but the physicians were willing to serve because the government was willing to pay.

According to The World Health Organization (WHO), the U.S. government, insurance companies, and individuals in this country spent an average of \$6,096 on each person who had access to the system in 2004. Canada's government-run universal system, in which most services are provided by private companies, spent \$3,038. Canada ranked 30th in system performance among 191 nations in a 2000 WHO survey; the U.S. ranked 37th.

Though the reason for these disparities is unclear, one fact is certain: prevention and early intervention can save billions of dollars and countless lives. Florida Hospital in Orlando implemented a self-care program with a booklet and flow charts that instructed employees on how to prevent certain illnesses and when to seek professional help. The program reduced clinic and emergency room visits by \$60,313 or \$75.30 per person in five months.

Most health care plans in this country, even for those who have access, lack extensive coverage for prevention and early intervention. Equal access to a broken system is not the answer.

Barriers to diabetes care

(Townsend Letter for Doctors and Patients, May, 2007 by Jule Klotter)

US family physicians, who care for about 90% of the nation's diabetics, face a difficult battle adjusting medications and monitoring patients for kidney disease, peripheral neuropathy, leg ulcers, and diabetic retinopathy during brief office visits. Education about nutrition and self-care help people with diabetes avoid these serious complications.

Unfortunately, the health system in the US is set up to deal with acute rather than chronic disease and does not support preventive measures. Patients

without insurance and/or with low incomes face an added challenge. Even if they understand the importance of monitoring blood sugar levels and seeing their physician, low-income diabetics cannot afford it. As one family physician told J.B. Brown and colleagues, "Diabetes is a fairly expensive illness. The testing, the medication, the diet and the frequency of visits."

During the late 1990s, four New York City hospitals set up "boot camps" for diabetics. At these education centers, diabetics learned about the consequences of uncontrolled diabetes, how to check their blood sugar levels accurately, and how to use nutrition to keep those levels more stable; they also began an exercise program. Specialists in endocrinology and ophthalmology monitored patients for disease progression. Within seven years, three of the four centers had closed because they were losing too much money. The fourth one at Columbia University Medical Center relies on generous donors to stay open.

Medicare Reimbursement to Physicians

From the American Academy of Family Physicians, February 10, 2005

This statement is submitted on behalf of the 94,000 members of the American Academy of Family Physicians to the House Ways and Means Health Subcommittee as part of its hearing on Medicare reimbursement to physicians.

The AAFP appreciates the work of this subcommittee to examine the issue of how Medicare reimburses physicians services and we share the subcommittee's concerns that the current system is unproductive. This fee-for-service system as presently constructed rewards increased volume of services whether or not these services enhance quality outcomes for Medicare beneficiaries. Such a system of physician reimbursement by itself and without improvement is unworkable and unsustainable over the long-term.

This is why the AAFP supports the restructuring of Medicare reimbursement to reward quality and care coordination. This restructuring must be built on a fundamental reform of the underlying fee-for-service reimbursement system.

Family physicians have a unique perspective on the effectiveness of the Medicare system. After all, the majority of Medicare beneficiaries who identify a physician as their usual source of care report that they have chosen a family physician. Family physicians take very seriously the obligation to provide the best health care possible to our Medicare patients. But Medicare reimbursement policies are challenging the ability of family physicians to fulfill that obligation.

The American Academy of Family Physicians supports congressional action to replace the formula known as the sustainable growth rate (SGR) used to determine the annual updates in the Medicare Physician Fee Schedule (MPFS) conversion factor. Above all, the reimbursement system should be designed to ensure that Medicare patients can continue to receive the care they depend on and deserve.

Congress must act to protect the stability of the ambulatory care portion of the Medicare program which is essential to meeting the medical needs of our

nation's seniors. Without action to fix the SGR, these insufficient updates will continue to disproportionately affect primary care offices relative to other subspecialties because of higher overhead costs.

Is There a Doctor in the House?

A look at the family doctor shortage in North America

From Medhunters.com – an Internet site April 2007 by Sheng Wang)

In a 2006 report entitled *The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care*, the American College of Physicians (ACP) warned that there is a severe shortage of primary care physicians (family doctors, pediatricians, and internists) in the United States. The situation is equally dire in Canada. According to a November 2, 2006 article from CBC News, five million Canadians, or 17% of the population, do not have a family doctor. Furthermore, nearly two million of those people have tried, and failed, to find a family physician in the past year.

This shortage of general practitioners has widespread implications for patients, doctors, and for the American and Canadian healthcare systems. Not having timely access to a family doctor leads to the overuse of emergency rooms, later diagnoses, difficulty in getting referrals to specialists, and poor management of chronic health problems. Ultimately, it results in poorer health across the country, as well as higher healthcare spending.

Since the baby boom generation will soon be relying on their GPs to care for them in their old age, the problem is expected to worsen. However, family doctors themselves are an aging population. An American Medical Association report found that one-third of US family physicians were over the age of 55, and most of those practitioners were expected to retire within 10 years. Furthermore, there will be fewer new graduates to replace them. According to a study by the American Academy of Family Physicians (AAFP), the number of medical students choosing family medicine has dropped by half between 1998 to 2003.

Even as the demand for family doctors increases, medical students are eschewing general practice in favor of better paying and more glamorous specialties. According to an AAFP study, in 1999, the average American pediatrician saw 122 patients per week and earned \$137,800 per year, while the average gastroenterologist saw 90 patients per week and earned \$299,200. Since the average American medical student is graduating with \$120,000 in debt, it's not hard to see why family medicine is losing its appeal.