

# From the President:

## Saving Private Practice

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"If you want to lower administrative costs, fire the administrators." Thus spoke Merrill Matthews, Ph.D., of the National Center for Policy Analysis (NCPA) in Dallas. He said this in 1995 at a seminar on medical savings accounts, a concept that has proven more valid now than ever.

Something is happening to the delivery of medical care in the United States, and it appears that the administrators are winning the battle for the healthcare dollar. Is this a good thing for the practice of medicine, or more importantly, is this a good thing for patients?

An Accenture survey last year found that a great number of U.S. physicians are selling their private practices to work at large healthcare systems. "By 2013, less than one-third of U.S. physicians are expected to remain in private practice, and patients may increasingly find that being treated by physicians in private, small-practice settings may be a thing of the past."<sup>1</sup>

What factors have led us to this point? Is private practice doomed or is it possible to reverse the trend?

### Medical Care circa 1960

In 1960, families did not have first-dollar coverage for basic medical care. They paid cash.

I remember our family doctor, Dr. Alan Jacobs. He was a young general surgeon willing to do primary care to earn a living. I remember the distinct antiseptic smells in his office where he would treat our earaches and bellyaches and ask about our progress in school. He would come to our house when we were too sick to travel, and my dad would pay \$7 in cash. In 1960 the average income was \$5,600 per year, so that fee would be equivalent to \$60-\$70 today. I remember when he diagnosed my mother's rheumatoid arthritis by clinical examination and an erythrocyte sedimentation rate. My dad worked for the post office, so we had "hospitalization," essentially high-deductible catastrophic insurance. Our family of seven managed just fine.

Once his practice was established and his surgical skills were in greater demand, Dr. Jacobs took on an internist as a partner. They worked side by side for many years. Dr. Jacobs became Chief of Surgery at Overlook Hospital in Summit, N.J., before he retired. He was a much-loved, skilled physician.

### Third-Party Payment Brings Bureaucracy

By 1965, the way we paid for medical care had changed dramatically. During World War II, a tax benefit was created for employer-purchased health insurance, so this became the norm. Workers came to expect it and accepted whatever was given to them. They did not consider the cost, as it did not feel as though it was coming out of their own pockets. However, their paychecks were smaller than they otherwise would have been.

The government initiated Medicare and Medicaid and inserted itself in between the patient and physician. Politicians

promised that the programs would never tell doctors whom they could see, what they could do, and what they could charge. But this promise was quickly broken. Before long, the government could not resist meddling in the smallest of medical interactions.

The infusion of government money into the system attracted many entrepreneurs who wanted a share of the collective funding. Administrators, billers, coders, regulators, quality control experts, and fraud detectors were hired to assure the public that their healthcare dollars were being spent appropriately.

Analysis of the change in administrative overhead is complex. One way of looking at it is the ratio of outpatient administrators to practitioners. In 1971, the U.S. had about three administrators to every four practitioners, a ratio of 0.75 to 1. In 2010, the ratio was about 5.1 to 1, about a seven-fold increase. This is a significant underestimate, as it does not include information technology support.<sup>2</sup>

There is no evidence that the increased bureaucracy has enhanced quality, but there is plenty of evidence that it has increased the total cost of medical care and the proliferation of medical services of questionable value. Patients can be talked into having many medical procedures or getting many medical devices when they are not footing the bill.

Today we have the Patient Protection and Affordable Care Act (PPACA), probably the most deceptively named law in history. It will not protect or increase the access to medical care for those who need it most, and it will certainly not be affordable to rate-payers or taxpayers. It will only add more layers of bureaucracy onto a system that is already being crushed by HIPAA, CLIA, JCAHO, CME, DEA, CDS, MOC, MOL, OSHA, FDA, and other regulatory bodies that often seem to make up rules as they go along.

Private insurers are scurrying to position themselves in the new paradigm. They see the need to attract patients who will no longer be getting their insurance through their employers. Health insurers believe that physician-owned private practices are detrimental to their profit margins and will seek to control them by pulling them into their folds. They promise doctors that stepping away from "fee-for-service" and moving toward "value-based reimbursement" will eventually lead to greater income and satisfaction. Many doctors remain understandably skeptical. Many will retire early or simply quit.

In the cryptic language of an administrator, Kevin Arner, CEO of PaySpan, a Jacksonville, Fla., "health care transaction processor," said, "I believe physicians will get paid more, but probably not in the way they want it. I think there's an appropriate recognition of the value of their role."<sup>3</sup>

Should physicians feel reassured that administrators believe doctors still have an important role in delivering medical care? In the real world, administrators are concerned about lowering payments for care, but assuring that their own roles and incomes are firmly established.

## Reform: Free Market, or More of Same?

A fascinating article written by economist Milton Friedman in 1991 cited a British physician, Max Gammon. The government dollars infused into England's National Health Service provided an endless supply of takers so that the number of personnel per occupied hospital bed increased eight-fold between 1946 and 1965. This has been called "Gammon's Law of Bureaucratic Displacement." Bureaucracy always tends to grow and crowd out payments for actual services rendered. Gammon wrote that in a bureaucratic system, "increase in expenditure will be matched by a fall in production.... Such systems will act rather like 'black holes,' in the economic universe, simultaneously sucking in resources, and shrinking in terms of emitted production."<sup>4</sup>

In evaluating the U.S. healthcare system in 1991, Friedman recommended re-privatizing medical care. He believed that every family unit should secure a major medical insurance policy with a \$20,000 deductible per year, and that we should end the tax exemption for employer-provided health insurance. He noted that eliminating the government supervisory role of the smallest medical transactions would cut costs precipitously. The higher take-home pay of the employee would be more than enough to fund the everyday transactions to access basic medical advice and treatment. Friedman suggested that consumer spending on medical care could be reduced to the 5 percent it was before the government entered the arena.

"Families would once again have an incentive to monitor the providers of medical care and to establish the kind of personal relations with them that once were customary. The demonstrated efficiency of private enterprise would have a chance to operate to improve the quality and lower the cost of medical care," Friedman wrote.<sup>4</sup>

Friedman mused that this type of common-sense approach would displease the many who are engaged in administering the present socialized system. He noted that with an unsuccessful private venture, its backers will finance the losses out of their own pockets or shut it down. If a governmental venture is unsuccessful, its backers can use their powers of persuasion to convince legislators to draw on the deep pockets of the taxpayers, replenish their own, and expand the failed program. Unsuccessful government ventures tend to be expanded rather than terminated.

Recognized leaders in organized medicine do not seem to understand the dangers our patients or we physicians face. Jeremy Lazarus, president of the American Medical Association, released a statement on Jun 28, 2012, shortly after the Supreme Court ruled PPACA constitutional. He stated:

The expanded health care coverage upheld by the Supreme Court will allow patients to see their doctors earlier rather than waiting for treatment until they are sicker and care is more expensive. The decision upholds funding for important research on the effectiveness of drugs and treatments and protects expanded coverage for prevention and wellness care, which has already benefited about 54 million Americans.

The health reform law upheld by the Supreme Court simplifies administrative burdens, including streamlining insurance claims, so physicians and their staff can spend more time with patients and less time on paperwork. It

protects those in the Medicare "donut hole," including the 5.1 million Medicare patients who saved significantly on prescription drugs in 2010 and 2011. These important changes have been made while maintaining our American system with both private and public insurers.<sup>5</sup>

These sound like the tired arguments for single payer. The reasoning goes that once everyone is "covered," all will get more timely and efficient care. It is assumed that the physicians will not mind the increased patient load and decreasing payments. It is also assumed that physicians will become obedient servants of our Accountable Care Organization leaders, following all the "guidelines," and taking their positions on the assembly line of cookbook medicine.

In that same vein, I was recently made aware of a House Ways and Means Health Subcommittee hearing being set up by Chairman Wally Herger (R-Calif.). Rep. Herger is described as a staunch conservative, but he has been asked to lead in an area that is anything but conservative—a big government healthcare program. This hearing would include physicians, a rare feature these days. The description states:

[This hearing will] explore physician organization efforts to promote high-quality patient care. Understanding these initiatives will inform the Subcommittee as it continues to examine how to reform the Medicare physician payment system. The Subcommittee will hear from organizations representing the physicians who are at the forefront of patient care and therefore most knowledgeable about what may be needed to optimize care for Medicare quality and beneficiary health outcomes.<sup>6</sup>

It is clear that once the government is in the business of funding every aspect of medical care for a huge population, there must be oversight lest funds disappear without a trace. But perhaps we are seeing proof that provision of medical care is truly outside the capabilities of federal officials.

I found the tenor of the description of this event to be insulting. It assumes that without government oversight, physicians are incapable of delivering high-quality care. They want to be sure that we are initiating "quality improvement" programs. These ought to be developed in medical schools and medical research—all possible without the government.

There is broad acknowledgement of the shortcomings of the current payment system, including the disruptive role of the SGR, and the growing importance of incentivizing patient-centered, high-quality, and outcomes-oriented care.<sup>6</sup>

Do physicians really need the government to incentivize them to deliver better care? Or do patients and families provide enough motivation? We are motivated to do the best we can for the patients we come to know and care about. What it appears they are doing is working to develop the Accountable Care Organizations, where all physicians will be under the thumbs of government regulators.

Recognizing that physician input is key to successfully incorporating quality and efficiency, the Subcommittee seeks to understand what physicians believe is meaningful to measure, what constitutes good practice in the care of patients, and what changes are needed to improve their practice environment.<sup>6</sup>

## Restoring What Works

Back in 1988, my husband and I secured a building, configured it into a medical office, put up a sign, and began seeing patients. In the early days, we made appointments from home and had outside jobs, but eventually were able to hire the staff needed to run an independent practice. We signed only one HMO contract, which we ended when it was taken over by a less physician-friendly company. We have been able to build a practice that is satisfying, charging what we need to charge to pay our expenses and earn a living. We do not have to charge the uninsured more in order to make up for the predatory underpayment by powerful insurers and Medicaid. We are clearly swimming upstream, but we love what we do and have actually been able to also establish a non-government free clinic to care for the poor at a location apart from our practice.

The lives of practicing physicians have been complicated by ever-burdensome regulations and pressures imposed by the physician-administrator-educator class. Specialty board certification was developed in the 1970s and has morphed into a multibillion-dollar industry with re-certification being demanded in the name of enhancing quality care. A case should be made that each patient encounter enhances our experience, and continuing medical education requirements are sufficient to keep physicians up to date. These re-certification burdens ought to be eliminated. No one can prove that taking another exam every few years will make a physician a better clinician.

Dr. Jacobs never re-certified. He just plied his trade and improved over time. The time away from our practices, the pressure to re-learn information that is not clinically relevant, and the exorbitant expenses incurred are all reasons to end the re-certification racket.

Students in medical school want to do primary care. Many would like to see themselves as modern day Marcus Welbys—appreciated, respected, and able to earn a comfortable living while making a significant difference in the lives of patients they come to know throughout the years. They would love to follow in the footsteps of physicians like Dr. Alan Jacobs. But times are tough, and the average student debt is \$200,000. At 6.5 percent interest they are looking at \$1,000 per month in interest payments alone. This incentivizes students to enter specialties with higher financial rewards. Primary care is at the bottom of the list.

Primary care is the specialty that is the most cost-effective. A good internist or family practitioner can diagnose and treat 90 percent of what he sees in his office. If 70 percent of young physicians were trained in family medicine, general internal medicine, or pediatrics, and if they could be freed from the bureaucracy of government and insurance company meddling, oversight, and underpayment, our healthcare system would become efficient. This would require a change in the mindset of the patients and a change in the government mandates on insurance. As Friedman suggests, we should obtain high-deductible insurance to protect against the catastrophic illnesses, and use simple fee-for-service direct payment for most illnesses. Even with the student loans factored in, young doctors could have a financially viable practice.

Since its inception in 1943, the Association of American Physicians and Surgeons has had as its mission the protection of

the private patient-physician relationship. This means that we will identify and oppose any government or insurance company action that would cause a breach in this personal interaction. Any time an authoritarian entity would cause a physician to act against his own conscience, it must be opposed.

We favor the payment for medical services at the time of service, a clean transaction that avoids bureaucratic oversight and its concomitant hidden fees. We oppose having to subsidize extra administrators who second-guess our every recommendation and action. They did not go to medical school and do not add value to what we do.

It is time for physicians to take the reins away from those who would try to control us to the detriment of good patient care. The nation must decide whether it is willing to have a healthcare “system” run by administrators, or if it wants to return to the time when families could establish a relationship with a trusted physician who would guide them through a complicated maze of medical options. Choosing a family physician ought not to be done by looking through a book of “providers” in one’s insurance plan. Patients ought not to be changing doctors when their employers find a lower-cost plan.

## Conclusion

AAPS believes we must reject the commonly accepted idea that the days of personalized private medical care can never return. We must not allow ourselves to be controlled by legislators, insurance executives, hospital administrators, and others who do not actually touch the patients. Patients do not need physicians whose minds are throttled, but well-trained physicians with the freedom to do what is in the best interest of the patients sitting in front of them.

The private practice of medicine is not dead, and it is in the best interests of patients and physicians to save it from extinction.

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