How Medicare Killed the Family Doctor

By Richard M. Hannon

I work for a health-insurance company, and my brother is a primary-care physician. As he tells it, my industry is responsible for the death of his. Insurance companies, he argues, have killed primary care by grinding down reimbursement and compelling doctors to see more and more patients just to make a living.

> Low government payment rates became the private-sector benchmark, resulting in fragmented care.

I sympathize with my brother, because I know that doctors' business with insurers isn't always easy. I'm also aware of the market's price sensitivity—and reimbursement paid to doctors comes from premiums paid by customers. Insurers must keep costs down.

Remember Marcus Welby, M.D.? He defined the family doctor on TV in the 1970s, exemplifying the four Cs: caring, competent, confidant and counselor. In the mid-'60s, I remember my father-in-law, a real-life Dr. Welby, telling me the exciting news that the federal government was going to start paying him to see seniors—patients who before he had seen for the proverbial chicken (or nothing at all). That fabulous deal was Medicare.

Medicare introduced a whole new dynamic in the delivery of health care. Gone were the days when physicians were paid based on the value of their services. With payment coming directly from Medicare and the federal government, patients who used to pay the bill themselves no longer cared about the cost of services.

Eventually, that disconnect (and subsequent program expansions) resulted in significant strain on the federal budget. In 1966, the House Ways and Means Committee estimated that by 1990 the Medicare budget would quadruple to $12 billion from $3 billion. In fact, by 1990 it was $107 billion.

To fix the cost problem, Medicare in 1992 began using the "resource based relative value system" (RBRVS), a way of evaluating doctors based on factors such as education, effort and specialized training. But the system didn't consider factors such as outcomes, quality of service, severity or demand.

Today most insurance companies use the Medicare RBRVS because it is perceived as objective. As a result of RBRVS, specialists—especially those who perform a lot of procedures—do extremely well. Primary-care doctors do not.

The primary-care doctor has become a piece-rate worker focused on the volume of patients seen every day. As Medicare and insurers focused on trimming the costs of the most common procedures, the income and job satisfaction of primary-care doctors eroded.

So these doctors left, sold or changed their practices. New healthcare service models, such as the concierge practice and the Patient-Centered Medical Home, drew doctors away from the standard service models that most patients rely on for coverage.

All of these factors have contributed to a fragmented, expensive health system with most of the remaining doctors focused on reactive instead of preventive care.

The solution to the problem is making primary-care physicians the captains of the ship. They must have the time and financial resources necessary to take care of their patients, tailoring care to patients' specific conditions and needs. And they need the data to track their patients' results, so they can guide patient progress. They will then be able to slow (and sometimes reverse) their patients' illnesses, keeping them out of hospital emergency rooms and specialists' offices. The end result: reduced costs and improved quality of care.

So who really killed primary care? The idea that a centrally planned system with the right formulas and lots of data could replace the art of practicing medicine; that the human dynamics of market demand and the patient-physician relationship could be ignored. Politicians and mathematicians in ivory towers have placed primary care last in line for respect, resources and prestige—and we all paid an enormous price.

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