

How Many Doctors Does It Take to Treat a Patient?

By PETER B. BACH

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In the mid-1990s I worked weekend shifts as a "moonlighting" doctor in a suburban Chicago hospital. When I would show up on Friday evenings, the other doctors would always say: "Peter, remember, no roundtrips on weekends." Translated, that meant no patients admitted over the weekend should go home before Monday afternoon at the earliest.

I soon understood the genesis of the "no roundtrip" rule. At the crack of dawn on Monday mornings, before their regular office hours, the doctors would go from room to room, providing consultations and filling out billing cards. Over time I learned that most of the patients had never seen the physicians who woke them before breakfast and were under someone else's care.

This spring my colleagues and I published a study of Medicare in the *New England Journal of Medicine*, showing that what happened in the Chicago suburbs actually happens nationwide. Medicare patients bounce between many doctors, most of whom are unaffiliated with one another and, as a result, few patients have a single doctor who is central to the care they receive.

The typical Medicare patient in one year sees seven different doctors, including five different specialists, working in four different practices. For vulnerable patients with multiple chronic conditions, care is even more fragmented and involves more doctors. Forty percent of the patients in our study had seven or more chronic conditions and they saw on average 11 doctors in seven practices; the upper quartile of this group saw 16 or more different doctors in nine or more different practices.

Health care is like this because of the way doctors are paid. Few doctors receive an hourly rate or a set annual salary; most are paid according to a system called "fee for service," in which visits, tests and procedures are reimbursed separately. Doctors face incentives to provide more services and more expensive services, and so they do just that.

The Office of the Actuary at the Centers for Medicare and Medicaid Services just reported that in 2007 total spending on physician services will rise more than 6%, as it has every year this decade. In 2008, we may very well top the dubious milestone of \$500 billion in spending on physician services in the United States, a number that nets out to about \$1 million in payments per practicing physician.

The government's finding that spending is rising could be seen as evidence that more patients are benefiting from the best medicine has to offer. But another government report, from the Agency for Healthcare Research and Quality, has a different message. Despite seeing many doctors, few patients get the treatments that are recommended for them, and few have their chronic diseases well managed.

For example, fewer than 30% of people with high blood pressure have it adequately controlled, according to the agency's most recent analysis of health-care quality. No surprise, really. Fee for

service incentives are linked to the number of services doctors provide, not the quality of those services.

Perhaps then our study's findings could be interpreted as a boon for patient choice? Not likely. From a clinical perspective, 16 or 11 or even seven different doctors treating a patient is no way to deliver high quality care.

Patients are best served when they have at most a few physicians who work together to develop and monitor a cohesive coordinated plan of care. In particular, patients with multiple chronic conditions do not need more doctors, they need a few who cooperate.

So why do Medicare patients see so many doctors in so many different practices? Again, the fee-for-service system can be blamed. The system rewards doctors more richly when they see other doctors' patients for the first time than when they see their own patients again.

So, costs are rising, quality is inconsistent, and care for the most complex and vulnerable of patients is fragmented. What needs to be done depends on which of these problems are viewed as a cause, and which as a consequence. Major physician organizations including the American College of Physicians and the American Academy of Family Physicians believe that the fragmentation of care is the core problem that drives up costs and reduces care quality. They propose that each patient should have a personal physician who will take responsibility for coordinating his care. Congress agrees with the vision, and has authorized Medicare to evaluate ways of implementing this "medical home" model for beneficiaries (Tax Relief and Healthcare Act of 2006).

But danger lies ahead. The notion that the fee-for-service system can be easily modified to make the "medical home" dream a reality is too tempting. For instance, one proposal is to add another fee to the long list physicians can already receive -- this one would be for "coordinating care." The leading idea for improving health-care quality also focuses on tweaking, rather than replacing, fee for service. Medicare is well on its way to paying physicians for services twice -- once when they provide the service, and then again if the service is appropriate for that patient.

But seismic changes in the care model, and radical improvements in the quality of care, cannot be achieved by piling other incentives on top of the system's existing incentives -- because the fee-for-service system is the real problem. If we are to improve the organization and quality of health care, and also control costs, we have to first unshackle doctors from it. Doctors should instead be paid in a steady manner to provide high-quality care in a "medical home" to their own patients, within a structure that integrates the judicious input of a few other physicians with whom they work regularly. Doctors should find it intuitive and appealing to get paid for care of the whole patient, not for atomized services that so often don't add up to the patient's best interests. There would be another nice benefit: on Monday mornings, both doctors and patients would get to sleep a little later.

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