The primary-care doctor is gaining new respect in Washington. Battles may be breaking out left and right over the various health-care bills emerging from Congress, but reformers on both sides agree that general practitioners should be given a central role in uniting the fragmented U.S. medical system.

This vision has a name: the “patient-centered medical home.” The “home” is the office of a primary-care doctor where patients would go for most of their medical needs. The general practitioner would oversee everything from flu shots to chronic disease management to weight loss, and coordinate care with nurses, pharmacists, and specialists. A 2004 study estimated that if every patient had such a home, the resulting efficiencies might reduce U.S. health-care costs by 5.6%, a savings of $67 billion a year.

Instead, most patients today get a scant seven minutes with a general practitioner, who has time to do little more than ask cursory questions and focus on the problem at hand. The patient rushes to specialists for chronic conditions that could be managed by a regular doctor. (Today, these different physicians rarely coordinate.) Last-minute appointments are almost unheard of — one reason patients with minor complaints flock to already crowded hospital emergency rooms.

This medical home may sound like the “gatekeeper” model of the 1990s, a managed-care creation that was all about holding down costs. But advocates say the new concept is designed to help patients, not insurers. It’s more like doctoring 1950s-style, when a Marcus Welby figure handled all the family’s medical needs.
needs. This time it's juiced up with digital technology.

It also represents a politically painless way to streamline a disorganized and wasteful system that chews up a crippling 18% of the U.S. gross domestic product. That burden is felt particularly by private industry, which covers 60% of the nation's insured. Since most businesses try to ferret out waste and disorganization in their own operations, the medical home is a concept they can embrace in good conscience.

One of the biggest advocates is IBM, which shelled out $1.3 billion last year on health benefits for its U.S. employees and retirees, equal to one month of the company's net income. Dr. Paul H. Grundy, 57, who holds the unusual title of director of health-care transformation for IBM, is a medical-home evangelist who led the company to start the Patient-Centered Primary Care Collaborative, a coalition of some 500 large employers, insurers, consumer groups, and doctors. Part of his goal, he says, is to show that "employers can drive the medical-home idea as buyers of care."

Four medical societies have also endorsed the concept, and pilot programs are under way in several states. Most significantly, the idea has the imprimatur of President Barack Obama, who has said any health-care bill should "encourage and provide appropriate payment for providers who implement the medical-home model."

The current practice of medicine in the U.S. is a long way from this model. One recent study found that only 27% of physician practices come close to qualifying as a medical
home. Still, for a real-world example, step into a nondescript building in Newport News, Va. There, Dr. Peter B. Anderson is examining Gretchen Parker, 72, his patient for 25 years. A year ago, Anderson warned Parker she was pre-diabetic, a condition that afflicts 57 million Americans. Instead of putting Parker on medication, his team helped her change her lifestyle and lose 55 pounds. Her blood sugar readings are now back to normal.

Anderson next examines a 46-year-old shipbuilder with a husky voice, the result of a three-pack-a-day, 30-year smoking habit. He quit last year—on Anderson’s advice—and today he’s in for a three-month checkup.

Later Anderson attends to an assistant high school principal and her 16-year-old son. She’d called only this morning because both had flu-like symptoms; the office always holds time open for same-day appointments. Anderson determines that the pair has colds, convinces them they don’t need antibiotics, and gets the mother to book an appointment in three months to check her high blood pressure. He even has time to discuss colleges with the basketball-playing son. By 6 p.m., he’s done for the day.

A SMARTER OPERATION
An ordinary day for Anderson, but extraordinary in the context of U.S. medicine. Unlike most primary-care doctors, Anderson and his team take ample time to counsel patients, guide them through lifestyle changes, and monitor chronic conditions with frequent checkups. He has helped patients avoid heart attacks, diabetes, and unnecessary surgeries by focusing on prevention and disease monitoring. He does all this while seeing 30 to 35 patients a day, compared with 20 to 25 for most practices. And he accepts Medicare. “This is what I always wanted to do,” says the 56-year-old Anderson, who converted to a medical home five years ago. “I’m seeing far more patients and delivering the best care I’ve ever done.”

Anderson has three full-time nurses on staff and one part-timer, where most doctors have one or two. The nurses spend much of their time updating patient records, a job that once ate up hours a week on Anderson’s schedule. “It takes a lot of time, but I don’t want to do any of that,” Anderson says. It helps that he has an electronic medical-records system, found in only 17% of doctors’ offices. Anderson also belongs to a group of 300 specialists and primary-care doctors, all on the same computer network, making it easier to consult with any doctor a patient may need.

Anderson’s nurses spend about 30 minutes with each patient on each visit, working through a long list of questions, assessing new health problems, and reviewing old ones. The nurses also discuss preventive measures and treatment options. Once Anderson takes over, he can spend the visit addressing a specific complaint and warding off future crises. To make sure he hasn’t missed anything, he has a nurse sit in with him and the patient during the exam, pointing out details in the medical record that a busy doctor could easily overlook.

As sensible as this routine may sound, it goes against the grain of most primary-care practices. Medicare and other insurers pay doctors on a fee-for-service basis that rewards quantity of care over quality. There are no reimbursements for discussing diabetes management with a patient,说, or talking over a case with a specialist. “The main hurdle to getting the medical home accepted more widely is the lack of compensation for cognitive work,” says Harvard Business professor Clayton M. Christensen, co-author of The Innovator’s Pre-
IBM’s Grundy is campaigning to change all that. There is some self-interest here, as IBM sells the electronic health-record systems that are a must for well-run medical homes. But Grundy, the son of missionaries who fought AIDS in Africa, also argues for social responsibility. He worries about the on-site clinics that many companies are establishing in an effort to control their health costs. “That’s just opting out,” he says. “We need to transform the system if we don’t want two-tiered health care.” IBM is working with several pilot medical-home projects around the country. The furthest along was started by Community Care of North Carolina almost six years ago, with 870,000 Medicaid recipients and 97,000 children enrolled. CCNC pays primary-care physicians in the experiment a premium of only $2.50 per patient per month to emphasize preventive, coordinated care. Yet a study by Mercer Human Resources Consulting Group estimates the state saved $161 million on health-care costs in 2006 as a result.

North Carolina aside, it is tough for many doctors to focus on coordinated care when there is no mechanism to pay them for their time. A nationwide switch to medical homes is also constrained by an extreme shortage of primary-care physicians, again because of the economics. Medicare reimburses primary care at a lower rate than any other specialty, so only 17% of medical graduates choose to enter the field.

Anderson insists it is possible to set up a profitable medical home with current reimbursements, but only by increasing patient volume. In fact, he made the switch strictly for economic reasons. “Even though I was working 50 to 60 hours a week, I wasn’t able to pay my bills, and one of my nurses was going to quit,” he says. “I had to increase my patient load.” A few years earlier he had heard a lecture about a Kentucky doctor who was able to see 50 patients a day after converting to a medical home. The efficiencies came from relying on a team approach, where nurses take on a lot of the record-keeping once left to the doctor. Trying the same model, Anderson hired an additional nurse, added some 15 patients a day, and was able to increase his annual billings by $200,000 to $620,000. He personally earns $240,000 and works 45 hours a week.

9%
Growth in medical costs U.S. employers face in 2009
Data: PricewaterhouseCoopers

Medical-home enthusiasts are lobbying for a change in primary-care reimbursements in any health-care bill that emerges from Congress, with a payment structure that rewards collaboration and prevention. They have a friend in Senator Max Baucus (D-Mont.), a key player in the health-care reform effort. As he points out: “Watching over a patient’s full medical history... is a quality measure and a cost-control measure.”

By Catherine Arnst
The business community has embraced the idea of health-care reform, hoping that Washington will come up with a method for reining in runaway medical costs. But Congress has spent most of its time so far focusing on ways to cover the 47 million uninsured.

All those ways call on businesses to finance expanded access through a “pay-or-play” mandate. That is, employers must either offer health benefits or pay a fine.

Pay-or-play isn’t sitting well with the business community, even though 99% of companies with 200 or more employees already offer health plans, as do 62% of those with 199 or fewer. “Employers are worried that government will dictate what they can offer and then hand them the bill,” says health benefits consultant Robert Laszewski.

Lobbyists and CEOs are arguing before Congress that pay-or-play would cause many employers to drop health-care benefits as too costly or lay off staff. Plenty of economists beg to differ. They argue that if overall health costs come down, that would offset the cost of insuring staff.

A report just out by Philip Cryan, an economist at the University of California-Berkeley, concludes that health-care reform may actually boost employment. His work was sponsored by the Institute for America’s Future, a liberal think tank, in partnership with the nonpartisan and respected Economic Policy Institute.

Cryan looked at all the various options under consideration by Congress at the moment. In his worst-case scenario—Congress enacts a high 8% “pay” penalty and no cost savings are achieved—166,000 jobs would be lost, or 0.1% of the workforce. But in the most likely scenario, there would be a net gain of 55,000 jobs. Why? New jobs would be created in health care, improved health would raise productivity; some employers who choose to pay rather than play would save money; and, again, the overall rate of health inflation would slow.

Small businesses in particular may come out ahead, according to a study just issued by MIT economist Jonathan Gruber for the Small Business Majority, a nonprofit advocacy group. Gruber estimates that small companies will spend $24 trillion on health care over the next decade if reform doesn’t happen, leading to a loss of 178,000 jobs in 2018.

He figures the various pay-or-play proposals could bring spending down as low as $1.8 trillion. The reduced spending would cut projected job losses by as much as 72%. “The notion that reform will lead to massive unemployment is simply unsupported by the data,” says Gruber.