



## **A Posit on the Cost and Effectiveness of State/ Federal Medical Care**

**"Economy and effectiveness of State/Federal health care like Medi-Cal and Medicare would be greatly improved by providing more compensation for primary care, and reducing compensation for procedure-intensive care."**

AMONG 134 RESPONSES, 80 agreed, 47 disagreed, and 7 commented without agreeing or disagreeing. Posits are contentious state-ments, usually overly simplistic, intended to encourage discussion among our members. The results are not a valid poll, and the opinions do not reflect the views of the editors, or the SSVMS Board of Directors. Commentary follows:

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"Tightening up on eligibility would help immensely in slowing down the drain on the system. The widely held historical inequities between compensation for primary care and specialty care have already been addressed. Further change in the balance will merely serve to make specialty care even more difficult to obtain. The 90-day 'global rate' for procedural charges needs to be relegated to antiquity as in many cases, a procedure oriented specialist can receive higher overall compensation by charging consultation and serial follow-up rather than charging for the procedure itself." - **Clifford C. Marr, MD**

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"We live in a society where primary care medicine is not valued; our society values procedure oriented specialties, even though most of the health care is provided by primary care." - **Vong M. Lee, MD**

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"This 'either or' approach just doesn't make sense. It is obvious that the powers that be are using the 'divide & conquer' approach on physicians to avoid putting any additional funding into these 2 vital programs." - **Earl Wolfman, MD**

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"This one is long overdue." - **Deane Hillsman, MD**

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"I think Primary Care does a lot of work/is held to a high standard/not compensated as well, which is why there are fewer providers." - **Renée A. Nelson, MD**

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"Time taken and expenses, i.e., malpractice insurance, must be continually re-evaluated to provide fair compensation for both primary and procedural care." - **Katherine Gillogley, MD**

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"...I doubt that simply paying more for primary care and less for procedure intensive care would improve matters for long. After all, primary care people can become as addicted to profit as politicians, specialists, and technocrats.

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"As I see it, one way to effectively control costs in a government paid system is to take systemic decisions out of the hands of professionals and pols, and put the whole system into a receivership, like a bankrupt financial institution. The receiver would have authority and responsibility to make the system honest and economically sound but could not compel anyone to participate. Therefore would need to act in a way that achieves consent. What he could do, how-ever, is to innovate and circumvent the oppressive bureaucracy..." - **John Loofbourow, MD**

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"The crisis in primary care is real. We need to reward doctors for thinking about patients, not windmilling them every 15 minutes or so and not for doing technical procedures. Should we ever get universal health care there will be no one around to see patients in

order to get them to the procedurists." - **George W. Meyer, MD**

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"To quote H.L. Mencken: 'For every complex problem there is an answer that is clear, simple, and wrong.'" - **Thomas J. Curran, MD**

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"Regardless of what is done in the realm of compensation for procedures, compensation for primary care must be increased. All one needs to do is to speak with current Internal Medicine residents. Whereas previously about 50 per-cent practiced some form of primary care after residency, now only about 20 percent choose that path. Since many of these young physicians are carrying massive debt from their training, they have little choice but to choose a specialty in which they will be adequately compensated and have a reasonable prospect of repaying their loans. The result is a current and even greater future shortage of primary care physicians. In such a scenario, who will perform the un-glamorous tasks of preventative medicine, discussing advance directives, and listening to the 'worried well'?" - **Mark Blum, MD**

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"This action would improve 'Effectiveness' but probably have little effect on 'Economy.'

"The data clearly show that application of primary care services have a measurable effectiveness on aggregate population-based health outcomes as well as individual health outcomes. Those data for much 'procedure intensive care' show little effectiveness on population-based outcomes but attractive outcomes for individuals on a case-by-case basis in both length of life and quality of life. For instance, screening for breast cancer has reduced the death rate for breast cancer among women in California by some 27 percent - a measurable population-based outcome. Similar outcomes for immunizations, hypertension control, diabetes control, and other 'primary care' modalities are quite attractive. Outcomes with some 'procedure intensive care' may have a disease prevalence (too few patients) insufficient to move the population-based indicators. Preferentially moving this cost center as proposed would proba-bly enhance the outcomes indicators.

"The data also clearly show that our quite-effective application of professional standards in the primary care setting have little to no effect on 'economy' as measured by amount of money spent in the medical care system. The industry is quite adept at leveraging additional cost centers regardless of changed patterns of illness and death. For instance, in the 1950s we successfully eradicated polio (vaccine) and rheumatic heart disease (penicillin), yet saw the costs of medical care continue to rise and rise. The same thing happened with application of other primary care modalities (other vaccines, other antibiotics) and indeed the 12 percent decrease in cancer rates in California over the past dec-ade with our successful Tobacco Control Program (adult smoking prevalence cut from 23 to 14 percent).

"The battle for the soul of our industry does not pit these two groups against each other for reimbursement rates - primary care vs. secondary and tertiary care ('procedure intensive'). Our professional part in this equation is 'effec-tiveness' where we are quite successful; the industry's part is 'economy' where they have been too successful - to the despair of many." - **Donald O. Lyman, MD**

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"The other important alignment of incentives [is] to pay for quality and better outcomes; improved health; risk adjusting [for] the populations." - **T. Warner Hudson, III, MD**

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"MDs are trying to make more by performing many unnecessary procedures." - **For-Shing Lui, MD**

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"I personally feel that medical coverage is medical coverage. Categorizations are what make providers money hungry. If an individual needs to have primary care/procedure together (with procedural care) or one without the other, both need to be compensated. There is 'free' nothing. Someone pays and it is usually us, 'the tax paying citizenry.' If we truly are a government of, by and for the people, then together we need to put a lid on it." - **Elisabeth Mathew, MD**

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"Decreasing state/federally funded compensation for procedure-intensive care is not the

answer; for most of these specialists can afford not to see these patients in lieu of the private sector. However, I do agree that primary care docs should receive more compensation for what we do." - **Anthony W. Russell, MD**

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"Pay is too low for everyone - even if PCPs get paid well, we are unable to refer to specialist because of low pay = inadequate care." - **Kenneth Corbin, MD**

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"We physicians have been for too long playing the fool and agreeing to the zero sum game of the 'fixed pie' fraud. This was foisted on us early in the managed care days. The concept is simple: get physicians to fight one another for a fictitious and arbitrary 'fixed pie.' While they are fighting, preferably one segment against the other, the real money is siphoned off and out of health care. I believe that the unbelievable profiteering that I read about comes out of this 'pie.' Where else can it come from? So we can continue to beg Washington not to cut our Medicare rates too much, fight over geographic distributions of moneys, sue the governor to stop Medi-Cal cuts because of the 'fixed pie.' Re-member when Medicare paid 20 percent of the UCR fees? Now Medicare is the ceiling, not the floor. The problem is not redistributing the 'pie'; the problem is unreasonable compensation for services rendered across the board. Pri-mary care has been undercompensated for as long as I can remember. It would really be nice to concentrate on pa-tient care, which is what we do best, instead of fighting to stay in business. I spend over half of my day doing adminis-trative work to stay in practice. Much of this is related to insurance coverage issues. What's wrong with this picture?" - **Lee T. Snook, Jr. MD**

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"Robbing Peter to pay Paul is not a strategy that will work. Specialists/proceduralists practices are already full; is paying them less going to motivate them to work harder or try to recruit additional partners? I think not." - **Sidney Yassinger, MD**

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"...When the primary care providers can do what the specialists can do or provide the same services, then they can expect part of the specialist's compensation. Unless you can prove the specialists are over-compensated for the hours worked and the acuity of the patients and complexity of the procedures, they should not be made the target for improving the primary care providers' income. There is not data that suggests 'economy and effectiveness' of health care is improved by more highly reimbursed primary care." - **James E. Boggan, MD**

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"Medical reimbursements are deplorable. Why would a physician work for so little money? With that said, I think caring for a percentage of Medi-Cal patients should be mandatory, or there could be incentives. Something so the people who need medical care most are not left to the wolves because of bad government policies and for-profit insurance." - **Tracy L. Burns, MSII**

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"If that happened, the primary care physicians can take care of the sicker patients by themselves!" - **W. Randy Martin, MD**

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"Procedure intensive care is already minimally reimbursed. Further reduction will severely impact access." - **Roseanne Pevac, MD**

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"Many procedures are under compensated already. There is a need to reduce payments for unnecessary care and repetitive charges for fraudulent care by phantom clinics." - **Forrest L. Junod, MD**

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"The state and federal government agencies need to provide better compensation for ALL those who provide care for these patients. Just increasing Primary Care compensation isn't going to help the patient who needs to see a specialist if they (the specialists) aren't going to be fairly compensated and, therefore, can't or won't see the patient." - **Monique B. Hanible, MD**

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"Agree with first part, disagree with reducing compensation for procedure-intensive care." - **Robert C. Lentzner, MD**

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"Radiology charges should be in Procedure Category." - **Colin P. Spears, MD**

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"Increase Medicare, leave procedure compensation the same." - **Joseph Lash, MD**

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"When are we going to stop this competition among different specialties in medicine? We all play critical roles and this fight among 'cognitive' and 'surgical' specialties seems ridiculous." - **Steven C. Patching, MD**

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"We only need to look at all the other developed nations that manage to provide universal coverage (through a variety of different mechanisms) AND achieve better health statistics than ours, all of them while spending less per capita than we do. What they have in common are systems which are much less specialty and procedure intensive than ours, and reimbursement schedules with much smaller discrepancies between generalists and specialists." - **Francisco Prieto, MD**

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"Increasing payment for primary care is essential, unless we turn it over to midlevels and society lowers its expectations. However, the issue is not primary care vs 'procedure-intensive care' but rather it is raising payment for E&M services. The nonprocedural and limited procedural specialties such as endocrinology, rheumatology, and neurology, to name a few, are short-changed by the current system. However, lowering payment for procedures will simply result in more procedures, or the panel of participating providers in certain specialties (in certain markets) will diminish to the point of inadequacy.

"So, we should raise payments for E&M and keep procedural payments at the current, already unacceptably low to many, levels. Obviously if you combine this with an objective of 'universal coverage' it will cost more. The message to society: 'be prepared to pull out your wallet and pay your taxes...or your premiums.' If we don't do this, we will witness the further deterioration, including unavailability to the middle classes, of *healthcare in this country.*" - **Ralph E. Koldinger, MD**

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"No one wins with this scenario, except the government bean counters." - **John R. Tucker, MD**

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"The notion of somehow improving the effectiveness of health care by restricting specialty care to those who receive support via governmental agencies but augmenting reimbursement for the primary care physician to this same group is the most egregiously preposterous notion I have been the victim of for years.... The most obvious area of improvement in the economy and effectiveness of health care in our society...would be to provide a better quality of education to this physician group so they would recognize serious and potentially debilitating disease processes early by personally taking a good history, doing a thorough physical examination then arriving at a specific diagnosis instead of throwing antibiotics or steroids at them or submitting them to random scanning. In my experience, one of the biggest problems that I see is the delay in diagnosis brought about by the lack of access of patients to the doctor due to lack of their ability to pay. Part of our moral obligation as physicians is to see everyone independent of their ability to pay. If providing more money to primary care would assure a longer contact time with all patients by these practitioners and a more astute understanding of uncommon disease processes to which they may become afflicted, it may be justified. But to ration access to the specialized care and new technology that has made the major contributions to medicine in the last half century is preposterous." - **Paul Donald, MD**

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"[I agree because] Primary care is the mainstay of prevention and control of disease." - **Richard S. Isaacs, MD**

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"...a dollar spent on prevention is worth hundreds to thousands later, but we simply can not refuse to compensate for procedures when they are necessary." - **Kelly A. Sharrar, MD**

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"Difficult to assess the impact on decreased compensation to specialists 'procedure-intensive care.' I do not know if paying more to primary care leads to improved care." - **Henry L. Kano, MD**

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"Why not increase primary care compensation, and make NO change for several years in compensation to specialists doing many procedures?" - **Catherine E. Moizeau, MD**

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"...Primary care has always been the triage center and their compensation is so vastly undervalued. We should increase compensation to primary care and trust in doctors to judiciously request appropriate procedures when re-quired. Administration of the programs is the problem and the bureaucracy in charge should be pared down drasticaly since they have so far been ineffective." - **Jose Ma C Leuterio, MD**

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And last but not least: "This is a joke, right?" - **Robert T. Wendel, MD**

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