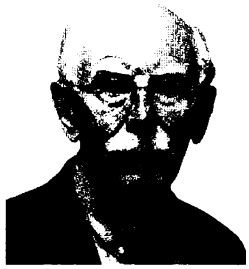

BY STEPHEN C. SCHIMPFF, MD.

Direct primary care does not lead to patient abandonment

I frequently hear the lament that when a primary care physician converts to direct primary care (DPC)/ retainer-based/concierge care models, a lot of patients get left out, equating to patient abandonment. Some go so far as to suggest that it is unethical for the physician to downsize. I find this a false argument.

Consider first that the 2,500-plus patients in a PCPs panel today are not getting the best possible care because the doctor is on a constant treadmill.

Yes, if lots of PCPs in one community converted all at once there could be a serious shortage. But that is not likely to happen. More likely is a gradual conversion process by those who wish to do so. It is not so unlike the PCP who quits his or her practice and seeks employment elsewhere. The affected patients will be cared for by other doctors in the community that still do "production line medicine." If it is a rural or other area without additional physicians, then it is time to recruit more providers including nurse practitioners and physician assistants.

DPC, retainer, or concierge care need not be expensive. Once it becomes clear that people can get better care at a reasonable cost, the general public will be the ones who will pressure their PCPs to make the conversion. It is supply and demand. If the demand is there, the supply will increase; but only if the system is fixed.

"[In DPC,] the physician and patient break the bonds with the insurer and replace it with a direct contractual relationship with each other."

DPC is one way to fix the system.

The alternative is to wait and let the doctor burn out and close his or her practice; then no one gets the benefit of that physician. The current high visit number is a direct consequence of a reimbursement system that has paid too little for too long. If that had never happened, there would never have been the pressure to see too many patients or have too large a panel size. The need today is to get back to a reasonable number of visits per day. Using better technology and team functions, that number can be greater today than it was years ago but it still needs to be a reasonable number that the PCP can interact with appropriately.

One other point: Doctors today spend an inordinate time on nonclinical paperwork. DPC gives that 20 percent of time back. That dramatically lessens the PCP shortage.

And as medical students begin to observe that it is possible to be a high-quality PCP giving superior care in a satisfying setting, more and more will once again choose primary care.

There is one other very important advantage: Total costs go down with many fewer referrals to specialists, fewer ED visits, and fewer hospitalizations. Given this reduction in total costs yet with greatly improved care and satisfaction, it behooves insurers (including government-sponsored Medicare and Medicaid) and employers to work with these models. They can benefit from the lower costs, the greater patient satisfaction, and improved outcomes.

Primary care need not be expensive. Paradoxically, the insurance methodology has made it so. In all these direct pay, concierge, and retainer/membership models, the physician and patient break the bonds with the insurer and replace it with a direct contractual relationship with each other. The result is better care, greater satisfaction by the patient and by the doctor and reduced overall healthcare costs. That is certainly not patient abandonment. ◘

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