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Point/Counterpoint

The Retainer Model or Single Payer -- What Will Save Primary Care?

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Point: The Retainer Model May Stimulate a Rebirth of Outpatient Internal Medicine

Robert Centor, MD

Outpatient internal medicine has joined the endangered species list, or at least so many commentators have opined. Fewer internal medicine residents are opting for outpatient jobs. Many outpatient internists are leaving practice, either for fellowships or for hospitalist jobs.

As I consider the medical student's choice of internal medicine for his or her career, I note that the fascination with internal medicine usually results from the complexity of the field. Internists champion the care of complex patients. We love diagnostic and management puzzles.

In the 1970s and 1980s, many internists embraced a definition of primary care that the Institute of Medicine (IOM) codified:

"A set of attributes, as in the 1978 IOM definition -- care that is accessible, comprehensive, coordinated, continuous, and accountable -- or as defined by Starfield (1992) -- care that is characterized by first contact, accessibility, longitudinality, and comprehensiveness."[1]

Training programs produced internists who could care for complex disease and also handle a wide variety of clinical issues, including episodic care and preventive medicine. Over the following 30 years, our society apparently has redefined primary care to a definition that degrades the original concept. The *American Heritage Dictionary* in 2006 provides this definition for primary care: "*The medical care a patient receives upon first contact with the healthcare system, before referral elsewhere within the system.*"

I believe that most insurers and other physicians no longer consider comprehensiveness when they think of primary care. I would argue that internists do not want and are not trained to do this limited conceptualization of primary care as defined by the *American Heritage Dictionary*; rather, we are trained to add primary care services to our comprehensive care. Such distinctions underlie the angst of many practicing internists. We have trained a generation of internists to provide comprehensive care, including episodic and preventive care, and yet insurers and especially health maintenance organizations complain that internists are not good at providing quick, efficient primary care. Family physicians are in a similar situation. We have a problem of semantics and thus our discussions about primary care remain confused.

Our reimbursement system also does not pay internists sufficiently to provide high-quality comprehensive care, although our patients are too complex and require more time than what insurers believe constitutes a standard office visit. Specifically, patients need various levels of intensity. A 30-year-old mother with a sore throat has different physician needs than a 55-year-old man with chronic obstructive pulmonary disease, heart failure, and type II diabetes mellitus. Clearly, the latter patient will need longer and more frequent visits. Moreover, our current system does not reimburse out-of-office continuity. We have no reimbursement for telephone calls or emails, although patients often have questions for their physicians. They would like to call their physician for advice, or to discuss a possible new symptom. And, conversely, we would often like to check on our patients to find out, for example, how they are responding to a new treatment.

Our current arrangements are slowly killing the outpatient practice of internal medicine. With this backdrop, some enterprising physicians re-created the retainer model. They imagined a practice and created a model that would both satisfy patient desires and improve physician satisfaction.

The idea is simple. The patient pays a fee for physician access, which allows same day appointments, telephone access, and email access. Physicians regularly call these patients and even make house calls when necessary. The physician's panel size has a much lower limit than most internists currently have. Although the retainer model has variations, the above principles represent the core concepts.

When interviewed, retainer physicians emphasize their professional satisfaction with this arrangement. They can spend enough time with each patient because they no longer have the pressure to see 20 or 25 patients each day. Patients apparently love this model. They want convenient access and are willing to pay for that access. Despite retainer fees, which generally range from $1000 per year to $4000per year, approximately 90% of patients renew their contracts each year.

Many have criticized these practices on ethical grounds and on the assumption that primary care physicians should care for a large panel of patients. I believe that retainer medicine may save outpatient internal medicine. I doubt that all patients will enter a retainer practice, but I do suspect that increasing numbers will join such practices because patients recognize the value of access to their healthcare.

Perhaps these practices, if they continue to flourish, will stimulate a resurgence of outpatient internal medicine. We will be able to continue to train internists who understand the spectrum and complexity of disease, because the retainer model provides an option for those who prefer the outpatient setting but also want complexity and comprehensiveness. Whereas many critics are concerned with the finances of this model and worry about inequities, supporters emphasize the retainer physician's ability to provide the level of care and attention that patients deserve.

The retainer model originated and is succeeding because of classic market forces. Physicians and patients find our current arrangements undesirable, thus this new alternative model gives them an interesting choice. Perhaps it will save outpatient internal medicine.

Counterpoint: But Will the Retainer Model Improve Health Care?

Charles Vega, MD

Dr. Centor should be commended for making salient points about the state of primary care. He is absolutely correct that the current model of primary care is unsatisfactory to both provider and patient. In fact, as Dr. Centor suggests, this model may not be sustainable in the long term. Physicians may continue to choose careers in medical and surgical specialties, which are more lucrative financially in our current system of healthcare.

The concept of retainer practices is a logical response to this dilemma. Retainer practices can solve some of primary care's most difficult challenges, including the following:

- Greater access to physicians? Check.
- Improved patient-physician relationships, with a chance to focus on the biopsychosocial model of healthcare? Check.
- More time for preventive care and patient counseling? Check.
- The chance to make this nirvana of medical practice financially feasible, if not highly profitable? Check.
- Improving the healthcare of our country? Well...

It is inspiring that healthcare is back on the national agenda. Each presidential candidate has staked out a position on healthcare reform, and regardless of party affiliation, the call has been for increased access to care. Such care will emphasize preventive medicine, quality, and evidence-based management of chronic disease.

Retainer practices may improve healthcare for the individual patient, but is it justifiable to have a larger proportion of our shrinking supply of quality primary care physicians devoted to these practices? As noted in an essay by Needell and Kenyon, physicians have "a responsibility to support the health of the entire community. [Retainer fee medical practice] does little to advance this cause except that by optimizing the conditions under which their own private patients receive healthcare, they call attention to shortcomings in prevailing public healthcare policies, which by comparison fall short of that standard."[2]

Primary care physicians are the means for creating this standard. We are the physicians focused on the well-being, not just the treatment of disease, of the whole patient. We are the best instruments for providing high-quality and cost-effective healthcare.[3]

Primary care is now facing its significant moment in history. At this critical juncture, should we allow insurance companies to dictate the way we care for patients? Retainer practices represent a retreat from expanding healthcare access and quality to our American community at large. With the closing of each general primary care practice in favor of a retainer practice, medicine loses a bit of its soul, and it would be naive to believe that there will not be a reckoning when we as a profession deviate from our responsibility to society.

How do we then fulfill this responsibility? Be advocates for change. Have a voice in how healthcare is delivered in this country, from issues as basic as reimbursement for preventive services to compensation for health counseling and the greater use of technology in routine medical practice. Our nation needs us, and we urgently need to respond.

Responses

Point Response: Robert Centor, MD

I appreciate Dr. Vega's concerns about "the health care of our country." He opines that retainer practices would decrease access to primary care physicians. Moreover, he raises the interesting point that physicians have "a responsibility to support the health of the entire community." He finishes his impassioned essay with a plea for us to advocate for change. He wants to change reimbursement and improve compensation for health counseling.

I believe that I can convince Dr. Vega that the retainer medicine model can satisfy all these needs.

As I stated originally, the current primary care model receives little respect and poor payment (a more accurate term than reimbursement). Thus, it attracts fewer and fewer students and residents. We in the South often say, "If it ain't broke, don't fix it." Well our current primary care model is broken, and thus we must develop a better model.

Dr. Vega represents the mainstream primary care idea: if only we tinkered with the payment system, everything would work well. My position is that the current system has such major problems that we should consider a better one.

Given no monetary constraints, patients would all prefer to have a retainer physician. We all want access to our main physician. We want him or her to have enough time to provide care. We do not want any incentive for our physician to speed through our appointment, or fail to provide email communication, or make it nigh impossible to talk on the phone.

When I think about the advantages of retainer medicine, I imagine a revolution in primary care. Physicians can provide reasonable cost retainer medicine; it does not have to carry a huge fee. For example, if a primary care physician could restrict their practice to 1000 patients and charge $50 per month, the numbers may well work. In such a practice, overhead would be minimal, because the physician would not need a cadre of billing and insurance experts.

I believe such practices would attract both patients and physicians. Given this more desirable profession, more physicians would choose to enter such practices and more physicians would continue providing care. Retainer medicine could increase the attractiveness of outpatient generalist careers.

Although I understand Dr. Vega's objections, I assert that the dynamics of a new model could improve access to generalist physicians.

Each physician has a primary responsibility to provide the best possible care to his or her patients. When we see too many patients, all of our patients suffer. When we consult subspecialists because we do not have time to spend with our patients, healthcare suffers. When we order imaging studies rather than spend more time interviewing and examining the patient, healthcare suffers.

We cannot be satisfied with a primary care system unless we provide outstanding primary care. Our current payment system actually discourages primary care physicians from devoting our most precious resources to our patients. Of course, our most precious resource is time. Our patients deserve our time, and we deserve fair payment for all our time.

We should examine the retainer medicine movement carefully. This movement focuses on the highest-quality care. I believe we should reinvent our payment system to make such care the expectation rather than the exception.

Counterpoint Response: Charles Vega, MD

Dr. Centor again does an excellent job of describing real challenges for primary care and for medicine in general in the United States. It is clear that no one is satisfied with the inefficient and unjust system at hand, and retainer practices can certainly be attractive for physicians. But the adoption of this practice on a wide scale would be a disaster for healthcare in the United States. These practices are exclusionary by their very nature: physicians open these practices to lower the number of patients they see. The annual "membership" fees for these practices cost thousands of dollars, and many of these practices exclude all but the most lucrative health insurance plans. Moreover, many retainer practices charge fees for physician visits, adding to the cost burden overall. And, for all of these costs, there is little evidence that these practices deliver superior health outcomes.

The real cost of our failure in establishing a better healthcare system goes far beyond disgruntled patients and physicians, or even the loss of the primary care specialties. Relatively speaking, these are selfish concerns. The inequities and problems in healthcare in the United States cost individuals their health, and too often, their lives.

I, too, would call for a revolution in the way that physicians practice in this country. Certainly we should advocate for a greater overall focus on prevention and the maintenance of well-being, as opposed to the treatment of disease, for the whole patient. Patients want an

empathetic physician who understands their needs. These are areas in which primary care physicians excel.

But those concepts in and of themselves are hardly revolutionary. Dr. Centor is perfectly right in saying that we need a new way forward that can sustain a better physician-patient interaction. Imagine a system in which primary care physicians are reimbursed fairly for the good work that we do. In this scenario, strong patient relationships and improved health outcomes are incentivized so that we all have a stake in better health. Best yet, this system is completely inclusive, guaranteeing access to basic health care for all.

An impossible dream? Not to every major industrialized country on the planet. This plan is called single-payer. You might have heard of it, perhaps when it's being disparaged by insurance and pharmaceutical companies.

There are many controversial issues related to a single-payer healthcare system, but it is time for all of the stakeholders in medical care to realize that the consequences of our current quagmire of a healthcare antisystem are too important to remain intransigent to change. The work will be hard, and some sacrifices will have to be accepted on all sides. However, in the end, we will have a system that is not only fair and efficient but caring and personal as well.

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