

Prepaid, Nonprofit, Comprehensive, Nationwide, Healthcare Organizations Are the Future

H. Norman Richardson, M.D.

Norman Richardson was born in Yonkers, New York. After graduating from Hackley School he attended Harvard University earning a B.A degree. He received his postgraduate medical training in Pediatrics at the University of Minnesota Hospitals, Minneapolis, MN, and subsequent training in allergy at Wilford Hall U.S.A.F. Hospital. He retired after twenty years and then joined the Southern California Permanente Medical Group where he practiced allergy for twenty years until retirement in July 1998.

Recently I have thought about my decisions as to how I led my life. At heart I am what many would call an impractical liberal. I think that the practice of medicine should be separated from direct remuneration to the provider. Fee-for-service medicine has been fraught with so many avaricious, greedy and self-serving features that it deserves the rapid demise it now enjoys.

I remember with shame a member of another class who talked about the cost of an electrocardiography machine. He planned to make a lot of money using it as a routine test. Jumping 35 years ahead, I was an observer when practitioners billed Medicare for the health problems of my parents. They did many procedures, which were of marginal if any help, yet were the “community standard.” They milked Medicare for all it was worth. One urologist I know “earns” \$1,800,000 riding the prostate-specific antigen fear about prostate cancer, doing biopsies liberally.

I have never been a part of the fee-for-service world, so it is correct to tell me that I don't know enough to be an expert. But I can have an opinion. It is that the “fee-for-service system” is getting what it has earned, i.e., near extinction in the foreseeable future. In California it is already true. It will come inexorably more or less completely throughout the country. This can affect doctor-patient relationships positively as this medical evolution is accepted.

Our 40th reunion was very challenging and interesting to me intellectually. We went everywhere. Taught by our teachers, we have had much to do and done it well. We learned our lessons. We have taught them to others.

The Air Force sponsored my pediatric residency at the University of Minnesota where, as an intern, I met my future wife. I took her to Japan. We had two small children by the time Barbara finished her B.A. degree in 1959. I incurred a four-year commitment to the Air Force. It meant I would have eight years' service before I could get out. It took me twenty-one. That must say something. In the early sixties, it seemed to me that Kennedy would soon start “socialized” medicine. Fortunately I was wrong. But it seemed better to me to be part of group Air Force medicine, if the government was taking over.

I was and am still very proud of military medicine. My fellow doctors were excellent and dedicated to the care of their patients. We did not measure worth of work by how much we earned. At all times we were provided with the tools and permission to use them to help our patients. Cost effectiveness was important since we were spending tax dollars. I was always able to provide or prescribe a treatment if it was needed no matter what the cost. It was a real benefit not to have to worry about my patients' ability to pay.

There were many jobs, frustrations and some sorrows. But they were good years and I learned a lot. One lesson was that I was not a super administrator. I did not want to return to the severe strain of being a front line pediatrician. That is really hard work and “poorly” compensated (except by how quickly children respond). I had always practiced some allergy since no one else wanted to do it. It had helped many of my patients. So I decided to take a fellowship in Allergy. I finished, passed the Board examination and later was recertified.

Retiring from the Air Force, I considered private practice with another allergist in northern California. Comfortable with group practice in the Air Force, it was more attractive to me to join the Southern California Permanente Medical Group. I told them that all I wanted to do was patient care. I had had enough of administration and politics in the Air Force. I have now served nearly twenty years with SCPMG (Kaiser) and find it hard to remember being in the Air Force. The Kaiser model is very satisfying. There is friendship, support, liberal consultation and a united wish to provide quality, timely, full care for even the most perplexing, difficult problems. Nothing is held back or stinted.

The Southern California health care market is one of the most competitive in the country. Even before Clinton's health care reform failed, the market here was making that effort unnecessary/redundant. Kaiser has decreased member dues by 6% each year of the last four years. [They have since gone up to maintain solvency.] The HMOs in the area have squeezed “private” doctors and hospitals with regard only to their bottom line and profit for their officers and shareholders. The fee-for-service physicians have had substantial decrease of income and are working harder. They are harassed by many more rules from many more “third party payers.” Kaiser life is not perfect. There are many arbitrary rules and pressures. But it is a sort of “heaven” compared to what I hear from community allergists. Each of their incomes on average has declined \$50,000 last year. [Pressures continue, but I think “private” physicians are happier. Kaiser continues to grow. It is investing up to three billion in automated inpatient and outpatient health care record systems.]

The charge for this essay by the reunion committee is in part to say, “...what changes, if any, in contemporary medical care you would make to preserve or improve the patient-physician relationship.” I found the whole focus of the paragraph loaded with the archaic picture of “horse and buggy” medicine of the early 20th century. The “sacred cow” of improved patient-physician relationship is held up as a goal.

In the 40s and 50s house calls became uneconomic and were largely discontinued. Modern medicine could not be practiced in the patient's home. Proper treatment required more accurate diagnostic tests. Patients needed to come to a central source. Yet there remains the sentimental wish for the doctor to come to the patient. As a locum tenens in 1959, I made pediatric house calls. They were not efficient and I was not at my best in those circumstances.

Since the 50s, the years and evolution of medical care led to more and more group practice of all shapes and sizes. Type of payment focused on fee-for-service. Sydney Garfield, a young physician in the 1930s, proposed a pre-paid system to meet the needs of the new southern California water system being built by Henry Kaiser. No medical care was available in its remote and difficult desert courses. This pre-paid concept was successful and later applied to such projects as the Grand Coulee Dam and the building of thousands of Liberty Ships during World War II. At first it served only the needs of union workers and their families. Pre-payment was anathema to organized medicine and aggressively resisted. The Kaiser Health Program was small and geographically minuscule. Its doctors suffered and were persecuted.

Third party payment systems oriented to fee-for-service grew and industry took on the burden of workers' health care. It was the only way to attract scarce workers during WWII when wages were frozen. The IRS encouraged employer-subsidized health care by allowing such costs to be a business deduction.

Some friends in "private" practice have described the 50's and 60's as "golden years." Since then there has been more and more intervention by the government and third parties. It started with Walter Reuther's demands for documentation of the quality of care given his union members. It spread slowly at first. In recent years, government, unions, insurance companies and national employers as well as small local businesses have demanded more and more documentation. They want proof of high quality, comprehensive care and prompt service at the least expense which can be negotiated. They are reducing costs by playing one doctor against another and imposing arbitrary standards of performance.

The (Kaiser) Permanente Medical Groups work to support physicians in their practices. Standards are high and improvement is required through Peer Review, Quality Assurance and many inspection programs. Effort is made to reward efficient, personalized care.

There has been an immense increase nationally in administrative costs to collect performance and quality-of-care data at all levels. Doctors need administrative staff as well as nurses and other health care practitioners. Small solo or group practices are at a disadvantage. They will become fewer in number since the overhead of administrative intervention is burdensome.

I need to return to the theme of this essay: to "... preserve or improve the patient-physician relationship." The very question is specious. There have always been such relationships. They have been in the past, exist now, and will be established and continued in future. There is nothing to preserve. They are good or bad depending on the interaction of an individual physician and patient. To keep them positive and strong will always be the result of physician effort and dedication on a day to day service basis. Patients want "free-choice." Doctors also wish it but are bound to put up with patients who are non-compliant. They demand service, which is often not indicated. It is good when patients shop until they feel comfortable. They should be able to do it in any future system. Also physicians should be able to kindly dismiss problem patients when their efforts to cope (that is their job) fail to lead to mutual comfort. Kaiser provides much choice within its system.

The essay challenge question does not face the many discordant organizational and administrative problems our society faces. It invites comment that there should be a return to the "good old days." I think they were good for "fee-for-service" physicians, not for the future or "ideal" medical care, nor ultimately for our patients.

I have had some experience of the socialized British system and had opportunity to learn about other such systems. I am not an expert but think that they have fallen short of the perfection which was their goal. They made everyone eligible. But their society would not pay the costs involved. Our fee system in a rich environment was able to demand payment for much of it, but it failed to serve our communities on an equal basis. We as physicians condoned this inequality. Now we are being forced to face very hard facts. The government, industry and insurance companies are not willing to pay unless they have proof of value before they agree to compensate us. We are no longer presumed to be competent. Correctly, we must prove it every day.

The government wants to reduce cost to decrease taxes or avoid a tax increase. Industry wants to show a better bottom line - health and retirement costs are hurting them. Many are raiding retirement plans. Insurance companies are in business to collect money. They resist paying bills. They need to give their stockholders a profit. All these influence the doctor-patient relationship adversely.

I was 24 when I graduated. It would be very hard to have to go once more through all the problems of the past 40 (now 50) years. But if you were to give me the chance for rejuvenation, make me 24 and give me the challenge, I would leap at it. Medicine is still the greatest profession which empowers one person to help another.

Some sort of summary is needed. I think that the concept of "pre-payment" for medical care from whatever source is the only way for the future. It must include all our citizens. Some way must be found to include alien individuals temporarily within our borders. The atrociously large bureaucracy, which eats up enormous dollars, must be cut and rationalized.

When a member changes his plan, it leads to unnecessary costs, with redundant tests and consultations. Consolidation of health care plans is good. The ultimate would be only one plan. Its power could be excessive unless governed by comprehensive, compassionate rules led by individuals who had authority to make it sympathetic to our patients' needs. It would be better to work on such a single system to make it "perfect," than to do what we are doing now - working on innumerable, imperfect systems, many doomed to failure.

I learned medicine with a group. We all helped each other as a group. I joined a group as an intern and resident. I worked with a group of Air Force physicians. I have recently for 20 more years worked with the Permanente Medical Group. The Air Force was also a prepaid program - it was part of the benefit for joining that group to defend our country. We should all support and join pre-paid, nonprofit, comprehensive, nationwide health care organizations. Kaiser's is a model to study and apply appropriately. It can be the future of medical reimbursement. We must work for excellence within this context.

I have had a serendipitous life experience personally and in the practice of medicine. I am grateful to my parents who as teachers molded and encouraged my efforts. My education at Gorton High School, Hackley, Harvard, Universities of Rochester and Minnesota along with the USAF Wilford Hall Hospital helped me. They implemented what my medical class peers set and reinforced as standards. I thank them. They have made me what I am.