



Tim Bartholow, MD

## Your patients are waiting... for your leadership

Tim Bartholow, MD

Senior Vice President of Member Services,  
Policy Planning and Physician Professional Development,  
Wisconsin Medical Society

Until October of 2008, I practiced family medicine for 16 years in a semi-rural community. I watched diabetic patients decide between rent, hamburger, or insulin. I took care of a healthy farming couple, both 55 years old, whose insurance cost \$900 per month with a \$15,000 deductible. In the event of an illness, they planned to sell a tractor to cover that deductible. When patients and other citizens sometimes need health care but can't afford it, I—along with other physicians—am indignant that in what is still the richest nation in the world, where we spend 16.3% of our Gross Domestic Product (GDP) on health care, citizens are unable to see their doctor.<sup>1</sup>

In November 2008, I joined the staff at the Wisconsin Medical Society because I feel so strongly that reform is needed and physicians need to take part in this reform.

Ultimately, the United States spends more than France, Germany, and others, spend on health care.<sup>2</sup> The problem isn't that we spend too little, the problem is how we

steward our resources. While many physicians feel agitated by payers (insurance companies) and purchasers (employers) forcing rules on us, as the only ones who can actually practice medicine, we physicians need to ask ourselves how we can provide leadership for reform and improvement.

First, let's look at our practices and examine if we are as efficient as we can be. Various manufacturers have embraced "Lean" production or similar thinking, eliminating waste using methods of continuous improvement. The Lean process identifies what each working team needs to achieve, agrees on "standard work," and then seeks to eliminate wait time and walking time for each worker. These investigations require teams to earnestly and honestly work together, knowing each team member is safe and able to report errors and opportunities. And surely, we physicians would make safe environments by *purposeful example*.

Using Lean, a Toyota executive recalled improving capacity at 1 clinic facility by 41%, while spending 63% more on primary care, 27% less on emergency department care, and 6% less on inpatient hospitalization. In this example, the manufacturer optimized "presenteeism" with a "get it done" expression of the much-touted patient-centered medical home.

Second, let's focus on chronic care. Healthy citizens are the work-

ers who drive our economy, and right now, we need everyone. For those with chronic disease, we need to manage these conditions doggedly or accept the predictable consequence of work loss and more cost. Primary care doctors can see a patient 2-3 times weekly for a year for the same cost to the system of a single hospital admission. Frequent visits to primary care doctors can also help stabilize chronic conditions.

Consider diabetes, an epidemic in Wisconsin and the nation.<sup>3</sup> Treatment for diabetes costs 2.3 times more than treatment of the general population.<sup>4</sup> Also worrisome is that in 2005, 47% of new diabetes cases were in 45 to 59-year-old patients, now the most common age range for onset of diabetes.<sup>5</sup> If the primary care doctor, their certified diabetic educator, and their nutritionist can see these patients frequently, these health care professionals can leverage the patient's readiness to change and can encourage more stable patient health and reduced costs.

This cooperation can be replicated for other chronic illnesses like asthma, anticoagulation, and congestive heart failure with doctors working in concert with other health care professionals. Patients benefit from ready access to their doctor. Perhaps payers could more fully reward clinics that are willing to be open late or early and who maintain same day appointment

**Author Affiliation:** Wisconsin Medical Society, Madison, Wis.

**Corresponding Author:** Tim Bartholow, MD, Senior Vice President of Member Services, Policy Planning and Physician Professional Development, Wisconsin Medical Society, 300 E Lakeside St., Madison, WI 53715; phone 608.442.3800; fax 608.442.3802; e-mail tim.bartholow@wismed.org.

availability, each of which result in avoiding repeated lab work, emergency department, or urgent care. For Medicare seniors and Medicaid recipients with chronic disease, Medicare and Medicaid as payers no longer cover the cost of primary care doctors to deliver that chronic care management—and this calculation is before further predicted cuts. This insufficient payment endangers the social contract we have made with our seniors, a growing cohort with the entry of baby boomers, many of whom struggle with chronic illness.

Third, we must assess our use of technology. Innovation is responsible for two-thirds of health care spending growth. While we value important innovations, many of us can identify some innovations that are not worth their cost.<sup>6</sup> The “value proposition for the patient” needs to be assessed before a technology is paid for by purchasers.

US Senator Max Baucus, D-MT, introduced legislation for such a “Comparative Effectiveness Institute.”<sup>7</sup> For each new technology or mandate added to Medicaid, Medicare, or insurance, the price of coverage becomes just a little higher, which means companies or the tax payers are just a little less able to afford it, and a few more people consequently do not have coverage. There are now 47 million of 300 million citizens who do not have insurance, and in the current economic climate we expect this will get worse.<sup>8</sup> Whatsmore, because doctors can recommend drugs and devices best suited to patients without the assistance of media, why not consider severely limiting direct-to-consumer advertising?

Finally, each individual citizen has a role. If we only eat what we need, eat many colors of vegetables, and minimize “the whites” (bread, rice, potatoes, and pasta), we reduce

our risk of diabetes. Exercise is also important and a delay of diabetes onset is shown for those who will commit as little as 30 minutes of walking 5 times per week.

For school children, including those on free and reduced meal status, we must evaluate and do something about the nutritional message being sent when schools serve French toast sticks with syrup and Pop-Tarts<sup>®</sup> with icing. How do we suppose these emerging adolescents, with this nutritional imprinting, will nourish themselves as adults?

In yet another individual citizen role, if I am your coworker using company health care, what is my duty to you when health care is so expensive? If I ignore advice to stabilize a chronic condition like diabetes, if I smoke, or if I drink to excess, then the predictable cost of the clinic and hospital care that I need will be reflected in next year’s insurance premium to my workplace. So, if I am not responsible with my health, my coworkers will help pay for it. Because health care is a significant amount of the national economy—and of workers’ total benefits—these improvements in individual health ultimately help your coworkers as well as the national economy. With health care costing what it does, the problem is no longer separate from other economic issues. And because poor health can jeopardize our nation, exercise and proper diet should now be regarded as our individual *civic duty*.

So that’s how this humble country doc sees it. Be efficient, avoid predictable illness of chronic disease by paying for primary care to make it happen, be more selective with innovations, and hold ourselves and our coworkers accountable for a crucial role in staying healthy. Most of this gets back to what our grandmothers once told us. When you look at the big

picture, relaying that message beyond grandma’s wing, the nation needs to buy more health and less health care, expecting better outcomes for our significant collective investment.

As physicians, what will our legacy be when we are all gone years from now? Will we have provided for the common good and the security of health care, including the real opportunity to access health care—or not? Will we, as physicians, have only complained about a system too complicated for powerless people like ourselves to have made any lasting change? *Or will we lead—in our practices, our hospitals, our communities, and in our state and national legislative bodies?* Doctors, your public awaits your answer.

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