

# Is Direct Primary Care the Solution to Our Health Care Crisis?

Edmond S. Weisbart, MD, CPE, FAAFP

**While attempting to solve one problem, DPC may be exacerbating other serious problems in our health care system.**

**D**irect primary care (DPC), a reformulation of concierge medicine, has intrinsic appeal to overburdened physicians. Its advocates promise a competitive income at a fraction of the volume of patient responsibilities, and they claim it as a patient-friendly, consumer-driven strategy that can meet the needs of patients across the economic spectrum.

In my observation, DPC membership fees are typically \$600 to \$1,500 per year, lower than concierge practice fees. The value proposition to patients is unlimited access to their primary care physician and all services provided within that physician's office. The value proposition to employers is a potential reduction in their medical insurance premiums if they adopt DPC combined with a wrap-around plan that covers non-primary-care services for their employees.

However, there are potential downsides to DPC, which this article will discuss.

## 1. DPCs exacerbate the growing physician shortage.

DPC promises physicians more time with each patient, which it accomplishes by reducing physician panel size. Retainer practices such as DPC practices commonly close their panels when they reach about 900 patients, which is

much lower than the typical practice panel size of around 2,300 patients.<sup>1</sup> This means the United States would need to nearly triple the physician workforce just to break even. Were the nation committed to the DPC strategy, it would take decades to “grow” enough new physicians.

## 2. DPCs are essentially unregulated insurance, capitating physicians and removing vital patient protections.

DPC practices claim they are not insurance, but like insurance companies, DPCs charge a regular fixed amount for access to a range of health care services. This is nearly indistinguishable from the practice of a managed care insurance company capitating a primary care provider. The economic implications for a medical practice operating under a flat fee are simple: More patients and fewer office visits equals higher net income. The more complex the patient mix, the more difficult it becomes for a practice to prosper.

Although incompletely effective, health insurance today is regulated to prevent insurers from marketing specifically to the healthy, from dropping coverage of the excessively ill, and from declining to cover those with pre-existing conditions.

Paying a monthly fee for a specific range of services is one definition of an insurance model. Despite that, DPCs often fall outside of insurance regulation. For example, Missouri's legislature recently passed HB 769, which specifically states, “A medical retainer agreement is not insurance and is not subject to this chapter [RSMo 376, Life, Health, and Accident Insurance].” Similar bills are being entertained in the United States Congress (e.g., S 1989, Primary Care Enhancement Act of 2015).

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### About the Author

Dr. Weisbart is a family physician in St. Louis, Mo. He is chair of the Missouri chapter of Physicians for a National Health Program. Author disclosure: no relevant financial affiliations disclosed.

Although it is easy to scoff at the complexities and increased costs driven by health insurance legislation and regulations, many of those complexities really do protect patients. Yet pure DPCs operating completely outside of the insurance industry are not as constrained by parts of HIPAA, the Health Information Technology for Economic and Clinical Health (HITECH) act, and the Affordable Care Act that protect patients' confidential medical information. In fact, there is little preventing DPCs from selling patient data to marketers. As the DPC model grows, the demand for this high-value data will undoubtedly drive increasingly irresistible financial offers. Additionally, there is no organized strategy for driving DPC practices toward best practices, guideline adherence, public health data collection, etc.

### 3. DPC relies on an erosion of medical benefits.

One of the key selling points of DPC is that it reduces health insurance premiums for employers. This encour-

ages further adoption of high-deductible health plans, which have been shown in some studies to produce blanket reductions in utilization, of both needed and unnecessary care.<sup>2</sup>

Much of a patient's health care requires services beyond primary care. High-deductible health plans can expose patients to full retail pricing for these additional services and medications unless their plans have negotiated discounted rates. These health care costs can quickly become a hardship for many patients. Nearly half of all non-poor families report having liquid assets below the standard \$2,500 single/\$5,000 family deductible; 63 percent report liquid assets below the standard \$6,000 single/\$12,000 family out-of-pocket limit; and 31 percent report being unable to borrow \$3,000 from relatives or friends in an emergency.<sup>3</sup>

An employer who offers a high-deductible plan coupled with paying the retainer for a DPC has essentially locked their employees into a defined practice. For parents who prefer their children to see a pediatrician, a woman who prefers to receive care from a gynecologist, or someone who travels frequently, belonging to a DPC practice may feel more restrictive than an insurer's narrow provider networks.

### 4. DPCs exacerbate disparities in care.

Although the evidence is still emerging, DPCs may be choosing to locate in areas most able to financially support the model. Studies have suggested that DPC physicians have smaller proportions of African-American, Hispanic, and Medicaid patients and see smaller proportions of people with diabetes.<sup>1</sup> A recent literature review on DPC said it is unclear if this is caused by the retainer pricing or by DPCs' tendency to locate in wealthier communities with less inherent racial diversity.<sup>4</sup>

### The wrong solution to a real problem

U.S. physicians are among the least satisfied in the modern world.<sup>5</sup> Much of this dissatisfaction is related to the amount of time spent on non-clinical administrative functions, particularly tasks related to insurance companies. Physicians' desire to reduce frustrating administrative work is understandable, but DPC is not the solution. Physicians considering a transition to DPC need to

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consider the impact on physician shortages, disparities in health care, and patient access to health care services outside the DPC. **FPM**

*Editor's note:* For a different viewpoint on DPC, see "In Defense of Direct Primary Care," page 12.

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