

FEE FOR SERVICE NEVER WAS

Fee for service never was. Fee-for-service refers to a “system” whereby a patient was charged presumably for whatever the doctor did for them that day. However, it was, in reality, always an average of what it took to support a physician so that he/she could stay in the business of offering care to sick persons, derived at by what a reasonable patient would be willing to pay for a perceived benefit.

Physicians used to charge whatever the patient could pay, in whatever currency. Often it was a chicken or goat -- or lawn or cleaning services, or a share in the harvest. They saw many people for nothing, but what they did collect was not confiscated in taxes. Who knows how scrupulous they were?: probably about the same mix as today. The resulting “system” came to be known as “fee-for-service”. Everyone knew that the actual service had only a little to do with what was charged. (What is it worth to save your life?) If the person was really rich, it was assumed he could pay more, and was charged more, to make up for the ones who were too poor to pay. Ledgers were not kept: it was assumed that eventually it all evened out in an unfair world.

Then came insurance companies, third party payers, the IRS (Internal Revenue Service) and regulations. Surgeons controlled the early Blues (Blue Cross and Blue Shield and other insurances), and it became normal for procedures to cost more than thoughtful diagnosis and management.

Yet, although the resulting medical system out-priced itself in recent decades, it wasn't the physicians who pocketed that overblown medical dollar. Physicians' collective share of the "health care dollar" was 19-21%, and considering that most physicians' overhead is at least 50%, that means that physicians have kept only 10 cents out of the entire health care dollar. Yet it was physicians on whom the escalation of costs were blamed.

Now it is required to "code" everything, even though doctors and patients know that it may take twice as long to handle the same sore throat when there has been a major family trauma or other issue needing attention, than when the sore throat is the only problem. For different patients with the same problems, the time and energy expenditure is enormously different, depending on their ages, disabilities, levels of understanding, etc. But if time alone becomes the factor a reverse incentive operates: to sit and schmooz with patients (to gain more income with less work) or to rush them so they won't have to pay too much (if we're worried about their ability to sustain the charge). Neither of these "incentives" should pertain: we need to give them precisely what they need when they need it, and to have the freedom to be personable to patients when that is our choice. The service that takes 2 minutes (diagnosing the sore throat) is really NOT the same as the one taking 20 minutes (diagnosing the sore throat and finding out that the real reason for the visit is that the patient is thinking about suicide and has piled up pills to do so).

Therefore, no one can put a true price or a real code on what occurs in doctor visits, although the RBRVS (Resource Based Relative Value Scale) tried to do just that in a costly attempt to allocate physician's fees more equitably by the Medicare bureaucracy. This system, of course, was then ripe for "gaming" by those intent on milking it. For those content to do their jobs it became a source of complication, requiring extra office staff, training sessions, etc., none of which improved patient care. On the contrary, all that energy robs patients of time doctors spend improving medical knowledge and skill, in favor of time spent learning newer and meaner rules and regulations.

Although over the years, the "fee" for the "service" was sometimes known to be too high, sometimes too low, the costs evened out (just like spreading risk in insurance systems) by charging everyone the same for a similar service, while continuing to give the right care at the right time. The newer systems, attempting to organize excessively and measure "outcomes" will not be able to separate the daily creative, intuitive and meaningful interactions from those which are cursory, non-caring and non-productive. They all look the same on paper and on the coding sheets.

The inverted incentives of capitated plans (your doctor is paid for you each month whether he sees you or not) absolutely abrogates these beneficial interactions, since if the doctor tried conscientiously to see each person on his list for whom he is paid, it would be humanly impossible. Yes, some physicians milked the fee for service system,

lining up patients and doing extra procedures. But the capitation system builds in powerful worse incentives written into the doctors's contract to encourage him not to give you care, and he is muzzled by the contract and cannot even discuss any of it with you.

The costly time it takes from doctor, nurse and secretary just to arrive at appropriate codes robs patients of medical attention. The unprecedented rate of changes in the coding systems necessitates frequent replacement of large expensive coding books, whole day-long conferences just to learn to use them, and computer systems designed to keep changing constantly. Entire bureaucracies feed on this activity, and it is getting worse, not better.

Measuring "outcomes" sounds good: who could argue with it? But just as with measuring outcomes from heart surgery (it looks better when fewer persons die at a given hospital or program) when one can't get a surgeon to operate on a poor risk patient because it messes up his statistics, one begins to understand the real dangers and perverse incentives in trying to measure obvious but erroneous "outcomes". The eventual outcome is certain: sooner or later, everyone dies. Yet how indeed to measure integrity, process and competence, even if one should wish to?

Fee-for-service in Medicine today is maligned and denigrated as antiquated by those attempting to capture doctors and patients to abrogate their freedoms. Both are tied up within systems over which neither has control, nor benefits fully from the interaction. Large profits go to middle-persons who extract benefit from both doctor and patient.

If physicians returned to their independent spirit, and patients used their own money (now donated to HMOs and insurance plans) to pay their chosen doctors directly (except for large costs which would still be covered by more-reasonable insurance) costs would stay down since patients, not third parties, would be parting with their own money.

On a practical note, what to do? How to give autonomy and funds back to both doctors and patients. MSAs (Medical Savings accounts) combined with excellent public health instruction and education, along with insurance for large charges only, should work well for 80% of the population. Indigent and unfortunate persons will require public clinics and hospitals (publically financed), not a bad deal for medical schools who have traditionally benefitted from the training grounds provided. The public also eventually benefits, since new doctors are well-taught.

Doctors do not need sympathy, patients do. The doctor's "plight" is not pitiful, except insofar as it makes true patient care -- with the patient's needs foremost -- difficult and sometimes impossible, when neither has control. Assuming insurance availability to spread risk for large costs, the so-called fee-for-service system, (which never was), implies "free-for-service" -- in that freedom of choice and real autonomy would be returned to patients and doctors. It is still the best way for doctors to deliver a semblance of justice to patients, along with their medical care.