

August 2004

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Recommended Citation

White, William G. (2004) "Justice and Medical Fees," *The Linacre Quarterly*: Vol. 71: No. 3, Article 1.
Available at: <http://epublications.marquette.edu/lnq/vol71/iss3/1>

Justice and Medical Fees

by

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The following is adapted from a presentation on October 11, 2002, to the Annual Meeting of the Catholic Medical Association, "Challenging the Culture of Death in Medicine in the 21st Century."

The topic of justice and medical fees may, at first glance, seem unrelated to the culture of life. But in reflecting on family life, marriage, and openness to life, I found myself thinking: "If my fee causes undue hardship to a family struggling to be generous in their service of life, if it keeps them from moving from a cramped apartment to a house with room for a growing family, if it prevents them from educating their children in a religious or private school which supports the value of life, if it prompts a young mother to leave her young children to get a money-paying job, or if it causes a couple to close their minds and hearts to life, and especially *if my fee is unjustly high*, then no matter what I *say* about contraception and abortion, I am not part of the culture of life, but of the culture of death."

In this brief work, I can only touch upon the complex topic of justice and medical fees. I do not attempt here to provide definitive answers nor to condemn any hospital or physician, but merely to call attention to the role of financial and billing policies in the mission of Catholic physicians and hospitals to provide care for the sick.

In the past, the concept of justice in medical fees generally referred to matters of commutative justice. According to the *Catechism of the Catholic Church*, commutative justice "regulates exchanges between persons in accordance with strict respect for their rights." In recent years, the focus has shifted to distributive justice, "which regulates what the community owes its citizens in proportion to their contributions and needs." This shift has, I believe, led to a neglect of commutative justice, as if fulfilling the requirements of distributive justice were sufficient. The Catechism continues, however, "without commutative justice, no other form of justice is possible."

Much of what I am about to say applies to physicians, but I will focus mainly on hospitals, which have, in my experience, suffered a more complete disconnection between their financial policies and their espoused ethical principles. I also focus primarily on Catholic hospitals, not because they are any less ethical than non-Catholic hospitals, but because I believe that theirs is a higher calling which demands a higher ethical standard. I suggest that, while Catholic hospitals may have become more aware of their obligation to provide care to the indigent, some have become less sensitive to their obligation in justice to provide care at a fair and reasonable "price" to those who pay.

I use the word "price" rather than "fee," because of the recently prevalent notion that medical services are commodities for sale at a price. In the past, Catholic hospitals were considered charitable, not merely because they were "non-profit" for tax purposes, but because they took part in the charitable mission of the Catholic Church. Three or four decades ago, the typical Catholic hospital was managed and largely staffed by religious sisters or brothers. These dedicated women and men devoted their lives to the care of the sick, not to the accumulation of wealth. Although financial viability was taken very seriously, it was considered a means to serve the hospital's charitable mission, not an end in itself.

The sick were cared for simply because of their need, without regard to their ability to pay. Care was not sold, but given. Hospital income was derived partially from patient fees, adjustable according to the patient's means, and partially from "catastrophic" insurance policies. Benefactors, prominently including the medical staff, donated a substantial portion of the funding of Catholic hospitals. Physicians participated in the charitable mission of the Catholic hospital both through donations and through pro bono services to the needy.

In principle, the mission of the Catholic Church in providing care for the sick remains unchanged. Its *modus operandi*, however, at least in the United States, has been radically transformed. Catholic hospitals have become large, profit-oriented businesses (though still technically "non-profit" for tax purposes). Many are still owned by religious orders but are managed by corporate executives who are often neither professed religious nor even Catholics. As the recent sale of St. Louis University's hospital illustrates, even Catholic bishops find their authority over Catholic hospitals to be tenuous at best.

Several factors have conspired to transform Catholic hospitals. The past several decades have seen the advent of tax-favored, employer-sponsored medical insurance, its evolution from catastrophic coverage to comprehensive prepayment, and the dramatic growth of Medicare. These third party payment schemes have shifted an enormous flow of cash from the control of ordinary working people to the control of corporations and

government. Like a double play ball from Tinkers to Evers to Chance, the money earned by workers now goes from employer to insurance or government to the "medical industry" while those who earned it look on from the stands. The massive shift of wages from take-home pay to medical insurance was disguised from workers by: 1) Inflation, which made paychecks appear to grow even as they shrank, and 2) Working mothers, whose labor outside the home at the expense of their children's happiness and well-being appeared to increase family income even as the "family wage" disappeared.

Disconnected from the restraint normally provided by the patient's interest in preserving his hard-won assets, demand for medical services skyrocketed. Obeying as they must the ironclad laws of economics, hospital prices responded to this increase in demand and influx of cash by climbing rapidly. As hospitals, in turn, spent their windfall, the prices of drugs, equipment, and supplies followed the same trajectory. Soon, an essentially charitable activity became a corporate boomtown, where zeal was directed not towards the suffering patient, but towards the thriving bottom line.

Inevitably, premiums for employee health insurance rose so steeply that employers insisted on restraint. But by this time, the huge expansion of both the insurance and medical industries had created a vested interest in continuing to game the market, i.e., to keep the flood of cash flowing into the "health sector" by excluding the individual from the decision-making process. The employee-customer-patient will naturally seek a reasonable balance between value and cost. That reasonable balance is determined by each individual on the basis of his own judgment of what best serves his and his family's needs. But the employer-insurance-government-medical-industrial axis refused to yield the control they had won. Rather, they began a series of regulatory demands, negotiated discounts, and reverse incentives (e.g., HMOs and DRGs). Thus, another factor in the transformation of the Catholic hospital: the increase in time, attention, and administrative staff devoted to complying with the regulatory burden imposed by government and insurance. Finally, as increasing costs exceeded the diminishing flow of revenue many Catholic hospitals were forced to close.

Having served in a variety of capacities in medical staffs, administrations, and hospital boards, I have shared the hospital's point of view in struggling with today's hazardous economic environment. As a family physician whose patients often tell me of their experiences in hospital billing offices, I also have a window into the patient's point of view. It's not always a pretty one.

A few months ago, two of my patients, members of the same family, separately underwent outpatient surgery at a local Catholic hospital. The

family provider was self-employed but by no means wealthy and, naively assuming that his family's medical bills would be reasonable, planned to pay for them himself. He was aware that hospital charges were high, and he was prepared to pay the hospital several thousand dollars for each of the two operations. The reality was a revelation to him. The hospital bills for less than twelve hours of care totaled more than \$30,000. Physicians' fees and follow-up hospital outpatient care brought the total to over \$60,000, well more than the average family's total annual income.

A look at the itemized hospital bill was revealing. There were several thousand dollars of charges for services and items that had not been provided. If I had not compared the bills and the medical records in detail on my patients' behalf, a process unavailable and uninterpretable to most patients, I would not have been able to identify these "mistakes." Many involved charging two or three times for materials or services provided only once. Pre-op labs, for example, were charged on the day they were done — two or three days before surgery — and again on the day of surgery. Time charged in the operating and recovery rooms invariably exceeded the time actually spent there, as documented in the medical record.

Even more interesting, however, were the charges themselves. A urinalysis (for knee surgery on a healthy twenty-year-old) cost \$40, 1600% of the \$2.50 which the same hospital charges physicians' offices and 1000-1300% of the \$3 to \$4 which insurance companies generally pay for the same service. An 11 mm. Meniscus staple was \$550.50. A 13 mm. Staple was \$1,782 and a surgical drape \$775. The charge for a cardiac monitor was \$629.20 for each half hour. The operating room was \$4,164.20 for 2+ hours (one scrub nurse, one circulator — all supplies were charged separately).

Shivering after surgery, one patient was graciously provided a plain cotton blanket by a kindly nurse. The charge: \$100 — and the patient didn't get to keep the blanket. (Apparently that was the laundry fee — a lot of quarters!). In general, materials were charged at ten to twenty times their estimated cost, while services were charged at ten to twenty times the combined services of every hospital employee in the room.

When I asked the hospital CFO about these figures, he had several comments: First, he admitted that these charges were far greater than the amount he expected to collect from any insurance company or government payer. Through its contracts with third party payers, the hospital had declared itself entirely satisfied with the reimbursement of a small fraction of its charges. However, any individual who was paying out of his own pocket was required to pay the full "retail" price.

Second, the CFO stated that his charges are consistent with "prevailing" charges at other hospitals in the area. Charges are based on

“what the market will bear” rather than on the reasonable recovery of costs. These “retail” or “list” prices are set far above the fee schedules of Medicare, Medicaid or managed care in order to maximize the return from the very small number of remaining indemnity insurance policies, as well as to get maximal reimbursement from those insurance plans which base their discounts on a percentage of the charges.

Third, this Catholic hospital executive stated that, because payments from Medicare, Medicaid, and managed care fail to meet the hospital’s costs, it is necessary to charge individuals more than their share in order to cover the deficit. [These “self-pay patients” comprise less than 20% of patients (those who actually pay, less than 5%), while government and managed care represent more than 80%. A deficit generated by 80% requires a compensatory sixteen-fold premium on each of the five percent who pay out of pocket.] If individuals lack the bargaining power to coerce hospitals to provide services for less than cost, then, as far as this Catholic hospital CFO was concerned, they deserve to be charged far more than the amount expected of those who hold such power.

Fourth (a thinly veiled threat), he informed me that he has had great success in suing patients who hesitate to pay his prices.

When I asked him if he thought that a Catholic hospital should be concerned about justice in its pricing policies, he at first appeared not to understand the question. After a blank pause, he offered the observation that the hospital social workers could help the indigent to apply for public aid. But as for patients who could be made to pay, apparently it was inconceivable that any price could be considered too high.

Perhaps the most unfortunate result of the prevalence of third party involvement in medical care is the almost complete loss of respect for those few remaining individuals who try to be responsible for their own care. The “self-pay” patient is generally regarded as the “no-pay” patient. It is assumed that because some patients without insurance are indigent or irresponsible that this must always be the case. Those few who want to pay a *reasonable* fee for medical services are lumped in with those who cannot or will not pay at all. No attempt is made to determine what a “reasonable” fee might be. If the individual balks at paying an artificial, conflated fee, he is threatened with lawsuit and bankruptcy.

I would be delighted to be informed that this particular example does not represent the norm among Catholic hospitals and medical practices, but I suspect that it is not an isolated example. Is it prudent to allow each Catholic hospital to follow its own ethical guidelines, if any, in its financial policies, or would it be better to have consistent policies established by the bishops and based on the moral teachings of the Church?

As with hospitals, the flow of third party cash and its accompanying web of strangling regulations also transformed the medical profession.

Individuals and small, independent group practices gave way to large entrepreneurial groups governed by business oriented, often non-medical managers.

Until recently medicine was recognized as a "learned profession" governed not by the rigid laws of economics, but by a centuries-old ethical tradition. The physician was not a tradesman selling a product, but an ethical professional who *gave* his services on the basis of the patient's need for care and then *asked* a fee which was adjustable based on the patient's circumstances. Only after the service was rendered was there any discussion of fees — the patient's need for care always took precedence.

Because of the importance of the patient's need and because of the duress of illness, medical care was considered an exception to the usual rules of free market transactions, wherein the "customer" has time to compare prices before freely agreeing or refusing to "purchase" a product or service. Because they were "professed" persons, dedicated to the needs of their patients, not merchants or entrepreneurs, physicians accepted the fact that, although they could expect to make a reasonable living, in some cases they would not be paid for their services.

This severing of the bond between commodity and price also implicitly recognized the fact that the value of the physician's services could not be quantified. They were, in fact, of infinite value, the value of life itself. After the physician *gave* his services, the patient made a *gift* of the fee, the amount based not on the value of the service (immeasurable) but on the patient's ability to give a suitable token of thanks and recognition. And as the patient could call upon the physician for care merely on the basis of need, the physician could expect to receive a fair fee, based not on the incalculable worth of his service, but on his need to live and support his family. Furthermore, just as the amount of time and effort expended by the physician was determined by the degree of the patient's need, not by how much he could pay, the "fair fee" was determined not only by the service given, but also by the physician's need to make a living, by society's need for the physician (it behooves a society which wants its best and brightest in medicine to offer them a reasonable income), and by the patient's ability to express tangibly his gratitude and acknowledgment. The amount of the "fair fee" thus varied from patient to patient, not just from CPT code to CPT code. This understanding of the physician-patient relationship did not eliminate economic forces from the practice of medicine but tempered them with other considerations.

Today this calculus has been inverted, as poorer individuals are charged far more than wealthier corporations. Physicians in large groups often cannot adapt their fees to their patients' means, since all discussion of fees is conducted by non-medical personnel *before* the patient is allowed to see the physician. Sad to say, some physicians also fail to understand the

nature of the learned profession of medicine and refuse to see uninsured patients.

As many have commented, the large segment of the economy devoted to medical care is fundamentally distorted. Although some blame its inequities on the "free market", others point out that the prevalence of a few major payers (government and a cartel of large insurance companies), while the consumer has no control over the financing of his own care, is anything but a truly free market.

Some, including many frustrated physicians, look favorably on a government takeover ("single payer") as the only solution to a miserable situation. Opponents of this scheme point out that it was politically motivated, market-distorting tax policies (i.e., making medical insurance tax deductible to employers but not to individuals) which established the present dysfunctional system. Furthermore, the experiences of England and Canada, and the rapidly increasing regulatory burden of Medicare and Medicaid in this country, provide rather discouraging examples of government medicine. Nevertheless, whatever the proposed solutions, almost no one considers the current situation to be tolerable.

In his novels, Aleksandr Solzhenitsyn describes the decline of morality in the Gulag, a microcosm of the totalitarian state. Trustees abuse ordinary prisoners, justified by the guards' brutality to them, they justified in turn by the oppression of the wardens, they in turn by the tyranny of the commissars, all the way up to Stalin's lethal temper tantrums. Are hospitals and doctors similarly justified in gouging our patients because insurance companies put the squeeze on us, because the government imposes costly and burdensome regulations on the insurance companies, because politicians want to curry favor with an electorate that has been promised ever more benefits at no cost to themselves? Does the Nanny State inevitably become the totalitarian state *through the cooperation of its own citizens*? If these questions seem overblown, perhaps we should ask ourselves how totalitarian regimes came to power in other countries. As much as we love our country, can we believe it to be immune to such abuses, which are rooted not in the ethnic or cultural deficiencies of other peoples, but in fallen human nature itself?

Clearly, Catholic hospitals require financial responsibility in order to survive to carry out their mission. It would be naïve to assert that they could go back to the 1950s. The question is whether the financial policies of Catholic hospitals serve their mission, or simply survival for its own sake, even at the expense of the mission and in violation of Catholic standards of justice.

I believe that several changes may help to restore the core identity of the Catholic health care mission as a work of charity. First, price gouging

should stop. Charging working families many times as much as large, wealthy, powerful third-party payers is fundamentally unjust.

Second, efforts should be made to revive charitable giving as a major source of revenue for Catholic hospitals, if only to bridge the gap between costs and third party reimbursement, and to replace the immoral cost shifting to individuals which now occurs. Perhaps a cue can be taken from Catholic universities, which continue to seek (and find) sources of charitable giving. Programs could be organized, for example, along the lines of a scholarship program to assist those whose insurance fails to meet the cost of their care.

Third, the effort to cut costs should be intensified. Magnificent new construction continues at many hospitals. The halls are glutted with junior executives. Medical staff dinners rival royal banquets. The economic constraints of the present may seem severe in comparison with the excesses of the recent past. But they are a result of it. Hospitals and physicians have not yet weaned ourselves from the luxurious lifestyle to which we have recently become accustomed.

Fourth, Catholic bishops should require that Catholic hospitals adhere not only to the Church's teachings regarding the life issues, but also that their business standards are consistent with Catholic doctrine regarding commutative justice. Perhaps an amendment to the *Ethical and Religious Guidelines for Catholic Healthcare Institutions* would accomplish this end. It may also be necessary to revise the statutes of some religious orders to assure that the enterprises carried out in their name are consistent with the mission of charity of the Catholic Church.

Finally, as frustrated as we all are with the cumbersome, inefficient, draconian, capricious, irrational, nit-picking, tyrannical, arbitrary and unfair system which looms ever larger as a dark cloud over our lives, at least let us, as Catholic hospitals and as Catholic physicians, refrain from being as unjust to our patients as the system is to us.
