

Virtual Mentor

American Medical Association Journal of Ethics
August 2011, Volume 13, Number 8: 534-538.

CLINICAL CASE

Enforcing Patient Copays

Commentary by Chris Brooks, MD

The Healthy Communities Clinic is a “free” clinic serving the uninsured population of an inner-city area. With the recent economic downturn, there has been a surge in patient visits; an ever-increasing number of residents are relying on the clinic’s services. The clinic director, Dr. Mizrahi, has mixed feelings about the boost in “business.” With most of the clinic’s funding coming from private donors, foundations, and a community health center grant from the federal government, she realizes that a new source of revenue must be identified to keep up with demand for services. After much discussion, the clinic’s board of directors decides to institute a sliding-scale fee system to help care for additional clients, update old equipment, and purchase more medicines for the clinic’s small dispensary. Signs about the new policy are posted throughout the clinic 3 months in advance to ensure that all patients are informed of the change.

A few weeks after the new policy has gone into effect, Dr. Mizrahi is happy to see that most patients have been able to afford the small copays required for clinic visits, as both new and established patients have continued to come to the clinic. In the middle of a busy Monday morning, Dr. Mizrahi pauses to read her next patient’s chart. Mr. Simon, one of her favorite patients, is to be seen for the routine check on his cholesterol. Before she enters the exam room, she is stopped by Ms. Gutierrez, the longtime front office manager for the clinic, who seems exasperated. “He said he couldn’t pay this morning. His proof of income indicates that he makes more than \$30,000 annually, and he says he is still employed. I don’t know why he says he can’t pay—but I roomed him anyway.” Confused, Dr. Mizrahi finishes reviewing Mr. Simon’s medical history, knocks on the door, and receives a friendly wave.

“Let me call you back, Jim, the doctor’s here,” Mr. Simon says into his cell phone. Dr. Mizrahi can’t help but notice that it is a newer 4G model equipped with camera, touch screen, and fancy case. “That’s nicer than mine,” thinks Dr. Mizrahi.

“Nice to see ya, Doc!” booms Mr. Simon. “Sorry about not being able to pay you today—you know how it is at the end of the month!” He points to a brightly colored sign indicating the new policy on the exam room wall and grinned. “I know about your new system, but I thought you wouldn’t mind. What’s one more visit?”

Commentary

The United States is one of few countries in the developed world that does not have universal health care coverage. Of the 30 country members of the Organization for Economic Cooperation and Development, only Turkey, Mexico, and the United States lack this entitlement [1]. Consequently, health care needs for the underserved in the U.S. are met by a variety of mechanisms with heterogeneous funding sources. The Healthy Communities Clinic in this scenario is typical of many across the United States that often struggle to provide the needed resources for their patients. Innovative methods to increase the financial viability of these clinics and allow them to maintain their level of service are constantly being sought. Copayments have been accepted as the standard for insured patients, and such payments instituted on a sliding scale have been adopted by many community clinics. Other methods to collect resources from patients have been less fruitful and can shift the burden to those who are more willing, as opposed to more able, to pay.

The argument that patients should share in the cost of their health care is quite strong. The idea of patient responsibility for health, both in terms of lifestyle choices and the financial burden of care, has been gaining popularity. Accepting this responsibility allows patients to have increased autonomy, making health care decisions that are more informed and based on more realistic cost-benefit assessments. The issue at hand is how can financial responsibility be equitably distributed in a society where the financial resources are not? Sliding-scale payments based on established and equally applied standards have been used as an attempt to address the issue. But when should such copayments be waived? The American Medical Association addresses the issue of insurance copayments in its *Code of Medical Ethics* [2]: “When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.” The question then arises, who should evaluate for medical need and financial hardship? How should this be done?

Cappelen and Norheim take a liberal egalitarian view, arguing that inequalities that result from “circumstances,” but not those that result from “choice,” should be eliminated [3]. It is the choice itself and not the consequence of the choice for which the individual should be held responsible. Denying health care to patients in need can be a form of holding them responsible for outcomes. (Cappelen and Norheim suggest that financial responsibility for health-related choices can be distributed in the form of rewards or taxes associated with behaviors.) In our patient’s case, however, it might be difficult to argue that he is in a particular time of need.

As part of a trend to increase “personal responsibility” for health status, in 2006 the federal government approved West Virginia’s plan to provide reduced basic benefits to Medicaid recipients and allow them to qualify for enhanced benefits by signing and adhering to a “Medicaid Member Agreement” [4, 5]. Under this plan, patients could lose health care benefits based on tracked behaviors that might be the result of factors beyond their control. The physician was unable to personally evaluate the needs and resources of the individual patient. The ability to intervene in special

circumstances, providing or referring to needed resources, was also removed. In our patient's case, the physician's ability to personally evaluate her patient's need is preserved. Doing so in a just manner requires that pre-established criteria for waiving medical copayments exist at the clinic. Preconceived notions on the part of the clinic staff about what constitute appropriate sacrifices to make to obtain access to health care may not necessarily be congruent with patient values.

Cultural differences in the value of health care, both intrinsically and relative to other needs, can play a large role in the perceived need to make copayments. Patient perceptions of "health" can relate to responsibility, inner peace, justice, independence, God's will, family, mental strength, and growth, among other factors [6]. Differences in how patients view their "health" can change the relative benefit of receiving care as well as the willingness to accept the burden of a copayment. Furthermore, different groups may rank health care differently in the list of perceived needs for their lifestyles. Deviating from cultural norms to obtain health care can also carry a large burden for many patients. For example, should an elderly patient forego a new uniform for the holiday parade or a youth do without a sports jacket in order to obtain basic health care? Many of these values may seem strange to those evaluating the need and ability to pay of patients who seek care at a community clinic.

The just delivery of health care and social justice are increasingly being recognized as inextricably bound. Samia Hurst, a Swiss biomedical ethicist, argues that, if our purpose is just health care, "ordinary medical fairness" (that is, giving preferential treatment to no one) is better than giving high-priority (extra or first) care to the disadvantaged, on the grounds that such preferential treatment erodes social cohesion and may further differentiate or stigmatize marginalized people [7]. This argument may be sound, but "ordinary medical fairness" is not a feature of the decidedly unequal American system. In countries like ours, overcoming other social inequalities must take top priority to allow for a just distribution of health care resources. It is also possible that patients who perceive that they do not have ready access to health care may need incentives to access the system. Physicians must balance the individual needs of patients with the political agenda of distributing goods, services, and opportunities as freely and equitably as possible for the common good [8].

Finally, what avenues are available to Dr. Mizrahi as she deals with Mr. Simon's refusal to pay? Saul Wiener makes some suggestions in "I Can't Afford That!" [9]. Physicians should explicitly ask about financial concerns. Doing so allows the physician to take into account the ramifications for the individual while considering alternative approaches to patient treatment. Physicians should be knowledgeable about the resources available in the community. For example, a clinic that does not charge a copayment might be available to Mr. Simon if he continues to choose not to make them.

Continuity of care should also be considered for the patient. Would he be better served at a location where additional resources might be more accessible? If not, that may increase the likelihood that Mr. Simon's copayment should be waived. If the patient must stay with the clinic that charges a copay, then a nonstandard form of care may need to be adopted. For example, additional copayments for procedures or treatments may change the manner in which these are recommended to the patient. Although this may seem to violate the concept of egalitarian health care, in reality this may be the only option for our patient. Mr. Simon would need to be informed that his desire to avoid copayments has ramifications beyond a single clinic visit. To serve our patients, physicians must ultimately address social justice outside the office.

It is up to the individual physician or organization to decide whose copayments will be waived. This should be done in a just manner that evaluates the medical and financial needs of the individual patient and that takes the patient's individual and cultural values as well as societal needs into consideration. Thorough knowledge of the patient's circumstances and community resources is imperative when making this decision. Expecting patients to share in the responsibility for their health care is acceptable when it is done in a just manner. The ultimate beneficiaries of this are both society and the individual patient, who can acquire a greater ability to make effective health care choices.

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