Editorial

Bad Debt and Medical Indigence in Primary Care

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Until recently, there have been no data on uncompensated health care in the office-based setting. While anyone who has worked in an office-based practice, from the receptionist to the physician, knows that a portion of patients will not pay, these costs to providers, and to the health care system in general, have not been closely examined.

Recent studies have provided survey data on uncompensated care at a variety of group practices.[1,2] It has become clear that most practices substantially subsidize large numbers of indigent patients by providing charity care and through the accumulation of bad debt (the former referring to free care willingly given, and the latter to the many instances when patients do not pay all or a portion of the bill for services they have received).

As a working definition, a patient is said to be medically indigent when he or she is unable to pay for either all or a portion of the care that is needed. Our nation's patchwork health care payment system distributes the costs of caring for the medically indigent indirectly among several groups, including providers, third-party payers, and other patients. The pressure is felt directly, however, in the office where the physician meets the patient. As the costs of health care rise, as co-payments and deductibles increase, and as the price of private insurance goes up, patients are increasingly faced with bills they cannot pay.

Despite the large numbers of nonpaying patients and the absence of regulations or public resources to guide and assist providers, an old-fashioned ad hoc system persists as a mechanism for rationing services. In a simpler and less costly era, barter arrangements and physician pro bono services were viewed as sufficient for meeting the needs of the medically indigent, and practices were generally able to absorb the financial losses without too much difficulty. Over the years, however, changes in the number of medically indigent, rises in the cost of care (especially for overhead), and increasing legal barriers to cost-shifting have radically outdated these once satisfactory, old-fashioned mechanisms. Nevertheless, in the continued absence of a system of universal coverage, a multitude of nonpaying patients are in the untenable situation of seeking necessary care to which they are not currently entitled, and providers are left to decide, literally, who to "let in the door." In the poorer primary care setting, this system of "rationing of access" is the modus operandi of daily business. In dispersed rural communities, there are often no large public hospital emergency departments to shoulder the burden, and just a few physicians in town. In the physician's office, especially at the front desk, dozens of decisions are made daily about who most deserves free care.

We are a long way from understanding uncompensated care. What are the economic costs faced by office-based physicians in treating the medically indigent? What is the relative magnitude of these costs when compared with market pressures from third-party payers for discounts from charges? Has the relative burden increased in recent years? Are there variations in the relative magnitude of losses in rural as compared with urban areas?

Part of the problem in studying the office-based practice is the lack of reliable data. Surveys are of limited usefulness. In the December 1991 issue of *The Journal of Family Practice*, Horner et al[3] suggest that even computerized billing data may not be accurate. Furthermore, there are methodological problems that need to be addressed. Past research on uncompensated care has focused on hospital settings where cost-to-charge ratios and other accounting tools are available for analysis. Hence, financial losses in hospital settings have been easily studied.[4] In office-based primary care, however, it is difficult to assess the true costs to the practice of not receiving full payment for a service rendered. First, the direct cost plus overhead associated with rendering a specific service is variable and difficult to determine in different practices. Therefore, it is not easy to assess the

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costs associated with nonpayment. Second, patients pay different fees for the same service, depending on their insurance status. Hence, it is hard to gauge what nonpaying patients would have paid had they not been indigent. Finally, it is difficult to assess the opportunity costs in a busy practice where a nonpaying patient may have displaced a paying patient. Without having either a measure of the actual cost or a uniform payment for each service, it is most difficult to assess the economic impact on a practice when care is freely rendered.

The losses associated with bad debt may be the final straw overwhelming an office already burdened with third-party-imposed constraints. The uncompensated care of indigent patients constitutes just a portion of the write-offs that a practice absorbs. This is because physicians increasingly find themselves in arrangements with third-party payers for which fees are fixed and set below the physician's normal charge for services. Physicians continue to bill their customary fee but write off the difference from what they actually get paid. In addition to the nonpaying patient and the write-offs associated with these private insurance arrangements, there are the losses associated with Medicaid and Medicare as well. Finally, there is a substantial loss to the physician when insured patients fail to forward checks sent to their home by a third-party payer.

Clearly, the issue of uncompensated care is integral to many of the important health care policy issues of the day. In the absence of a system of universalized health care coverage, either the costs of serving the medically indigent patient are shifted or care is denied. In the face of increased market pressures on physician practices, denial of care may become increasingly necessary. In geographic areas where levels of indigence are highest and the margins of profit lowest, practicing medicine may not be viable. Health management organizations and other managed care institutions may be unable or unwilling to expand to some areas with potentially high need or demand because so many patients could not afford to enroll. Given such far-reaching implications of "uninsurance" and the problems associated with medical indigence, it is in the best interest of all—insured patients, third-party insurers, and providers—to resolve the problem once and for all.

Partial solutions to the problem of medical indigence are being implemented at the grass-roots level in some communities. There are reports of county medical societies organizing their own system for assessing the degree of indigence of uninsured patients in the local community, and distributing responsibility to local physicians for some level of care to those patients who need it most. With creativity and good will, a group response on the part of a local medical community can go a long way in providing emergency and day-to-day care to the medically indigent.

The grass-roots approach is unlikely to be tenable, however, as a long-term comprehensive solution to the problem. Because the need is so great, generous county medical societies are liable to be overwhelmed with demands for services. Futhermore, from the standpoint of the uninsured patient, ad hoc care will never be reassuring or perceived as a reliable form of coverage. The concept is somewhat akin to that of the homeless shelter, which can never function as a home.

While emergency care for the indigent may feasibly be managed on a local level, routine, day-to-day visits, especially for preventive care, will probably require national or state administration. We must explore options such as implementation of publicly or privately supported insurance programs with higher allowances for practices in low-income geographic areas. The problems of cost-shifting and of geographic pockets of high medical indigence must be addressed, as we strive for some level of coverage for everyone.

It appears that many communities cannot support a physician's practice, and we must understand the economic forces and policies driving these practices away. Policymakers cannot proceed competently, however, without detailed information on the distribution and implications of costs associated with medical indigence. We should appeal to private industry—insurance and pharmaceutical—as well as federal sources to help fund this research. Ultimately, good data on uncompensated care will be essential as we restructure our health care system.

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