

NEW PERSPECTIVES: PART I

Is Anyone's Time Valuable?

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Elizabeth Cohen's recent "Would Your Doctor Pay for Wasted Time?" at CNN.com¹ focuses on patients' frustration with regular long wait times at physicians' offices. Rather than exploring the etiology of wait times—or solutions to reduce them—the article describes compensation paid by physicians to patients who are made to wait. One prominently featured patient has billed her physicians for excessive wait times with a surprisingly successful collection rate. Innovative physicians featured in the story attempt to mitigate wait-time fall out with a variety of token gifts, with one physician handing out \$5 bills to every patient made to wait. While efforts on both sides to remedy (or at least compensate for) long wait times are much appreciated, long wait times are not simply due to a pervasive lack of physician respect for patient time. They are reflective of much deeper problems with the compensation for medical services paid by insurers. What we are left with is a world in which patients are forced to trade their time for our services.

Who would design a system that always keeps people waiting? Under the current fee-for-service model that dominates primary care, physicians are basically "on time" based on the number of 5-digit codes that they can generate per patient in a specific period of time. To comply with billing rules, physicians must personally perform all actions submitted as an office visit, regardless of whether the work could be done by someone else or with a different communication medium, such as e-mail. Once codes are generated, physicians are still unable to negotiate the payment rate for time/codes in any meaningful way. Given that Revenue = Price x Volume, we are left with increasing volumes of billed codes as the only

mechanism to increase revenue. As costs of delivery in health care are completely opaque, physicians and health care executives operate under the assumption that a growth in revenue through volume will equate to a growth in profit (which is not always true). So our system is rigged to force physicians to squeeze 18 hours of work into eight to 10 hours of time in order to generate enough revenue to keep their practices open. This creates a notion of "Magic Time" in which physicians are faster and more efficient than they are in real life. Since we do not live in Magic Time, but reality, we must shorten our time with patients and schedule more of them each day, resulting in longer waiting times.

It is not the financial interests of medicine that are to blame for our current situation. Whether continued by tradition or institutionalized by scheduling software, physicians everywhere adhere to the *fictive schedule*—a term coined by ACP's Chesluk & Holmboe² to describe the "unending stream of 15-minute visits." As they reported, despite everyone in the office knowing that the schedule was not accurate and could not be followed, the rapid fire visits nevertheless set up expectations that no one can meet. Without incorporating patient factors such as triage information or level of complexity, this schedule is designed to succeed at pushing many patients (codes) through the door but completely fails at providing any reasonable guidance for the complex service business that is medicine. One Ob/Gyn clinic that I know of schedules 50 patients for two appointment slots per day—8 am and 1 pm. Frankly, this absurdly reduced schedule is no better or worse than most others, so why do we insist on having such a schedule?

With our physicians stuck on a wheel, cramming more visit into less visit time, there are only two possible outcomes: lower quality visits or endless waiting. Both the short visit and the long waits generate a sense of physician scarcity within our patient population. In both shorter and lower-quality visits, patients feel hurried and rationally attempt to keep the doctor in the room knowing they may not get a chance to see him/her again. This can breed frustration for a physician trying in vain to keep the fictive schedule. If patients and their physicians are unable address all their concerns during the visit, they also have the option to schedule more frequent appointments. This increased visit frequency actually improves the physician's top line in a fee-for-service model but sharply decreases overall access. In turn, the decreased overall physician access can lead patients to introduce too many problems during one visit so that none can be addressed properly. My record is 14 problems in an expansive 25-minute visit. I am not the first to observe this phenomenon: Very short, frequent visits with high paperwork burden were documented in the Soviet Union medical system as early as the 1970s!³

For those unwilling or unable to speed through patient visits, longer waiting times remain the only option. For better or worse, the longer waiting times stem from our basic commitment to our patients. We are well trained and dedicated to caring for the person in front of us. As a great teacher told me, patients do not mind waiting for you if they know that they will get your undivided attention. While very true, the long wait times generate real costs for our patients, resulting in a sense

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of entitlement. Since patients have “paid” for our time by waiting, they feel entitled to take their turn with us as long as they need. While this is logical to the individual, it has disastrous systemic consequences.

Beyond the ways in which our payment system affects schedules directly, there is a more sinister way in which third-party fee-for-service payments fundamentally alter our relationship with our patients. In the Cohen article, patients complain accurately that they are not treated with the respect that customers deserve. However, because money flows from patient to payor, then payor to the physician, patients are in fact not the true customers. In the current system of practice, the payors are our customers, and we like keeping them happy by meekly asking to be paid, filling out forms, and complying with endless regulations. Unfortunately for our patients, our customer cannot assess quality and thus buys on low prices rather than high quality. As a result, patients, physicians, and payors remain out of alignment. Think about your own waiting rooms for a second. When you see your list of patients for the day, are you excited like a restaurateur with a full house, or are you exasperated like Lucy trying to wrap all of the chocolates on the assembly line?

Perhaps the analysis above will

lead to the conclusion that patients should pay directly for their primary care visits. While I have entertained the design of such a system, the fact is that patients already pay dearly for their health care through direct contributions, job inflexibility, and an artificially imposed fear that poor job performance could result in a loss of health care. Despite all that they give up for health care, hardly any of this goes to their physician. Doctors and patients aside, by deciding that we cannot negotiate the price for our services, and by setting that price too low, we have demanded that everyone give up a resource more valuable than money—time. While this may seem like a fair distribution of misery, I would argue that it is not.

The solution lies in changing the way we as patients pay for our primary care. We must move away from visit-based fee-for-service, which constrains our ability as physicians to only care for the patient before us, rather than the population to which we are beholden. With the end of fee-for-service, we will minimize wait times by freeing physicians and patients to delegate tasks to other staff, deliver care outside a of visit-dominated model, and eliminate the massive apparatus dedicated to billing and coding. Fortunately, people across the country are working on solutions to this problem through capitation models

such as Medicare Advantage Plans, direct payment for services, concierge medicine, and employer-sponsored primary care.

So while I commend clever patients billing physicians and smiling doctors handing out \$5 bills, they are completely missing the point. The deck is stacked against both physicians and patients, as primary care is paid for through an elaborate, misaligned, draconian third-party payment system that forces office visits to be the dominant venue for care despite patient preference and world-changing communication technology. If we want wait times to vanish, we need to change the way we handle money in primary care. Returning the patient to the role of customer will fix the problem of waiting times and beyond. I have seen the future of primary care, and fee-for-service is not in it. It is time for new models to take hold.

References

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