Ways to cut down medical costs discussed in European study

Medical prices are rising at twice the rate of the cost of living. In the coming fiscal year the Medicaid program alone will cost about $1.5 billion more than it does now, according to government officials.

How can we get the most for the government's and the patient's money? Part of the answer to this urgent question may be derived from studying the methods of paying doctors in other countries, according to William A. Glaser, author of "Paying The Doctor: Systems of Remuneration and Their Effects," published recently by The Johns Hopkins Press.

Some systems encourage doctors to "make work," prescribing diagnostic procedures and tests which are not strictly necessary and which add to cost.

Other systems tend to encourage neglect of the patient. None is ideal. All require vigilance by control mechanisms, and honesty on the part of doctors.

Professor Glaser studied four types of payment systems in 16 European countries when he visited these countries from May, 1961 to August, 1962.

"Fee-for-service," the first payment system discussed in the book, is payment for each medical procedure. The second system presented is "case payment," a fixed sum paid to the doctor for giving the patient all necessary care.

The principle danger in these two types of payment is the performance of medically unnecessary procedures. "Since the patient pays nothing and may not know how the doctor bills the sick fund, the patient might not protest repetitious and unnecessary care, and the physician might bill the fund for procedures not performed."

One of the causes of this type of abuse: low fees.

Under some systems the sick fund pays the money to the patient and expects him to pay the doctor his fee for service. Doctors often press for this way of paying (known as "cash benefits") because "the doctors believe the arrangement will preserve their autonomy in full. Since the patient and not the physician communicates with the sick funds, the profession believes the funds can never limit its fees, regulate its clinical decisions, or influence the choice of doctors by patients," Glaser asserts.

However, there are several bad effects: If the doctor charges a fee which is higher than permitted by the medical fund, the fund may refuse to pay the fee or may make the patient pay the difference between what is allowed and what is charged. Another danger is that the need to pay cash causes some patients to delay seeking needed care.

The third type of payment system, "salary," a fixed amount of money scaled according to the rank of the job, has been associated with both weakness and excellence. Hasty care, few home visits, excessive referrals sometimes occur, but there are often desirable results, such as non-mercenary attitudes, close colleague relations, interest in personal professional growth and economical care.

"Capitation," the fourth system discussed, is a fixed annual payment for each person on a list regularly assigned to the doctor. Neglect of the patient can result because the system gives no pecuniary motives for more effort or for work of better quality. There is a world-wide trend away from simple capitation systems.

The U.S. will probably follow a pattern set by many countries — notably Sweden — nationalizing the private insurance structures which already exist and using their mechanisms to pay the doctor.

Also, the rights of private practice will probably be incorporated into the official scheme in the U.S.

Mechanisms for combatting the evils of each payment system are included in the discussions. However, Glaser concludes that no payment system will work well unless doctors are honest.

Their ethics must extend further than high-principled attitudes toward individual patents, important as these are. They must include a moral commitment concerning the use of public funds.

A potpourri of international gossip about the medical profession is gleaned from these accounts of systems in many countries. Doctors in France earn much higher incomes than other professional men, including lawyers and university professors and government officials.

Germans have been notorious for malingering, some making almost a career of taking sick leave, with the cooperation of their physicians. Sweden has a greater shortage of doctors than most countries, with one to every 933 persons. Swiss doctors seem exceedingly busy, seeing 60 patients a day much of the year and 100 in winter. A striking conclusion for any American reader accustomed to paying the doctor out of his own pocket is that fifteen of the sixteen countries visited had some form of national health insurance or a national health service even as long ago as 1961 and 1962.

The book will be valuable background reading for doctors and for government officials interested in shoring up the delivery of medical services. It provides essential information for everyone who is active in fighting for a humane and just system of medical payment in the U.S.

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