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May Medical Centers Give Nonresident Patients Priority in Scheduling Outpatient Follow-Up Appointments?

Armand H. Matheny Antommaria

ABSTRACT

Many academic medical centers are seeking to attract patients from outside their historical catchment areas for economic and programmatic reasons, and patients are traveling for treatment that is unavailable, of poorer quality, or more expensive at home. Treatment of these patients raises a number of ethical issues including whether they may be given priority in scheduling outpatient follow-up appointments in order to reduce the period of time they are away from home. Granting them priority is potentially unjust because medical treatment is generally allocated based on medical need and resource utilization, and then on a first-come, first-served basis. While it is difficult to compare the opportunity cost of waiting for an appointment to different patients, nonresident patients incur higher expenditures for travel, room, and board than resident patients. Giving them priority in scheduling to reduce these costs may be justifiable. Preferentially scheduling nonresident patients may also indirectly benefit resident patients consistent with Rawls's difference principle. This potential justification, however, rests on several empirical claims that should be demonstrated. In addition to reducing resident patients' waiting times, medical centers should not prioritize nonresident patients over resident patients with more urgent medical needs. There is, therefore, a limited and circumscribed justification for prioritizing nonresident patients in scheduling follow-up appointments.

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INTRODUCTION

With increasing financial pressures on academic medical centers, some have sought to recruit patients from outside their historical catchment areas. Some of these patients live beyond a reasonable commuting distance from the institution and require local accommodations. Being away from home is an issue for these patients and those paying their expenses due to the personal and financial costs, and the question arises whether it is ethically acceptable to expedite outpatient follow-up appointments to facilitate their return home. This question can be analyzed in terms of justice, and useful analogies may be drawn with concierge medicine and the treatment of very important persons (VIPs). The formal principle of justice is based on treating similar cases similarly. Potential criteria for what makes patients similar or different include medical need and resource utilization; status; opportunity costs; and the costs of travel, room, and board. The allocation of healthcare resources is typically based on patients' medical need and resource utilization. Patients with similar need and utilization are then generally treated on a first-come, first-served basis. While concierge practices may provide patients within the

practice greater access to providers than other practice models, these benefits do not typically extend beyond the practice itself. At times, however, different treatment in some respects is justified in order to treat patients similarly in other, ethically relevant respects. For example, additional effort may be required to protect celebrities' confidentiality. While status and opportunity costs are not ethically relevant to scheduling, a potentially relevant consideration is the increased travel, room, and board costs nonresident patients incur. In addition to the formal principle of justice, there are a number of substantive principles. Unequal treatment may also be justified by Rawls's difference principle; privileging nonresident patients in scheduling may indirectly benefit resident patients. This empirical claim should be verified. The difference principle, however, does not justify prioritizing nonresident patients over resident patients with more urgent medical needs. Therefore, while there are some potential justifications for giving nonresident patients priority in scheduling outpatient follow-up appointments, they are limited in their scope and force.

BACKGROUND

Given the economic downturn, uncertain reimbursement environment, and increased competition, some academic medical centers in the United States have sought to diversify and strengthen their sources of income. One potential mechanism is recruiting patients, either domestic or foreign, from outside of their traditional catchment areas. This article will refer to these patients as nonresident. (Residency is independent of citizenship.) These individuals may seek treatment that is unavailable, higher quality, or lower cost than in their local community. In addition to increasing facilities' patient volume, these patients are attractive to medical centers because their treatment is typically reimbursed at a higher rate than Medicare or Medicaid through self-pay, commercial insurance, or government sponsorship. Medical centers may also seek wealthy patients as potential donors. Recruiting patients from new catchment areas may also support the institutions' education and research missions.[1]

Treating such patients may generate additional issues for medical centers. They may need to provide interpretation services and develop their staff's cultural competence. They may also need to facilitate lodging and provide appropriate dietary choices. Care of patients from other cultures may also raise ethical issues, such as requests for careproviders of a particular gender or differences in informed consent or end-of-life care.[2]

One prosaic ethical issue that has arisen in the treatment of nonresident patients relates to the scheduling of appointments. Nonresident patients may be away from home for significant lengths of time, hundreds of days. During some of this time, the patients may have been discharged from the hospital and be living in the local community awaiting outpatient follow-up. It may not be possible to schedule these follow-up appointments prior to the patient's arrival, and outpatient clinics may have significant waiting times, weeks or months, for appointments. The issue has arisen whether it is ethically acceptable to schedule nonresident patients sooner than resident patients. (Note that this particular response is not an effort to reduce waiting times in general, which would benefit both resident and nonresident patients.[3]) This issue is most appropriately analyzed in terms of justice.

FORMAL JUSTICE

Justice does not require treating everyone the same. Rather it requires treating similar cases similarly. The crucial question is what are the ethically relevant similarities and differences.[4] Medical care in the U.S. is generally or ideally allocated based on medical need and resource utilization and then on a first-come, first-served basis. (It should be acknowledged that many individuals' access to healthcare is constrained by their ability to pay.)

Medical Need and Resource Utilization

Primary care. In the primary care setting, even within concierge practices, appointments are typically based on medical need and then on a first-come, first-served basis. Careproviders typically have fixed-length appointment slots and assign different categories of patients different numbers of slots. Categories may include sick, well, and new patients. Careproviders may also have access rules that specify how available slots may be assigned. They may, for example, reserve a certain number of sick visits that cannot be scheduled more than one day in advance in order to accommodate urgent needs. (Clinics may also accommodate excess demand by double-booking patients or extending service hours.) Each category of visit is generally scheduled on a first-come, first-served basis: the first caller has the first choice among available appointments. Scheduling specialty care is more complex because it generally involves different length appointment slots and a higher percentage of urgent patients.[5]

Some careproviders have developed a practice model called various names including retainer, concierge, boutique, and luxury primary care, in which

patients pay an annual fee for greater access. The annual fee is typically $2,000 to $4,000. (A practice may also bill patients' insurance. Some insurance plans, however, prohibit balance billing or charging access fees.) This source of revenue allows careproviders to have smaller panels of patients: approximately one-third fewer. Careproviders offer amenities or special services such as longer appointments, house or office calls, and accompanying patients to specialists or procedures. The practices typically provide patients with 24-hour-a-day, seven-day-a-week access via telephone or email.[6] Analysts contend that, while patients receive additional services, they do not necessarily receive a higher quality or standard of care.[7] Data regarding resource utilization and health outcomes in retainer practices compared to conventional practices are lacking.

Some have criticized this model for reducing access[8] or unjustly creating two tiers of healthcare.[9] Within this system, however, patients are treated similarly in the allocation of appointments. Patients generally do not receive similar amenities when they see a specialist or are hospitalized.[10] (For the purposes of this discussion, executive physical programs—corporate-sponsored examinations for top executives at referral centers[11]—are more like domestic medical tourism than retainer medicine, because they involve generalist and specialty care, but do not provide patient-centered, comprehensive primary care.)

Emergency care. In acute and emergency care, patients are generally triaged based on medical need and resource utilization. Most triage systems utilize five, rather than three or four, levels.[12] The most commonly used triage system in the U.S. is the Emergency Severity Index (ESI). The highest level, Level 1, are patients who require immediate lifesaving interventions, and the second highest level, Level 2, are patients who are in high-risk situations; are confused, lethargic, or disoriented; or in severe pain or distress. Levels 3, 4, and 5 are differentiated on the basis of how many different resources—laboratory and radiographic studies, treatments, specialty consultations, and procedures—patients need. Level 3 patients, who require many different resources, can be increased to Level 2 if their vital signs are in the "danger zone."[13] ESI has been shown to be both reliable and valid.[14] (Military and disaster triage systems differ from emergency triage by including a category for patients who will die even with treatment, and by potentially prioritizing individuals who are essential to the war effort or to the common good.)[15]

Level 1 patients are seen before Level 2 patients, and Level 2 patients are seen before Level 3, 4, and 5 patients. Level 3, 4, and 5 patients are generally tracked to the appropriate level of service and then are seen on a first-come, first-served basis. In triage in the emergency department, need and resource utilization are the relevant criteria, and patients with the same level of need and resource utilization are treated similarly.

Security and Confidentiality

While medical treatment in the U.S, is predominantly allocated based on medical need and resource utilization, there are other potential criteria for allocating treatment. An example of just, although potentially different, treatment is modifying treatment based on the need to protect patients' security or confidentiality. The confidentiality of all patients should be protected. To provide the same level of protection, some patients may, however, be treated differently. There may be more interest in politicians' or celebrities' medical information, and special actions, such as placing them in a private area or treating them under a pseudonym, may be necessary to provide the same level of protection.[16] Note that being placed in a private area, such as a treatment room, does not mean being treated sooner.[17]

Status and Opportunity Cost

An example of potentially unjust treatment is the preferential treatment some VIPs (very important persons) receive in emergency departments. VIPs may include not only celebrities and political leaders, but also individuals who are influential within the healthcare organization, such as board members and their families.[18] Schenkenberg, Kochenour, and Botkin reinterpret the I in VIP as *influential,* to include anyone whose clinical or personal characteristics produce a significant alteration in the clinical approach.[19] It is an open question whether this different medical treatment represents higher quality of care. Some have raised the concern that being treated by the department chair or being spared uncomfortable or complex procedures may produce worse outcomes.[20]

Empirical data suggest that VIPs are frequently treated sooner than other patients in emergency departments.[21] Diekema, among others, argues that this is unjust because social status is not a morally relevant criterion. He contends that while individuals who have contributed to society deserve benefits, VIPs generally have already received benefits, and that these benefits should not extend to healthcare because the healthcare system was largely developed through public funds. [22]

A second possible justification for seeing VIPs sooner is the opportunity cost incurred by waiting; the cost of alternatives foregone by waiting. Some

individuals' time may be much more valuable than others' and they may, therefore, bear a greater cost waiting. An engineer's hourly wage, for example, is substantially higher than a cashier's. It is not, however, clear that this is an ethically relevant criterion. The economic or social effect of the lost income may be more significant to an hourly, minimum wage employee who has no or limited financial reserves. This individual may also not have paid time off, have limited childcare resources, and/or risk losing his/her job as a result of missing work.[23]

Travel, Room, and Board

Consideration of opportunity costs suggests another, potentially relevant consideration: the additional expenses nonresident patients incur while waiting. Martin, for example, argues, "International patients' medical care must be expedited because of the time invested and expense incurred when they travel to the United States."[24] Individuals who travel for healthcare typically must pay for lodging in the destination community in addition to maintaining their home. They also experience increased per diem costs for food and other amenities. If they were to go home and come back for an appointment, they would experience additional transportation costs. (These expenses may be paid for by a sponsoring agency that nonetheless has an interest in reducing these costs.) There are also nonmonetary costs, including being in a foreign culture and away from family and friends. These are costs that local residents do not incur. It may be reasonable to attempt to reduce these costs by decreasing waiting times.

It is important to note that this argument justifies reducing wait times for follow-up appointments, but not for the initial evaluation. In addition, while some institutions attempt to facilitate scheduling multiple appointments on a single day, this service is generally available to all patients.

A potential counter argument is that these patients elected to travel for medical treatment, and the additional costs should have been considered in their decision; because they were voluntarily accepted, they are not unjust. This argument would have more force if reduced cost were patients' primary decision-making criterion. It holds less force when the treatment sought is not available in a patient's home location or is only available at substantially lower quality.

THE DIFFERENCE PRINCIPLE

Some individuals argue that facilitating the treatment of wealthy, influential, or nonresident patients benefits other patients: the economic resources that these patients generate can be used to treat other patients.[25] This claim is potentially consistent with Rawls's difference principle.[26] Rawls contends that basic liberties should be equally distributed among persons, but the distribution of income and wealth may be unequal under certain conditions. He argues that social and economic inequalities "must be to the greatest benefit of the least advantaged members of society."[27] (It should be noted that Rawls limits the application of his principles to the basic structure of society.)

An appeal to the difference principle is based on a number of empirical claims that should be verified. One is that decreasing nonresident patients' waiting times will increase the number of nonresident patients. A second is that treating nonresident patients generates additional revenue. While these patients' treatment may be paid for at a higher than average rate, their treatment may involve additional costs.[28] For example, it may require hiring additional medical interpreters. It would be important to be clear that there is a positive net financial benefit.

It would also be important to verify that the additional revenue is utilized in a way that benefits other patients. This may not be the case in a publicly traded healthcare organization where additional revenue is returned to investors. A further issue is whether the patients who are benefited must be the same patients whose appointments were delayed, and whether the benefit must be in kind. The simplest arrangement would be to use the increased revenue to decrease waiting times.

Some commentators argue that preferential treatment is not justified because other patients are harmed in the form of inconvenience, discomfort, and worse outcomes from delayed treatment.[29] The difference principle, however, requires that the inequalities benefit the least advantaged, making them better off than an equal distribution. An analogy might be drawn to Rawls's serial or lexical ordering of his principles; basic liberties cannot be violated to produce social and economic benefits.[30] In the case of scheduling follow-up appointments, medical need should have priority over residence status. It would be inappropriate to give priority in scheduling a nonresident patient's non-urgent, follow-up appointment over a resident patient's urgent appointment.

CONCLUSIONS

With changes in healthcare, medical centers are attempting to diversify their sources of revenue, including recruiting domestic and foreign patients from outside of their local community. There are

pressures to treat these patients differently, including giving them priority in scheduling outpatient follow-up appointments. Access to healthcare is generally based initially on medical need and resource utilization, and then on order of presentation. Giving some patients preference over others based on their status or opportunity cost is unjust. Reducing nonresident patients' travel, room, and board costs may, however, be a reasonable consideration. Unequal treatment may be justified by the difference principle, but only in cases of similar medical need. The increased revenue generated should be verified and used to improve resident patients' access.

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NOTES

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