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Introducing a Sliding Scale Fee System:  
Lessons From Health Clinics

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Retrenchment Papers

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FORWARD

The following papers have been developed under a grant from the Office of Field Services of the Legal Services Corporation.

They represent the views of their authors only and in no way should be construed as OFS policy. Their aim is to help programs think through the many difficult issues presented by the current threats to Legal Services and to develop effective plans. The papers are based on many interviews and work with local programs as well as derived from the wider literature on retrenchment planning. Given the press of time, we have chosen to make them available in initial drafts. We would appreciate criticism and alternative formulations on these issues and if appropriate will include feedback in subsequent papers or revised drafts. Please send any comments to

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In 1972-1973 ambulatory health clinics changed their method of financing due to changes in the law. Prior to that period services were either payed by third party payers or were given free of charge. After that period the clinics developed sliding scale systems to finance part of the cost of their service. Their experience in introducing sliding scale systems may be of relevance to those legal service programs considering charging clients on an ability to pay basis.

At present most health clinics charge clients some proportion of the full cost of a unit of service. The proportion is deterimined by a formula that combines family income and family size. In a typical formula, a client with an income, weighted for family size, that falls below the poverty level of the area pays nothing. Families with a weighted income up to 50% greater than the poverty level pay some percentage of the unit cost of service, and families with income at twice the poverty level pay the full cost of service (this applies of course only to that portion of the unit cost not covered by third party payers).

In introducing this service clinics faced the following political, management and moral problems.

1. Clients were intially angry -- they did not see why they should pay for services that were once free.
2. Community members of the boards understood that the clinics had to be fiscally viable but believed that fee collection would be politically and ethically difficult. They were particularly concerned about the ability of clinic staff to differentiate between "malingerers"and people who genuinely could not pay despite the fact that their measured income was above the poverty level.

3. Staff and board were concerned that attempts to collect bills would hurt the relationship between clients and the health providers. The health providers worried that clients would postpone going to the clinic until their problems were considerably worse. (This happened on occasion.)
4. Staff worried that collection would introduce a new "business ethic" into the clinic and drive out the service mentality which shaped and secured the mission of the clinic to serve poor people.

In coping with some of these problems successful clinics used the following system.

1. A financial counselor was hired to oversee the problem of collections. Billings were handled by a separate billings department, health professionals did not monitor payments by clients. A system of "aged accounts receivables" was established. When a person reached a point where they owed a certain trigger sum (e.g. \$250) he or she was directed by the billing clerk to the counselor. The counselor discussed the problem of billing with the client and was free to write off some (or all) portion of the bill if circumstances justified such a decision. (As a rule of thumb, the clinics found that if you didn't let a bill go past thirty days uncollected you had a better chance of collecting it.) They could also work with the client to develop a plan for repayment (e.g. so much a month). Initially collections were at 15% of billables but eventually rose to and stabilized at 50%.
2. Clinics found that collection agencies were not helpful. The amount collected minus the charge for collection often did not exceed the amount the agency could collect itself. Equally important,

clinic staff felt that if they used the collection agencies they would "alienate" themselves from the community they served and create an adversary relationship between the clinic and its clients. Instead, through their board and open meetings they emphasized that the clinic belonged to the community and clients were therefore responsible to see what they could do to keep the clinic fiscally viable. In this context when clinics introduced the sliding scale, or modified it in anyway, they first consulted clients through open community meetings.

3. The counselor had a difficult job. It was important that the counselor have both a service and business "mentality." It was not good if the counselor saw himself or herself as the business agent of the clinic since this could induce conflict between the counselor and the rest of the staff. The latter would complain about the heartlessness of the former and the former would complain about the irresponsibility of the latter. It was better if the counselor could represent both points of view. His or her difficulty in reconciling them would then lead the professional staff to be supportive and helpful in the bill collection process. This meant in turn that such counselors had to be carefully selected and trained.

Instituting a sliding scale imposed new costs on the clinic. They needed cashiers, a computerized billing service, an administrator to price the full unit cost of services and a staff-board process for revising the basis of the scale itself. These future costs must be considered in weighing the costs and benefits of a sliding scale fee system.

Finally, I believe it important for legal service clinics to develop ability to pay systems on the basis of real cost pricing. Some programs have developed ability to pay systems simply on the basis of the hourly wage of the client without regard to the cost of the service. This can cause great trouble in the long run since clinics will be unable to calculate the relationship between the cost of delivery and the support provided by the sliding scale system. If the latter returns too small a proportion of total clinic expenditure, the clinic staff will be unable to know in what portion they should change the mix of services, the basic charges or the collection system itself, to increase revenues from the sliding scale system.