POINT OF VIEW

Consultation Fees as a Barrier to Regular Follow-up

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Abstract

Regular follow-up visits are essential for effective management and prevention of complications of chronic diseases like hypertension (HT), diabetes mellitus (DM), cardiovascular disease (CVD), and coronary artery disease (CAD), and many more, for continuity of care and improved patient outcomes including quality of life. However, consultation fees act as a significant barrier, particularly in low- and middle-income populations, where out-of-pocket expenses deter patients from adhering to follow-up schedules. This article explores how consultation fees influence patient behavior, reduce compliance with medical advice, and ultimately compromise the quality of care and life. A review of current literature highlights the financial challenges faced by patients and allows us to think about potential policy solutions, including subsidized follow-ups, bundled care models, and extended free follow-up windows. Addressing this financial constraint is critical for ensuring equitable access to ongoing care and improving long-term health outcomes. Well-planned research on this issue is required for long-term planning.

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Introduction

In India, consultation fees, though modest by global standards, act as a significant barrier to regular follow-up, particularly among financially compromised populations. Chronic conditions such as diabetes mellitus (DM), hypertension (HT), cardiovascular disease (CVD), cancers, thyroid disorders, and many other illnesses require regular monitoring and frequent consultations to achieve optimal outcomes. However, out-of-pocket expenses associated with each visit—like consultation fees, diagnostic workups, transportation, and loss of wages—may deter patients from adhering to scheduled follow-ups.

This issue is relevant to patients in India and other low- and middle-income countries (LMICs) with respect to trust and perception. This issue is unexplored or underexplored in clinical journals, but it is an important component of the long-term management of various chronic diseases such as DM, HT, and CVD. This is a big gap in management as well as literature. A review and its implications could be a first of its kind in the Indian context.

Discussion

The importance of frequent follow-ups cannot be ignored as they are the backbone of chronic disease management, medication adherence, monitoring of side effects, and timely therapeutic adjustments. Yet, we often encounter patients who do not return for follow-ups—not because they are not willing, but because they are unable to afford the financial burden of repeated consultation fees and other expenses already mentioned, such as transportation, diagnostics, and loss of working hours for both the patient and the attending person.

In India, where a significant portion of healthcare expenditure is out-of-pocket, even modest consultation charges discourage patients from follow-ups. This is not only true for economically disadvantaged patients but also for financially stable patients who are suffering from multiple comorbidities requiring frequent follow-up, such as thyroid disorders, CVD, DM, HT, malignancies, and others.

We know the impact of missed follow-ups is not benign. We see patients coming after long gaps with deteriorations and complications such as uncontrolled sugars, exacerbated heart failure, and worsening asthma, which are entirely preventable complications. Each missed opportunity is a step backward, often leading to avoidable hospital admissions and even mortality.

Studies have shown that the discontinuity of care, due to any reason including cost, contributes to poor control, increased complications, and higher rates of emergency admissions. Patients often opt for self-medication, irregular medication, or visit only when symptoms worsen, leading to a reactive rather than preventive or proactive approach.

From the physician's perspective, missed follow-ups impede therapeutic monitoring and limit opportunities for timely intervention or patient education. This disconnect can also strain the doctor–patient relationship, and physicians are often blamed for lack of progress or no improvement despite inadequate patient engagement due to financial barriers.

To address this issue, there is a growing need to explore alternative models of care, such as subsidized follow-up visits, bundled payments, telemedicine for stable patients, or inclusion of regular outpatient care in insurance plans. A more nuanced understanding of the economic pressures faced by patients is essential for designing equitable and sustainable healthcare delivery models.

Consultation costs and irregular follow-ups are a hidden crisis in chronic disease management, and consultation fees rarely act in isolation; the cumulative burden of medical expenses, including diagnostics, transportation, medication, and lost wages, contributes to discontinuity of care.

A qualitative study among rural women with HT in India found that socioeconomic barriers for low adherence to antihypertensive medication are low awareness of HT and its complications, poor access to medical care and financial constraints. Out-of-pocket payments for consultation, medications, diagnostics, transportation, borrowing money, and lack of insurance were central to poor adherence and discontinuity of care.[1]

Research on glaucoma patients in South India highlighted that for about 44% of patients, cost is a key obstacle to appointments, and for 47%, distance, transportation, and lack of escorts are barriers to follow-ups.[2]

A study of 172 patients from a tertiary cancer care institute in a lower-middle-income setting revealed that financial distress and travel difficulties were among the main reasons for irregular follow-up. The average distance traveled was 143 ± 13.15 km. The most common reasons for loss of follow-up were lack of social support, financial constraints, difficulty commuting, and being too sick to come.[3]

Investigation into tuberculosis care in India captured firsthand physician insights that "Lack of money for transport and feeling

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well after 2 months of treatment is the reason for drop-out. Still, financial problems are the major issue."[4]

Broader research on user fees in LMICs demonstrated that eliminating consultation and diagnostic fees leads to substantially increased health service utilization. Systematic reanalysis noted that outpatient visits rose by 30–50% soon after the removal of user fees, with sustained increases over time.[5]

One review suggests that reducing or removing user fees increases the utilization of certain healthcare services. However, emerging evidence suggests that such a change may have unintended consequences on the utilization of preventive services and service quality. The review also found that increasing fees can have a negative impact on health services utilization, although some evidence suggests that when implemented with quality improvements, these interventions could be beneficial. Most of the studies included in the review had important methodological problems. More rigorous research is needed on this issue.[6]

One analysis based on a nationally representative health expenditure and utilization survey conducted in 2014 calculated the incidence and intensity of catastrophic health expenditure (CHE) based on households' out-of-pocket payments during a visit as a percentage of total household consumption expenditure. It shows that following the removal of user fees, the majority of patients benefited from free care and a reduced likelihood of CHE. This analysis also concludes that despite the removal of fees at primary health care, CHE remains high among the poorest, and the cost of transportation is mainly responsible for limiting the protective effectiveness of user fee removal on CHE.[7]

Conclusion

The importance of frequent follow-ups cannot be overlooked. Chronic conditions such as DM, HT, CVD, cancers, thyroid disorders, and many more require frequent consultations and monitoring to achieve optimal outcomes. They are the backbone of chronic disease management, medication adherence, monitoring of side effects, and timely therapeutic adjustments. Yet, patients do not return for follow-ups—not because they are not willing, but because they cannot afford the financial burden of repeated consultation fees and other expenses such as transportation, diagnostics, and loss of working hours for both the patient and the attending person.

In LMICs, including India, consultation fees, though modest by global standards, act as a significant barrier to regular follow-up, particularly among financially compromised populations.

We must find out other ways to reduce the burden of consultation fees along with other expenses such as telemedicine, prolonged follow-up interval for stable patients, providing necessary devices such as glucometers in DM care, and rewarding patients for achieving their targets.

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