UNDER MY SKIN

I've Got Needs!

On Wednesday, little Esmeralda's eczema took a turn for the worse. "It's infected," I told her mother, "so I'm prescribing this antibiotic syrup and topical cream. Here is my private extension. I need you to call me first thing Friday morning so I'll know how she's doing before the long weekend."

BY ALAN ROCKOFF, M.D.

No message was waiting Friday, so I called at 9 a.m. and left one myself. I left another at noon. As I was preparing to leave at 2 p.m., Esmeralda's mother called, not to tell me that her daughter was improving, which she was, but to ask me to fax a report to Esmeralda's day care providers. I offered to call instead. "No," she said, "I need you to fax them what you recommended."

That same Wednesday, I got a call from a pulmonologist. A mutual patient, Fishbane, had come down with tuberculosis but was itching like crazy and refusing to take his medications. He needed to see me at once, but I was in my other office and he wouldn't come there. Could I see him Thursday? Sure. Arrangements were made, with thanks for my being so helpful. Fishbane never showed.

All this is familiar, of course: Patients follow through when it suits their needs.

"Hi, Henry. It's been 5 years. Are you back because you had that squamous cell, and I asked you to come annually?"

"Oh no, Doc. I have this new spot I'm worried about."

Nonhermits have many kinds of relationships. These relationships involve needs that each party satisfies to some extent. In the doctor-patient relationship, patients need us to diagnose correctly, prescribe properly, and behave with courtesy. We need them to show up, call back, and either cooperate with treatment or at least let us know why they can't.

Relationships flourish when people make allowances, but they founder when needs, duties, and shortcomings are aggressively spelled out.

"I've been waiting an hour," hissed Spencer. "I'm a professional like you, and I too have other appointments. It's clear that you care only about your own needs, not mine."

Maybe Spencer is just having a bad day, but suppose he's always like that. Imagine being married to him. His complaint is not without merit, but I have needs too. Spencer wants to get on with his day. I want to stay busy even when some patients don't show, others come late, and still others must be fit in right away (or, like Fishbane, claim they do).

Most of us know we'll get only some of what we need and decide to muddle through. Patients expect to wait a while. Doctors know that many patients won't remember which treatments didn't work. Some people, though, aren't satisfied with muddling and demand precision: yes or no, right or wrong, exactly how many minutes' wait is too many. That's how lawyers and bureaucrats think—an approach useful in its place but toxic to ordinary relationships, which are rife with fuzziness and ambiguity. Think of the difference between the arrangements a husband and wife make to pick up their kids versus those dictated by a divorce court.

"Thanks for taking off my wart, doctor," says Sue. "Would it be okay if I asked you one more question?" Well, sure, especially since you're asking so nicely.

But what about Phyllis, who has nine separate issues to discuss with magisterial deliberation and a sense of serene entitlement, and who catches you at the door trying to escape with, "And oh yes, doctor, my hair is falling out"?

How many questions does Phyllis have a right to ask? One? Three? Six from column A and two from column B? She needs to have her concerns addressed, but I have needs too. I need to get the heck out and see another patient. Sue is very considerate, but now and then the office serves up a Phyllis, just as life brings us bores who won't shut up or guests who won't leave.

Most people are considerate; others are endlessly needy. One way or another, we negotiate needs all day long. Considering how many people we deal with every day, it's a wonder how well things usually go. Sometimes a Phyllis or two shows up and throws things off. Then we can go home and crack open a beer. Whack a golf ball. Write a column. ■

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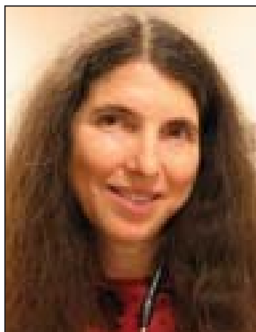
POINT/COUNTERPOINT

Do high-deductible plans coupled with HSAs promote underinsurance?

The sick and poor are left underinsured.

Consumer-directed health care (CDH) is premised on the odd idea that Americans are too well insured. In policy wonks' dreams CDH couples high-deductible insurance policies with health savings accounts (HSAs) that patients can use to pay the deductible. But in practice, most CDH plans come with little employer contribution to the HSA, leaving patients with high deductibles and no savings to pay them.


STEFFIE WOOLHANDLER, M.D.

CDH plans threaten the middle aged, sick, and poor—and women, whose pregnancies and preventive care needs are expensive. Under CDH, the young and healthy get low premiums and pay little out of pocket. But for those with diabetes, heart disease, arthritis, grey hair, or a uterus, out-of-pocket costs under CDH often exceed any premium savings.

CDH incentives discourage low-cost primary and preventive care. In the Rand Corporation's famous 1971-1982 Health Insurance Experiment, the researchers found that high deductibles cut immunizations, Pap tests, and visits for serious symptoms like angina.

But CDH plans can't reduce the high-cost care that accounts for most health spending. When severe illness strikes, patients have no choice. Even one day in the hospital pushes most patients over their deductible, leaving them with no further incentive to economize. Hence, CDH inflicts financial pain on the severely ill who account for 80% of all health costs, but won't reduce the overall costs of their care.

In Canada, copayments had little impact on costs; doctors less frequently saw poor (and often sick) patients who could not pay, but filled their appointment slots with more affluent patients (N. Engl. J. Med. 1973;289:1174-8).

Also, CDH and HSAs add new layers of expensive bureaucracy. Insurers and banks are already vying for the estimated $1 billion annually in HSA management fees. And CDH makes physicians collect directly from patients, many of whom are unable to pay. That's even costlier than billing insurers.

While CDH proponents paint a rosy picture of consumer responsiveness and personal responsibility, CDH would do little to contain costs, while shifting them onto the sick and middle aged, and discouraging timely care. ■

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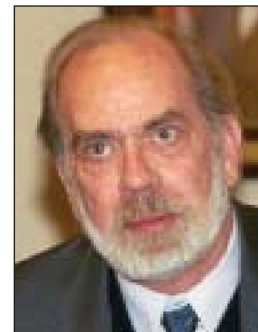
Consumer-directed care cuts bureaucracy.

In fact, high-deductible plans solve the problems of "underinsurance" and "overinsurance" and lead to "just-right insurance."

Most economists recognize that excessive reliance on third-party payment is the source of many of our problems in health care. When everything is paid for by a third party, consumers lose all interest in or knowledge of the cost or value of the care they consume. This leads to enormous waste. By some measures, 30%-50% of health care services provided in this country are unnecessary and in some cases downright harmful.


GREG SCANDLEN

Third-party payers react by rationing the care they cover. Such rationing may involve waiting lists, underpayment of care, reduced number of providers, or outright denials of care. These tactics amount to depriving people of the care they want to have and feel they need.

Third-party payment also adds administrative costs, both for the insurer and the caregiver, to what should be simple, routine services. A dollar's worth of premium will often buy just 50 cents worth of care.

High-deductible plans reduce the amount of money that is lost to the insurance company every month, and health savings accounts allow people to take that same money and use it for the care they need and want to have. Paying in cash at the time of service cuts the administrative costs for both the insurers and the provider. And the HSA means that people can make their own decisions about what is a valuable service and what is not. They don't need the insurance company's permission to see a chiropractor or a nurse midwife.

Because people are making their own decisions about how to spend some of their money, they become invested in the care they receive and are far more likely to follow treatment regimens and drug protocols.

All of this has been proven over and over again in real-world circumstances involving real patients and real money. The evidence is overwhelming that people are able to make these decisions and enjoy better health as a result.

The days of adult patients being treated like puppy dogs at the vet are over. In the 21st century, we have less need of bureaucrats deciding what care we and our families are worthy of receiving. We will decide for ourselves, thank you. ■

MR. SCANDLEN is an expert in health care financing and founder of Consumers for Health Care Choices, a not-for-profit organization that advocates for consumer driven health care.