LETTERS

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The Penalty For Being ‘Difficult’

I read with interest the Narrative Matters essays by Michelle Mayer and Tony Miksanek (Sep/Oct 08) about “difficult” patients. While they agree that patients and doctors both suffer from a broken health care system, it seems to me that it is the patient who loses the most.

Mayer’s experience resonates with me, as I am a parent of a child with a chronic disease (Crohn’s disease). She articulated beautifully my own experiences in trying to find a doctor who will listen, understand, and show compassion for patients.

I mistakenly believed that health care at my local children’s hospital would somehow be more compassionate, more sensitive, or more understanding than at a typical adult hospital setting. I never refused recommendations, demanded tests, or displayed anger or pessimism (as Miksanek’s patients evidently do), and I never ever considered myself “difficult.” That didn’t spare my son and me from painful consequences, however.

I was summarily “fired” by my son’s doctor without warning. The letter that arrived said that I didn’t trust my doctor or agree with his recommendations. Neither was true, but there was no recourse. I was presumed guilty. I could only speculate that questions were considered challenges.

Where would my son receive care? Who would help us? Despite this experience, I have summoned the courage to continue asking questions, clarifying issues I don’t understand, and asking about alternative treatments.

I’m not sure what the doctor who “fired” me lost in this experience, but I can tell you what I lost: trust and confidence in the system. I learned that even if you are deferential and humble, you may still be labeled as “difficult” and blacklisted from care. Thanks to Mayer for speaking for so many patients who don’t have a voice and are lost in this “broken” health care system.

Jon Harding
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Editor’s Note: When Michelle Mayer wrote her Narrative Matters essay, “On Being a ‘Difficult’ Patient,” she was already extremely ill. Sadly, Michelle died on October 11, her eleventh wedding anniversary. You can read Michelle’s final thoughts posted on her blog, Diary of a Dying Mom, at http://diaryofadyingmom.blogspot.com, where her husband, Bill Steinback, continues to add posts.

It was typical of Michelle that as she neared the end of life, she wrote not to rail against her imminent death but to tackle a wider topic: that some patients need to become “difficult”—as she did—to get the medical care they need. In her essay and her life, Michelle taught us to look both illness and death squarely in the face, as well as how to continue life’s important conversations until the very end. Thank you, Michelle. We appreciate it. —Ellen Fichlen, Editor, Narrative Matters

Regulation In China, India, And The United States

Recent articles on China and India (Jul/Aug 08) share the assumptions that markets for medical care and health insurance require extensive government regulation and that each nation should focus on universal coverage. I am unfamiliar with the history of regulation in those nations. But the track record of
clinician and insurance regulation in the United States is not encouraging. Both have been used by incumbents to block competition, leading to higher costs and lower quality. Gerald Bloom and colleagues worry that unless India imposes clinician licensing, “the natural process of competition is expected to force each insurer to come up with its own accreditation policy and reimbursement procedures.” Does that mean that prepayment would compete openly with fee-for-service? And that physicians could not increase costs by blocking health plans from employing midlevels when appropriate? Dear God—not that.

Ashoke Bhattacharjya and Puneet Sapra write, “It is encouraging to note that notwithstanding the myriad issues and challenges discussed above, both countries are developing a constructive working framework to balance the interests of government, providers, employers, the insurance industry, and patients, en route to the goal of universal coverage and fairness in health care financing.” That’s just the problem: a policy of universal coverage puts too much power in the hands of elites. It inevitably “balances” those interests, when patients’ interests should trump all others. Does not the fact that “these countries lack the fiscal resources required for universal coverage because of their...low average wages” suggest that many residents have more pressing needs than health insurance? For things that might just deliver greater health improvements? In a profession where universal coverage is a religion, such questions are heresy, I know.

China and India are in the process of a slow climb out of poverty. It is entirely possible that the best thing those governments could do to improve these markets and population health would be to enforce contracts, punish torts, contain contagion, and nothing else.

Michael F. Cannon
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share of gross domestic product (GDP) absorbed by health spending in virtually all developed countries, it is no stretch to argue that China and India both face a golden opportunity in the century ahead. By simultaneously “right-sizing” the nature and scope of health coverage and health regulation, both nations can secure a sizable competitive advantage in the race against the United States. The bad news is that until and unless the United States wakes up and realizes just how hard it is to race against more nimble foes unencumbered by health-related efficiency losses that soon will exceed 10 percent of GDP, the gold medal count in the 2008 games may simply be a fore-shadowing of what is to come sooner rather than later.

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Don’t Follow Our Example, Either

The two papers on the regulation and financing of health care in India and China, by Gerald Bloom and colleagues and by Ashoke Bhattacharjya and Puneet Sapra (July/Aug 08), are adequately descriptive but prematurely prescriptive. After some apparently nostalgic longing for the good old days of Maoist centralized health care, the general lament is that the two nations have not yet repeated the mistakes of overregulated, third-party-financed, Western-style health care.1 Ironically, the latter’s more lavish regulatory arsenals and financial resources also still struggle to influence providers to follow a reasonably standardized set of procedures, reduce unsupported price variations, and limit inappropriate treatment practices.2

In the cases of China and India, how effective a regulator might government be when the quality of care at its own hospitals and clinics is abysmal? Both countries were heavily state-controlled in past decades.

A striking feature of these economies, particularly India, is their very low level of insurance coverage in the face of high medical costs (nearly 80 percent of all health care spending is out of pocket). Are people unaware of the existence of private health insurance or unwilling to buy it—when poor-quality, low-cost, government-organized health care remains widely available and crowds it out?

The image of all Indian health care portrayed in these papers also is at odds with that nation’s becoming touted as an attractive health care destination. A growing number of spotlessly clean private hospitals are positioning themselves as the best medical tourism hot spots for procedures ranging from coronary bypasses to orthopedic surgery at the most affordable costs. Growing numbers of foreign patients opt to undergo surgery in India for reasons such as long waiting times in the United Kingdom and high costs or lack of insurance coverage in the United States. A natural outcome has been growing demand for global accreditation and an improvement in medical standards, including hospital documentation standards. Indeed, more-vigorous market competition for self-paying consumers in this realm yet may lead to more effective self-regulation and better health care options.

Tom Miller and Aparna Mathur
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NOTES
1. “A standard for health systems in developing countries,” Bhattacharjya and Sapra, p. 1007; and “Institutional arrangements that supported cost-effective health services with wide access during the command economy were no longer in place by the 1990s,” Bloom and colleagues, p. 954.
2. See Bloom et al., p. 958.

China And India: Bloom And Colleagues Respond

The decision by Health Affairs to publish a special issue on China and India reflects the growing awareness in the United States that the integration of these countries into global markets will affect us all. The letter by Chris Conover highlights the increase in global economic competition. A country’s capacity to organize efficient mechanisms to meet its population’s health needs could confer a competi-
tive advantage. This is highly relevant to the competition between China and India, and, if either country establishes an effective, low-cost health system, the pressure on U.S.-based companies could grow. Tom Miller and Aparna Mathur point out the growing success of Indian specialist hospital corporations in global markets, even as their services are inaccessible to most Indians. We can all agree that we are entering a period of heightened economic competition.

Our paper outlined some problems that the Chinese and Indian health systems face. Many people seek care from people with limited medical expertise, and they spend a lot of money on inappropriate drugs. This exposes individuals and the public to financial and health risks. Opinion polls in China find that both rich and poor families are very concerned about the high cost of medical care, and politicians are under pressure to respond. They have good reason to want to learn from the successes of other countries and to avoid costly mistakes. It will take a substantial effort, however, to bridge the barriers of language, culture, and different institutional realities to ensure effective mutual learning.

The letter by Miller and Mathur underlines the danger of bringing ideological baggage to the discussion. It is hard to deny that China greatly improved its health indicators during the period of the command economy. This does not imply a wish to recreate a system that provided the most basic of health services, even if this were feasible, given the emerging reality of a dynamic market economy. Michael Cannon acknowledges his unfamiliarity with the history of regulation in these countries, yet provides specific recommendations based on his reading of issues pertinent to the United States.

The governments of China and India are reinventing their roles in all sectors, including health, as are their legal systems, their private companies, and their citizen groups. Both countries face major challenges in meeting the expectations of large populations, many of whom remain very poor. We cannot anticipate the degree to which they will create effective health systems, and we do not assume that China and India will mimic the United States or Europe. On the contrary, we suggest that the health systems of the twenty-first century will be very different from either.1 However, it is difficult to anticipate a model that does not include an important role for government. These are, indeed, interesting times for health systems and those who analyze them.

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NOTE

Editor’s Note: Ashoke Bhattacharjya and Puneet Sapra will respond to these letters in the Mar/Apr 09 issue of Health Affairs.

More On ‘Healthy Kids’

The paper by Ian Hill and colleagues (Mar/Apr 08) shows the impact of health insurance expansion in California, called Healthy Kids. This paper and other studies provide evidence that an insurance model overcomes barriers to the health care system. Healthy Kids covers primarily undocumented immigrant children. These improvements also benefit the health care safety net by reducing the demand for uncompensated care. Los Angeles County supports indigent care by directly providing care through its Department of Health Services.
To determine the impact of Healthy Kids on the safety net, we compared the observed number of pediatric visits by uninsured patients to DHS and PPP clinics in a three-year period from fiscal year 2004–05 to FY 2006–07 to an expected number based on FY 2003–04, the year the Healthy Kids program began. We calculated the cost differences by applying DHS average costs per visit and PPP reimbursement rates to the differences in the observed and expected visits.

While Healthy Kids enrollment increased, pediatric visits to DHS and PPP sites declined. For the three years after Healthy Kids began, 396,306 uninsured pediatric visits were expected at DHS sites. But the county provided 106,000 fewer visits than expected.

In the PPP program, the county expected to provide 129,765 visits over the three-year period but had 45,000 fewer visits than expected. This decline resulted in $37.5 million savings for primary care for uninsured children ($33.3 million based on average variable costs in DHS clinics, and $4.24 million in reimbursements to PPP facilities).

The Healthy Kids program shifted 40,000 children to a licensed, full-risk, capitated health insurance program. In doing so, precious county resources were saved or redirected to other populations. Thus, a local program for expanding coverage can reduce costs to local government while increasing access to comprehensive care.

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The Misdirected Debate Over Physician-Owned Specialty Hospitals

The U.S. hospital industry has drawn a line in the sand, opposing physician-owned specialty hospitals on the grounds that they select paying patients and procedures, stranding full-service hospitals without the revenue to support indigent care. On the other side are arguments emphasizing the salutary effects of competition, and claims of increased efficiency and effectiveness within “focused factories.” Various studies published in Health Affairs have explored both sides.

The public health perspective tends to support the full-service hospitals’ position; the free-market perspective tends toward sympathy with specialty hospitals. These polar positions, and the intensity with which they are argued, distract us from a set of more basic issues: (1) If we separate the issue of physician-ownership from the question of when and how specialty hospitals might add value to what is euphemistically called our health care “system,” does the discussion change? (2) Concerns about physician-ownership focus on the risks of overuse, but resource maldistribution and overuse are in fact endemic and ubiquitous problems, requiring a much more comprehensive approach than one simply focused on physician-ownership of specialty hospitals. (3) From an outcomes perspective, does it matter who owns the hospitals? Are not the more central issues under what circumstances do specialty hospitals deliver improvements in efficiency and effectiveness, and where the savings and profits flow? (4) Given the arguments in favor of “focused factories,” should we not expect large systems to build such facilities, using the surplus generated to support the mission of community service? Should we expect smaller not-for-profits to form consortia to the same end? If either answer is “yes,” how should we structure policy to drive the desired behavior?

The point of this letter is to implore a shift in focus to a more useful set of policy questions.

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