The cost of promoting “personal responsibility”

SELECTED SUMMARY

The cost of promoting "personal responsibility"

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Robert Steinbrook, MD. Imposing personal responsibility for health. *N Engl J Med* 2006; 355: 753-756.

The emphasis on personal responsibility in health care stems from the belief that those who follow a healthy lifestyle will be rewarded by feeling better and having to spend less money. A healthy lifestyle is defined as not smoking, frequent exercising, and weight control. However, it is unknown which well-meaning measures to promote responsible behaviour actually make a difference and which are primarily coercive and potentially counterproductive.

There are many examples of initiatives to promote personal responsibility, such as employers' refusal to hire people who smoke, and there is much public support for such actions. A national survey showed that 53 per cent of Americans think it is "fair" to ask people with unhealthy lifestyles to pay higher insurance premiums and higher deductibles or co-payments for their medical care.

The redesign of the West Virginia Medicaid programme has recently become a leading but controversial example of efforts to reward personal responsibility. The state's plan provides reduced basic benefits to most low income, Medicaid eligible, healthy children and adults, while allowing them to qualify for enhanced benefits by signing and adhering to a 'Medicaid member agreement'. The enhanced benefits include vouchers for fitness clubs or healthy foods. To remain in the enhanced plan, members must keep their medical appointments, receive screenings, take their medications, and follow health improvement plans; members whose benefits are to be reduced because they have not met these criteria will receive advance notice and have the right to appeal.

There have been no previous efforts to change Medicaid benefits in the way West Virginia intends to do, nor are there comparable examples among private health insurance programmes. Thus, it is difficult to predict the effects of this programme on costs, beneficiaries' health, and medical practice.

While the state hopes to save money, the plan may not save any because even though healthy children and adults are inexpensive to cover, any savings for these groups could be offset by the costs of administering the changes in Medicaid or by increased costs for mandatory services for patients who remain in the basic plan.

There are many reasons why patients might not comply with medical recommendations. These include poor physician–patient communication; side effects of medication; advice that is impractical to follow (e.g. job responsibilities and difficulties with transportation or child care, psychiatric illness, cost, the complexity of the recommendations, or the language in which they are communicated, etc.).

Although personal responsibility for health care may seem intuitively attractive, the design and implementation of specific initiatives may be complicated. Before such plans are implemented, it would be best to evaluate them rigorously in a controlled trial conducted by an independent group. If they do not improve health or save money, or have unanticipated negative effects, they can be discarded or revised.

Gene Bishop, MD, and Amy C Brodkey, MD. Personal responsibility and physician responsibility — West Virginia's Medicaid plan. *N Engl J Med* 2006; 355: 756-758.

The authors begin the article with a case history of a 53-year-old schizophrenic on atypical anti-psychotics who developed diabetes and obesity. She signed a treatment contract to keep all her clinic appointments, attend diabetes education classes, and lose weight. She attended one class but became paranoid and left halfway through, and she gained five pounds.

She doesn't understand the educational materials that you have provided. She has just missed her second consecutive appointment with you; the last time, she didn't have bus fare. Neither her glycated haemoglobin nor her blood lipids are at target levels. You are now legally obligated to report this information to the state Medicaid agency, and the patient may lose her health benefits.

Under this new Medicaid plan, residents who are eligible for Medicaid must sign documents outlining "member responsibilities and rights" wherein they promise to take their medications, keep their appointments, and avoid unnecessary emergency room visits. Non-compliance will lead to elimination or reduction of benefits.

Personal responsibility is a laudable goal with intuitive appeal, but used in this context, it is at odds with current models of the doctor–patient relationship where physicians and patients negotiate treatment plans. Failure leads to renegotiation.

Mamdani B. The cost of promoting "personal responsibility". *Indian J Med Ethics* 2007; 3: 38-9.

An exploration of the reason for a missed appointment may improve future behaviour, whereas humiliation and punishment may result in decreased adherence to treatment.

The plan raises fundamental issues of fairness. First, it places responsibility on patients for factors that may be out of their control. Persons who depend on public transportation can attest to the unreliability of these systems. Primary care offices have limited evening and weekend hours, forcing working patients to visit emergency rooms. And at least 75 per cent of the beneficiaries who may be affected are children, who will have to depend on their parents or guardians for adherence to the rules.

Second, the plan holds Medicaid patients to a standard of behaviour that is not required of patients with private insurance. Privately insured patients may reject their physicians' advice without losing their health benefits—and they may have the confidence to express that disagreement overtly, leading to renegotiation—whereas poorer and often less well-educated Medicaid patients may simply choose silently not to comply.

At present there is a paucity of evidence to support the plan approach to improve health related behaviours. Even under ideal circumstances of a clinical trial, the rate of compliance with medication ranges from 43 per cent to 78 per cent, and there is no consensual standard for what constitutes adequate adherence.

Medicaid beneficiaries have poorer health indicators and higher rates of non-compliance than many other patients. Poverty results in reduced access to child care, transportation, healthy foods, and exercise facilities, as well as lower literacy, more life crises, and higher rates of untreated psychiatric illnesses. People with fewer experiences of success are less likely to believe that they can change their health status. This plan asks the most vulnerable population to do more with less ability to accomplish what we ask of them.

The plan compels physicians to violate all three fundamental principles enumerated in the Physician Charter on Medical Professionalism: the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice. It raises potential conflicts by placing physicians in a reporting situation in which public health is not at issue, possibly asking physicians to harm their patients or their relationships with patients.

The plan promotes discrimination not only on the basis of socio-economic status, but also on the basis of diagnosis: surely, people with mental illnesses, who have trouble managing activities of daily living such as keeping appointments, will be discriminated against under a plan that rescinds their health benefits because of such lapses.

Clinicians often abstain from policy discussions until it is too late for them to have an impact but in an era of "personal responsibility", physicians must assume the responsibility of speaking out about how such policies affect their practices and their patients' health.

Commentary

It is interesting to see how the political climate influences the medical scene. In the liberal 1960s and 1970s, with the extension of human rights to the patient, medical paternalism was replaced by patient autonomy. Recognising the need to assure adequate health care for the poor, the elderly and the disabled, the US Congress enacted Medicaid and Medicare laws in 1964. As the costs of these programmes increased exponentially, rather than increase taxation, the conservative Reagan administration brought in tight limits on hospital stay for elderly Medicare patients in the mid-1980s—a system that was quickly adopted by the private insurance programmes, leading to a lot of surgery moving to the out-patient arena and emptying out hospital beds. Ongoing efforts at cost curtailment and cost shifting led to the health maintenance organisations (HMOs). The original HMO models emphasised preventive medicine and early intervention through regular clinic visits. This was meant to reduce costs by avoiding expensive emergency room visits and complications of advanced disease. However, today the HMOs provide little preventive care and mainly curtail use of medical services to reduce costs.

Conservatives have always hidden mean spirited cost cutting behind honourable aims. The basic premise of the HMOs seemed above reproach—provide preventive care to reduce the need for more expensive emergency care. But the intention was always to reduce costs, so the HMOs failed to achieve their purported aims. Similarly the idea behind West Virginia's plan to improve health related behaviour seems to be a sound one: how can one argue against personal responsibility? Physicians often encounter patients who will not follow any medical advice to change their habits but simply ask for a pill to counter the effects of a poor lifestyle. Wouldn't it be nice if we had some way to compel them to follow medical advice? But, though the West Virginia plan is couched in terms of improving health behaviour, once again cost curtailment is the driving force. Therefore the plan has put the cart before the horse—cut benefits before one even finds out which methods work to improve behaviour. The poor will bear the brunt of this programme.

People in India need to be aware of the trends in medical care in other countries, particularly of the West. As US style private health insurance programmes proliferate in India, it is quite likely that models to limit care and curtail costs may be introduced here. The Indian health system is already hierarchical and authoritarian and could adopt such punitive programmes with little challenge from even the well-to-do. It would be in the interests of health consumers to exercise vigilance and prevent the introduction of such policies in the health care sector, whether public or private.