EDITORIALS

Money Talks, Patients Walk?

One day in medical school, I dragged myself to the dentist to get a filling replaced. While signing in at the front desk, I was surprised to see that the dental office prominently displayed the credit cards it accepted. (At the time, such displays were rare in medical clinics.) After flashing my Visa card, I went in to see the dentist. He told me I had two options—an old fashioned metal filling which would cost $45, or a new "tooth colored filling" that would cost $125. I requested the cheaper filling, confident that its cosmetic deficiencies would not be the difference between loneliness and romantic fulfillment.

I have thought about this visit on many occasions since, not because the cosmetic deficiencies of the metal filling ruined my life, but because this dentist's forthright economic disclosure contrasted so sharply with what I had witnessed in the medical world. Even now, 15 years later, people are more comfortable talking about the financial aspects of their dental care than of their medical care.

IGNORANCE IS BLISS: MANY PATIENTS WANT TO REMAIN IN THE DARK ABOUT PHYSICIAN REIMBURSEMENT MECHANISMS

Two excellent articles in this issue of the *Journal* give us an opportunity to reflect on why people are uncomfortable talking about the financial aspects of their medical care, especially the messy details of how their physicians are paid. In their provocative study, Kao et al. found that many patients were neither knowledgeable about physician reimbursement mechanisms nor interested in learning about them.[1] My dental experience points to one possible reason people are uncomfortable talking about physician reimbursement: they have very little experience dealing with their health care finances. Most health care expenses have traditionally been covered by insurance. Moreover, most people are not even aware of the cost of their health insurance, because their employers (or the government) have typically paid their health insurance premiums.

Reluctance to discuss health care finances also arises because many health care issues involve high stakes, where money talk feels improper. When our grandfathers need ICU beds, our mothers need kidney transplants, or our fathers need bypass surgeries, we do not talk about money. We get them the health care they need, and deal with the financial consequences later.

Perhaps most importantly, it is disconcerting for people to think about physician reimbursement, because such thoughts remind people that physicians face conflicts of interest that could potentially influence how they care for their patients. Fee-for-service reimbursement mechanisms give physicians an incentive to do too much, capitation mechanisms entice physicians to do too little, and salaries encourage physicians to do nothing. Patients understand that physicians are well paid. But thinking about how they are paid can only cause distress.

NO LONGER ALLOWED TO BE IN THE DARK

In an effort to control expenses, third party payers are asking patients to incur an increasing proportion of their medical expenses. Moreover, with prescription costs skyrocketing, patients are being exposed to increasing out-of-pocket prescription expenses. Thus, patients' experiences with their physicians are beginning to resemble my visit to the dentist: financial issues are becoming much more explicit, and patients are beginning to discuss their monetary concerns with their physicians.

Does that mean the time is right to start discussing physician reimbursement mechanisms with patients? And if so, who should communicate this information to them? And how much detail should patients receive?

PROBLEMS WITH INFORMING PATIENTS ABOUT PHYSICIAN REIMBURSEMENT

Traditions in law and ethics hold that patients have a right to information about physician reimbursement, because such reimbursement could influence the medical care they receive. Similarly, traditions in health economics hold that "rational" patients should want such information, so that they can better decide whether to accept the recommendations they receive from their clinicians.

However, I seriously doubt whether these traditions are correct to urge physicians to talk with their patients about how they are reimbursed, especially in the context of clinical encounters. (In the spirit of full disclosure, I should reveal that I am not the most traditional person in the world. The only recognizable music in my wedding ceremony was from the Wizard of Oz.) Talking with patients about physician reimbursement is a problem first and foremost because outpatient encounters are often brief, and leave physicians very little time for important clinical matters. For example, my managed care plan lists 15 goals that physicians are supposed to achieve each

time they see a diabetic patient, including taking a thorough dietary history, discussing exercise, and checking their feet. In addition to these 15 goals, physicians are expected to deal with other acute and chronic medical issues that their diabetic patients present to them. In the meantime, physicians are having difficulty finding time to screen their diabetic patients for depression, anxiety, spousal abuse, alcohol abuse, and the like. Should physicians try to find time to explain capitation reimbursement mechanisms to these patients? If physicians are choosing between screening their diabetic patients for depression or explaining capitation to them, I hope most physicians opt for the former. (Of course, explaining capitation might make patients depressed, thereby killing two birds with one proverbial stone.)

Discussing physician reimbursement with patients during clinical encounters will also be difficult because many reimbursement mechanisms are very complex. For example, imagine a physician who is paid an annual salary, plus a bonus that is based on patient satisfaction, resource utilization, and preventive care performance. How much detail should she give her patients about this reimbursement system? Should she explain how resource utilization influences her bonuses? Should she tell them how the health plan is measuring utilization? Should she tell them the formula used to calculate her bonus? Should she inform patients about how much money she stands to gain or lose based on a typical patient encounter? If she is like most physicians, she will not even know that information herself. And even she does, it is not clear that she should give such information to her patients. Patients might be reassured to learn that her salary will only go up or down $15 based on a typical clinical encounter. But they may forget that she will have thousands of such encounters in a year, making the overall effect on her salary potentially large. Perhaps, then, she should tell her patients the total percent of her salary that is influenced by her end-of-the-year bonuses. Maybe she should even tell patients her salary. As this example illustrates, it is challenging to discuss reimbursement mechanisms with patients, not only because such mechanisms can be complex, but also because it is not always obvious what information is best to give patients.

Along these same lines, discussing reimbursement mechanisms with patients is also challenging because such mechanisms do not necessarily influence utilization on a patient-to-patient basis, but instead, exert their influence on a more general level. For example, a physician who primarily cares for capitated patients (and only sees a handful of fee-for-service patients) probably treats all her patients as if they were capitated. What information is most relevant to give to one of her patients? Should the physician tell her patients how she is being reimbursed for their services? Or should she tell them how she is being reimbursed for her typical patients? Perhaps, fully informing patients requires her to provide them with both types of information. But what patient would be able to make sense out of that information?

WHAT SHOULD CLINICIANS DO?

I do not know how clinicians should discuss these complex issues with their patients. My best guess is that physicians should not make such discussions a routine part of their clinical encounters. My worry is that, to the extent physicians do make such discussions routine, they will provide self-serving explanations that underestimate the extent to which they are influenced by financial forces.

What should clinicians do if patients ask them about reimbursement mechanisms? I favor 1) letting patients know that physicians not only have duties to take care of their patients, but also duties to help control health care costs; and 2) informing them that physicians try to offer proper clinical care to their patients, while paying attention to the bottom line.[2] But I have no confidence that this is the best approach.

Physicians need to experiment with their own patients about how to talk about these issues. Those, like Wendy Levinson,[3] who have had provocative encounters with patients, should follow her lead and communicate the content of these encounters to other physicians. Most importantly, before making reimbursement communication a routine part of clinical care, physicians need to ponder the possibility that such communication will make doctor appointments as pleasant as having a root canal. —

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