designed a study, conducted in eleven cities around the globe, to see whether self-reported reduction in AIDS risk behavior on the part of injection drug users could be corroborated by evidence of decreases in HIV incidence.

Their results provide a heartening validation of the harm reduction approach. Not surprisingly, the effects were partial, but the trends were uniform and the collective effect was to decrease the amount of HIV available for further spread—a goal for which we should all be striving mightily as the number of infected people reaches into the millions globally, and as injection drug use assumes an ever greater importance in the US epidemic.

Several lessons emerge. Unquestionably, primary prevention of illicit drug use needs to be pursued, but that must be done intelligently and with methods proven by careful research to be effective and appropriate to the population groups in question.

For active users, treatment should be first and foremost on the agenda of interventions. The complexity in achieving this goal introduced by mandatory imprisonment laws is considerable, just as will be that of mandatory pregnancy testing for HIV if antiviral treatment is unavailable.

In the real world, however, where treatment efforts have failed or are inaccessible, full backing must be given not only to primary prevention but also to every facet of secondary prevention. Thanks to Des Jarlais et al., we know that such efforts will bear fruit in reducing the harm of HIV amplification. The magnitude of this benefit is not diminished by the advent of new therapeutic agents for HIV; they are, and will remain for many years, an option for the richly endowed. For populations such as those caught in the web of injection drug use, they are likely to remain, for years to come, as far out of reach as health care itself. If there ever was a community-based "good," harm reduction is it; and we should personally and collectively support those public officials and programs brave enough to embrace it in an era of unparalleled hostility to illicit drugs and their users. □

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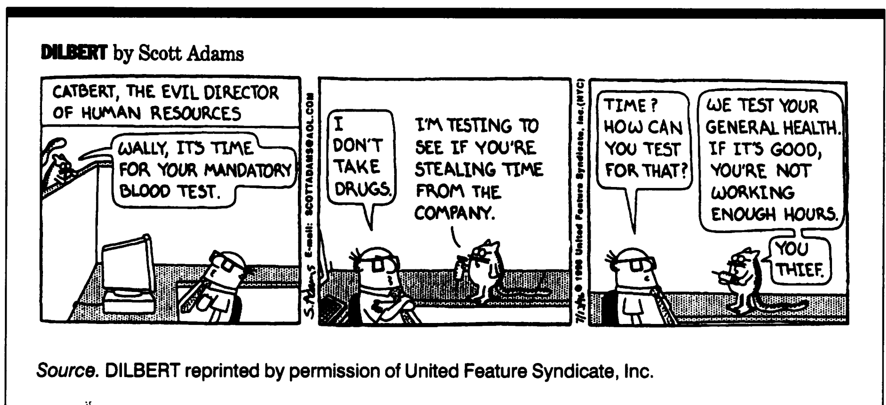
Annotation: Patients on the Auction Block

Doctors' potions and operations did more harm than good for millennia—and too often still do; but, despite noxious effects, patients have avidly sought medical ministration, authoritative reassurance, comfort, and guidance to navigate suffering. Now comes corporate medicine stripping "of its halo every occupation hitherto honored and looked up to with reverent awe. It has converted the physicians . . . into its paid wage laborers"[1] and patients into commodities bought and sold.



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Bonds between doctors and nonelite patients long have been stretched by the gulf of social class and race; the cupidity that fee-for-service generated among physicians frayed them further. But today's medical market displaces patients and doctors from center stage, elbowing aside the human relationships and cultural crux of care. The employer–health maintenance organization (HMO) contract is the new nexus of medicine.

Employers define optimal care as optimized productivity (see cartoon), minimized cost, and maximum leverage over employees—strike and you lose your health care. HMOs win contracts by promising employers the modern version of the company doctor: willing to squeeze care, avoid embarrassing diagnoses of workplace-induced illnesses, and equate quality with lowered absenteeism. From Freud's definition of health, the ability to work and to love, the latter is deleted.

For-profit HMOs owe, by law, first allegiance to their shareholders. Their employer-customers are second on the queue, patients a distant third. When Aetna purchased US Healthcare's 2.2 million "covered lives" at $4000 per "life," patients and doctors were mere objects of the deal, excluded from the deliberations. In addition to patients, Aetna sought US Healthcare's expertise at aligning physician incentives with corporate profitability—the impolite word is "kickbacks."[2]

Caregivers and patients are granted access to each other only so long as their relationship profits the HMO that owns the patients; the uninsured need not apply. Virtually all managed care plans engage in "economic credentialling," assessments of caregivers' contribution to profitability, and most now base practitioner income, at least partially, on such profiles.[3] Such managed care plans have the right, nay, obligation to terminate unprofitable doctor–patient dyads. Thus, most managed care contracts allow the firm to fire practitioners "without cause."

These trends undermine much that is rational and desirable in doctor–patient interactions. Patients want from their doctors more time, more information, more caring, and more mutuality in decision-making, therapy, and prevention.[4,5,7,8] Instead, HMOs press for shorter visits and increased volume—all this despite a nationwide physician glut. Empathy, humanity, and imagination are neither profitable nor readily quantifiable,

Editor's Note: See related article by Weiss and Blustein (p 1742) in this issue.

and, as US Healthcare's billionaire chief executive officer opined, "It doesn't count unless you can count it."[9] Instead, managers measure care in the false coin of throughput, short-term satisfaction, and quality indices such as Health Plan *Employer* Data and Information Set (HEDIS) that assess tiny and easily manipulated slices of clinical life.

While economists and Wall Street cheer market-driven care,[10] patients grumble. HMO enrollees are more than twice as likely as fee-for-service patients to complain that care is not appropriate, that examinations are not thorough, and that physicians do not care enough or spend enough time.[11] Twice as many HMO patients express dissatisfaction with care overall, three times as many are dissatisfied with the quality of care, and four times as many complain of poor access to specialists.[12] In Massachusetts, 22% of HMO patients are afraid that their doctors would not provide needed care, and only two-thirds have confidence in their physicians.[13] Among sick patients, 22% of HMO patients and 13% of fee-for-service patients cite problems in getting treatment that they and their doctors believed were necessary.[11]

Doctors who see fewer patients—who are, in the language of managed care, "unproductive"—involve patients in decision-making more actively.[5,7] This in turn correlates with higher patient satisfaction and less switching physicians. Both physicians' sense of autonomy and a long duration of the doctor–patient relationship are associated with these same positive features.[5]

In this issue of the Journal, Weiss and Blustein describe an economic benefit of such long-term caregiving relationships for the elderly.[6] "Faithful patients" incurred lower costs of care, especially for hospital care. The cost curve appears S-shaped, with very high costs for new patients (reflecting, at least in part, people who sought care at the onset of an illness), a plateau phase between years 1 and 10, and a further fall thereafter. Unmeasured confounders may account for these findings. Long-term patients may have older, more conservative physicians, or more stable housing and social environments. But it is plausible that giving doctors and patients time to get to know each other facilitates clinical parsimony. The intimacy and continuity of doctor–patient interactions previously has been found to affect resource use,[14,15] compliance,[16,17] and the number of hypertensive patients lost to follow up.[18]

The authors evince appropriate concern about market-driven disruptions of continuity. Indeed, the very theory of market competition demands willingness to switch health plans in search of the best deal. When a patient is forced to change HMOs because his or her employer's benefits manager found a bargain, or because of job loss, or because of Medicaid enrollment or disenrollment, the patient moves between restricted panels of providers, more or less ensuring discontinuity.[12]

Continuity of care may save society money, but for a managed care plan, the costs of long-term patient–doctor relationships outweigh the modest savings that Weiss and Blustein document. Because a small number of patients account for a large proportion of costs, subtle encouragement for the sick (and their doctors) to leave a plan is a far better financial bet than promoting continuity. Business sense also dictates that HMOs walk away from unprofitable communities or enrollee groups.[19] Moreover, job insecurity makes physicians toe the managed care line, and anyway doctors tend to accumulate older and sicker patients over time and become less attractive to HMOs.

Ephemeral medical relationships are becoming the norm. Twenty percent of Medicare HMO enrollees dropped out within 12 months of joining.[20] In Medicaid HMOs, about 5% of patients disenroll each *month,* usually because they have lost eligibility.[21] Even in older, mostly not-for-profit HMOs, the relationships of depressed patients with their caregivers are truncated.[22]

Time is needed to search for needs rather than merely satisfying immediate wants, to educate both doctor and patient, and to involve them as co-producers.[23,24] Only time will allow us to engage the social and psychological problems that most patients have and not merely rule out the biological problems they do not have.[25] Good care can be sparing of everything but time.[25] □

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