

What a fair and rational health system would look like

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Abstract

The costs and consequences of America's fragmented and profit-driven health system have reached unsustainable levels. Far too much is spent on redundant bureaucracy, and on medical interventions that are either unproven or have been shown to be ineffective, while millions of people lack coverage for basic cost-effective health care. The current level of corporate influence on research, education, and dissemination of scholarly work is unacceptable. It is high time that we design and deliver government-mandated health insurance that makes evidence-based cost-effective health care universally accessible. All comparable nations achieve better outcomes with fewer resources using this model. We can too.

Revising the Health System

Complaints regarding America's health system are nothing new. Patients say that the system is complex, imposing, and difficult to access. Doctors complain about endless paperwork and about less satisfying interactions with patients. Everyone laments soaring costs, which are increasing at an unsustainable pace.¹ Pressures associated with health insurance costs are forcing

benefit-reductions, layoffs, and plant closures. Despite tremendous need and at least 1 proposal for radical yet rational reform,² there is little progress toward the overhaul that is so clearly needed. In this context, we would like to offer our opinion regarding a few of the factors that would contribute toward a fair and rational health care system.

To start with, a health system should exist for the purpose of improving health, and should have reasonable evidence that it can do so. Health facilities and personnel should be focused on the interventions that have been proven to prevent disease, alleviate symptoms, improve function, or save lives. Interventions that have been proven not to work (e.g. antibiotics for common cold), or have not yet been adequately assessed (experimental therapies), should either be avoided altogether, or used only within research frameworks. Even a modest attempt at following these principles could save billions of dollars.³

When the evidence is unclear, as it too often is, patients and their doctors should be allowed a wide latitude of choice, assuming that costs are reasonable. When costs are high and evidence is lacking, pooled resources—both private and public—should not be used on unproven therapies.

Thankfully, we have entered the era of evidence-based medicine.⁴ Randomized controlled trials (RCTs) have provided good evidence regarding many available treatments.

Nevertheless, a great number of urgent questions lie unanswered, and a great deal of improvement is possible in the conduct and reporting of medical research. If there is one thing we have learned, it is that RCTs are useful but imperfect measures. Interpretation and application of trial results are prone to biases introduced by those who design trials, analyze data, and report the results.^{5,6} Initial positive results are often contradicted by later studies. When later trials do confirm effectiveness, the magnitude of reported benefit is usually smaller.⁷

Trials sponsored by pharmaceutical companies are especially problematic. Inevitable and largely unresolvable conflicts of interest occur when the corporations that sponsor RCTs stand to gain or lose large sums of money based on the results. These conflicts naturally lead to overly optimistic interpretation of positive findings, and to non-publication or disregard of negative results, if not to outright fraud. Most RCTs are designed to detect benefits, not harms. When adverse effects are found, they are too often unreported, or when reported, minimized or explained away.⁸ To reduce the impact of these biases, lawmakers, regulators, editors, and professional societies need to set and enforce appropriate rules. Not only should drug companies be required to register all trials, as major journals have recently proposed,⁹ but they should be required to measure and report adverse effects with the same attention they devote to benefits. Trial sponsors should be required to publish or post

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their protocols before their data are unblinded, and should be required to share the actual data sets with other researchers, as well as with regulators such as the FDA.

Systems of continuing medical education and dissemination are good, but could be a great deal better. Peer-reviewed journals, professional conferences, and other forms of continuing medical education are too often inappropriately influenced by drug companies and other for-profit entities. The idea that entire residencies could be financed by drug firms should send shivers down our spines.¹⁰ Journals and conferences should not be dominated by product advertisements. In our opinion, they should have no advertisements at all. Scientific journals and meetings among non-medical sciences manage to produce high quality output without the massive influx of drug dollars. How can our journals be objective when they are filled with glossy drug-promoting images and slogans, and when their finances are dominated by pharmaceutical money? How can we not feel ashamed when the press cameras at major meetings broadcast images of huge banners promoting brand name drugs?

Physicians and other health professionals should get their information from unbiased scientific sources, not from drug reps.^{11,12} Numerous sources of excellent information are easily accessed, and are usually inexpensive or free.¹³ Physicians and medical researchers should not accept gifts from drug companies. Stays at lavish resorts and so-called “consulting fees” for medical opinion leaders are a form of graft, and should not be tolerated. It’s one thing when physicians and researchers are employed by pharmaceutical firms and are clearly identified as such. It’s quite another when they ostensibly work for universities or publicly-funded research institutes, thereby influencing the practice of medicine with a veneer of objectivity and impartiality, and are all the while taking home large supplemental in-

comes from drug firms. Even in the tarnished world of politics, such practices are recognized as corruption, with recipients earning public condemnation, prosecution, fines, or jail.

Finally, and most importantly, everyone should be provided access to quality health care. It makes no sense to treat medical care as a commodity. Fully informed rational choice in a competitive health care market is an unsupportable myth. Only the most fortunate have any real choice in health plans, and even they are usually making their insurance decisions long before the product they need—care for a specific illness—can be evaluated rationally. It is abundantly clear that market-based solutions to health care problems have failed miserably. Massive resources are wasted on overhead and bureaucracy, while many simple needs go unmet. The United States spends over \$6400 per capita each year, far greater than any other industrialized country, and yet more than 45 million people are uninsured, with tens of millions more underinsured.¹⁴⁻¹⁷ Approximately half of current bankruptcies are caused at least in part by illness or medical debt.¹⁸ As a direct result of this misalignment of resources and need, the United States has the worst health outcomes among comparable nations.¹⁹⁻²¹

Conclusion

In general, it’s the people with the greatest risk who should be screened, and those with the most severe disease who should be treated, as these are the people who will receive the greatest benefit at the least cost.²² Unfortunately, as the renowned British general practitioner Julian Tudor Hart described in 1971 with his “inverse care law,”²³ it is the people who could most benefit from health care that have the least access:

“The availability of good medical care tends to vary inversely with the need for it in the population served. The inverse care law operates more completely where medical care is

most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the misdistribution of medical resources.”²³

In recent decades, the political elite of the United States have clung blindly to failed market-based solutions for health care. At the same time, every other developed country achieves better outcomes with fewer resources, using some form of government-sponsored universal health care. Despite this history of repeated mistakes and tragic outcomes, we derive some hope and solace from the famous quote by Sir Winston Churchill: “You can always count on Americans to do the right thing—after they’ve tried everything else.”

In our opinion, it is time to demand a universal-access health care system that delivers high quality cost-effective evidence-based medicine. A single payer government-mandated system would eliminate redundant bureaucracy, reduce profit-seeking corporate influence, and target resources towards areas of need. Such a radical change is long overdue, sorely needed, and is the only rational solution to the devastating problems we now face.

References

1. Bodenheimer T. High and rising health care costs. part 1: seeking an explanation. *Ann Int Med.* 2005;142:847-854.
2. Woolhandler S, Himmelstein DU, Angell M, Young QD, Physicians’ Working Group for Single-Payer National Health Insurance. Proposal of the Physicians’ Working Group for single-payer national health insurance. *JAMA.* 2003;290:798-805.
3. Bodenheimer T. High and rising health care costs. part 3: the role of health care providers. *Ann Int Med.* 2005;142:996-1002.
4. Guyatt GH, Rennie D. Users’ Guides to the Literature: A Manual for Evidence-Based

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- Clinical Practice. Chicago: AMA Press; 2002.
5. Abramson J, Starfield B. The effect of conflict of interest on biomedical research and clinical practice guidelines: can we trust the evidence in evidence-based medicine? *J Am Board Fam Pract.* 2005;18:414-418.
 6. Kjaergard LL, Als-Nielsen B. Association between competing interests and authors' conclusions: epidemiological study of randomized clinical trials published in the BMJ. *BMJ.* 2002;325:249.
 7. Ioannidis JP. Contradicted and initially stronger effects in highly cited clinical research. *JAMA.* 2005;294:218-228.
 8. Ioannidis JP, Evans SJ, Gotzsche PC, et al. Better reporting of harms in randomized trials: an extension of the CONSORT statement. *Ann Int Med.* 2004;141:781-788.
 9. De Angelis CD, Drazen JM, Frizelle FA, et al. Is this clinical trial fully registered? a statement from the International Committee of Medical Journal Editors. *N Engl J Med.* 2005;352:2436-2438.
 10. Kuehn BM. Pharmaceutical industry funding for residences sparks controversy. *JAMA.* 2005;293:1572-1580.
 11. Brody H. The company we keep: why physicians should refuse to see pharmaceutical representatives. *Ann Fam Med.* 2005;3:82-85.
 12. Neale AV, Schwartz KL, Bowman MA. Conflict of interest: can we minimize its influence in the biomedical literature? *J Am Board Fam Pract.* 2005;18:411-413.
 13. Lowenhaupt M. Evidence-based medicine grows up. *Health Manage Tech.* 2005;26(6):8,10,12.
 14. Holl JL, Slack KS, Stevens AB. Welfare reform and health insurance: consequences for parents. *Am J Pub Health.* 2005;95:279-285.
 15. Mitka M. Forecast for US uninsured remains gloomy. *JAMA.* 2004;291:2305-2306.
 16. Olson LM, Tang SF, Newacheck PW. Children in the United States with discontinuous health insurance coverage. *N Engl J Med.* 2005;353:382-391.
 17. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. *N Engl J Med.* 2003;349:768-775.
 18. Himmelstein DU, Warren E, Thorne D, Woolhandler S. Illness and injury as contributors to bankruptcy. *Health Aff.* 2005;W5:63-73.
 19. Baker DW, Sudano JJ, Albert JM, Borawski EA, Dor A. Lack of health insurance and decline in overall health in late middle age. *N Engl J Med.* 2001;345:1106-1112.
 20. McKenna MT, Michaud CM, Murray CJ, Marks JS. Assessing the burden of disease in the United States using disability-adjusted life years. *Am J Prev Med.* 2005;28(5):415-423.
 21. Starfield B. Is US health really the best in the world? *JAMA.* 2000;284:483-485.
 22. Kindig DA. *Purchasing Population Health: Paying for Results.* Ann Arbor: University of Michigan Press; 1997.
 23. Hart JT. The inverse care law. *Lancet.* 1971;405-412.
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