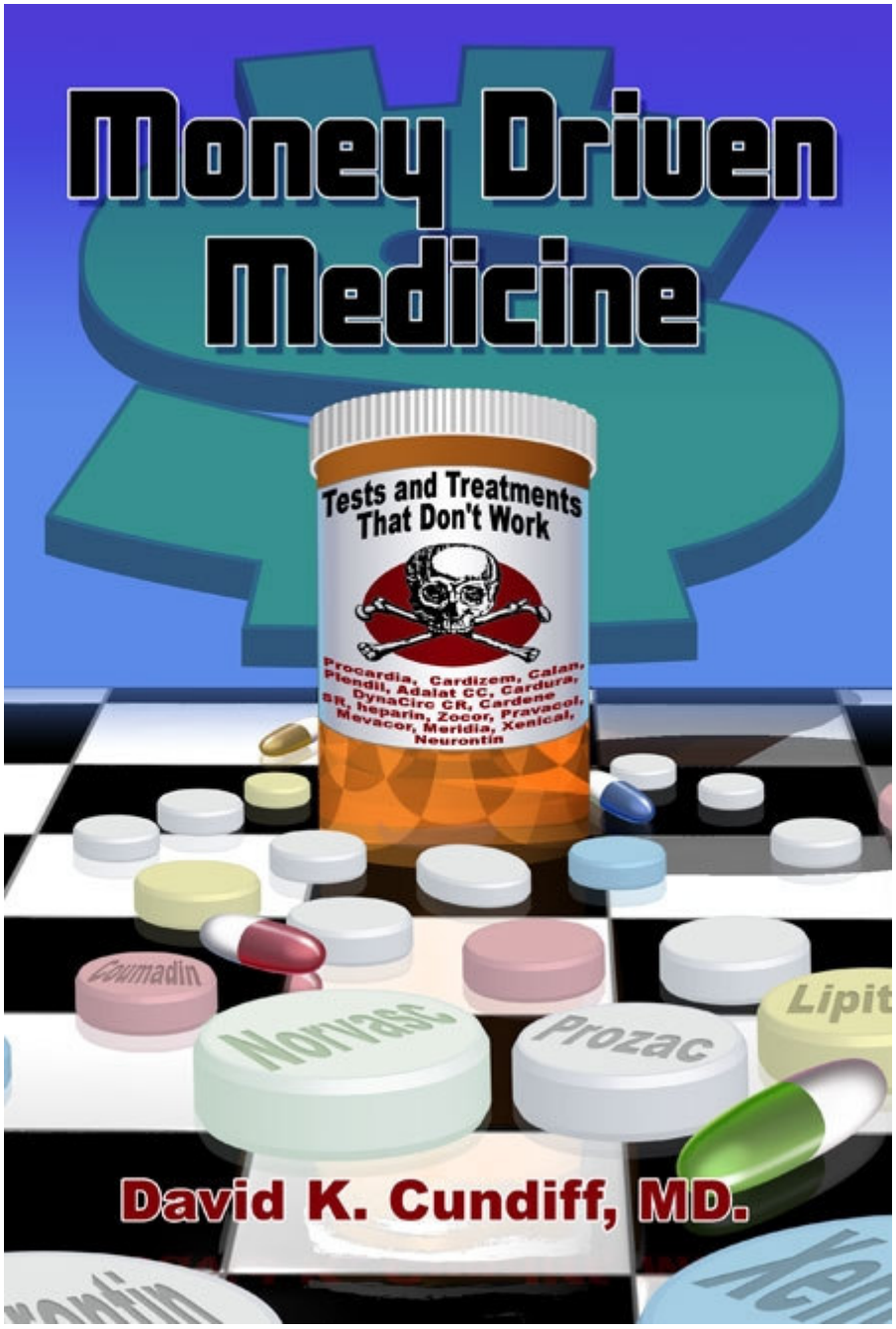
Money Driven Medicine
Tests and Treatments That Don't Work
Procardia, Cardizem, Calan, Plendil, Adalat CC, Cardura, DynaCirc CR, Cardene SR, heparin, Zocor, Pravacol, Mevacor, Meridia, Xenical, Neurontin
Coumadin
Norvasc
Prozac
Lipit
David K. Cundiff, MD.

Money Driven Medicine

Money Driven Medicine

Tests and Treatments That Don't Work

---

by
David K. Cundiff, MD

Dedication

To the patients and staff of the LA County + USC Medical Center, who deserve to receive and deliver the best possible medical care.

Book cover: Eddie Young

Disclaimer

- This book is for general informational purposes only and is not a substitute for professional medical advice.
- You are encouraged to confirm information with other sources and confer with your doctor with regard to information contained in this book.

Library of Congress Cataloging in Publication Data
Cundiff, David K.
Money Driven Medicine—Tests and Treatments That Don't Work
by David K. Cundiff
ISBN 0-9761571-0-1
1. Medical care—United States. 2. Health care reform—United States. 3. Medicine, Preventive—United States. 4. Health care economics—United States.
Dewey Decimal # pending 2006
2004097330

Introduction

In a commencement address of a prominent American medical school in the 1960s, a highly regarded senior physician counseled the graduating students something like this: "Over the past four years, your teachers have imparted to you a tremendous amount of information about the diagnosis and treatment of medical diseases and you have learned it remarkably well. Unfortunately, I have to tell you that half of what we taught you was wrong. Over the rest of your medical careers, your job will be to determine which half was wrong and which was right." While research studies and other medical literature about the diagnosis and treatment of medical diseases have grown exponentially since the 1960s, the ratio of scientifically valid versus invalid medical tests and treatments may not have changed much over the past 40 years.

In a survey of the health care provided to 6,712 people in 12 US cities, RAND Corporation researchers found that 45% of the time participants did not receive care recommended by orthodox medical establishment guidelines and that 11% of the tests and treatments they did receive were unnecessary or possibly harmful. They concluded, "The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public."[1, 2]

Accepting the premise of this RAND Corporation Quality of Care Report (i.e., that all guidelines for medical tests and treatments endorsed by a consensus of government and academic medical scientists are scientifically derived and valid) means that de-facto rationing of necessary medical care is already widespread in this country. It also means that we have no extra health care funds for currently under-funded health care priorities like long-term care, computerized medical records, stem cell research, alleviating the nursing shortage, and prevention of cardiovascular disease, AIDS, cancer, and obesity.

Is there a cure that can be offered for the grim prognosis of the current American health care system?

Yes!

In this book, I will challenge the premise of the RAND report, that following officially endorsed health care guidelines leads to better health outcomes. In Chapters 3 – 7 and 9 – 20 of this book, I will dispute the evidence-basis for many risky and expensive yet standard medical interventions including 41 quality measures cited in the RAND Corporation Quality of Care Report (Appendix 1). These chapters will show that the real reason health care costs escalate out of control while quality of care suffers and access to basic treatment diminishes is medical tests and treatments that don't work. In 2007, they will kill 73,000 – 110,000 Americans and cost $922 billion – $1,158 billion (Chapter 24). In relation to these staggering figures, Napoleon Bonaparte's words of 200 years ago seem prophetic, "You medical people will have more lives to answer for in the other world than even we generals."

True comprehensive health care reform in this country will elude economists, health policy wonks, and government and academic scientists until insurance coverage for ineffective and dangerous tests and treatments is dramatically reduced. Additionally, rampant fraud that will consume $72 – $240 billion in health care funds in 2007[3, 4] and administrative redundancy and inefficiency that will waste over $400 billion call for creative solutions.

Clearly, American medicine also does a lot of good. As the world leader in medical technology, American health care triumphs include combination chemotherapies for childhood and some adult cancers, antiviral drugs for AIDS, modern anesthesia for surgeries, vaccinations against smallpox and other infectious epidemics, campaigns to reduce nutritional deficiencies, surgeries to replace worn out joints, heart valves, and many other treatments that can truly be called miracles. I think that American medicine does more good than harm. My focusing in this book on problems with current American medical orthodoxy does not negate its immense benefits.

Major problems with our health care system include:

- Our social program safety net to avoid the consequences of poverty (including diseases) is being dismantled. (Chapter 21)
- Medical errors kill up to 98,000 Americans per year[5] in addition to the 73,000 – 110,000 from worthless tests and treatments that I detail in this book.
- Our medical malpractice system requires reform not because it costs 1.7% of the health care budget ($40 billion in 2007) but because it compensates no more than 3% of malpractice victims.[6-8]
- Antiquated medical information systems foster duplication of services and errors in patient care (Chapter 22).
- We have a critical shortage of nurses because of stressful working conditions leading to burnout and insufficient space in our nursing schools for qualified applicants.[9] (Chapter 21).
- In 2007, 49 million US residents will not be medically insured of whom 22.6 million will be year-round, full-time workers (Chapter 21).[10, 11]
- The cost of health care insurance for a family of four exceeds the pay before taxes of a minimum wage worker.[12] (Chapter 21: In addition, a typical family's out of pocket health care costs will total $3,770 in 2007.[4])
- Many nursing home residents receive scandalously poor quality care (Chapter 22).
- We treat alcohol and drug abuse as legal problems rather than as medical problems (Chapter 19).
- Americans have inadequate access to and incentives for practicing preventive medicine (Chapter 22).
- Funding for mental health problems is not at parity with that of physical problems (Chapter 22).

- HIV-AIDS prevention efforts world-wide reach less than 5% of the at-risk population (Chapter 22).
- In the US, standard public health methods to control an infectious epidemic have not been applied to HIV-AIDS (Chapter 22).
- Patients in managed care have no "bill or rights" (Chapter 21).

Chapters 21 – 23 document how adequately financing the solutions to these and related health care problems would cost an additional $2.2 trillion. Without fundamentally restructuring the health care system before 2007, the total bill for all medical establishment endorsed tests and treatments, including about $1 trillion for ones that don't work, and paying for currently under-funded health care needs would be $6.2 trillion ($2.3 trillion projected already + $1.7 additional needed according to RAND report + $2.2 trillion for critically underfunded current needs = $6.2 trillion) or an unsustainable 35% of a much higher gross domestic product ($6.2 trillion / $17.8 trillion = 35% of GDP versus $2.3 trillion / $13.8 trillion = 16.9% of GDP projected for 2007).

In this book, the orthodox medical establishment refers to pharmaceutical companies, special interest medical associations, medical journals, insurance companies, government regulatory agencies, medicine-related nonprofit advocacy organizations, and the medical media. These institutions of the orthodox medical establishment all make positive contributions to health care and should all continue to function. Altruistic, dedicated, and talented health care professionals exist in all areas related to healing the body, mind, and spirit. With few exceptions, everyone in medical and allied professions wants to improve the health of people. The system is the problem; not the people in the system.

I focus on some, but not all, of the establishment-approved tests and treatments that don't work. Exposing waste and inefficiency in orthodox medicine is always a work in progress. If this book does not discuss a specific test or treatment, it does not necessarily imply that scientific evidence supports its safety and efficacy.

We all want our health care dollars to go for tests and treatments that work in the real world, not just in highly controlled research settings. So what went wrong? The medical field has adopted many ineffective tests and treatments through historical precedent. Others have become orthodox or standard care in recent years due to flawed medical research designed and funded by special interests.

What can the public do about orthodox tests and treatments that don't work? The public can advocate that rigorous scientific proof of effectiveness determines funding of health care interventions. This is called "evidence-based medicine" and is discussed in Chapter 1. The pervasive influence of money on human nature together with widespread lack of understanding of evidence-based medicine leads good people to promote ineffective and / or dangerous tests and treatments. In Chapter 2, I describe how special interests groups have perverted evidence-based medicine to further their own monetary interests.

Using evidence-based medicine principles as the point of reference, this book addresses medical orthodoxy-endorsed tests and treatments (e.g., Food and Drug Administration approved) paid for by medical insurance that are unproven to work and are unsafe and expensive.

Playing Politics With Spending For Government and Private Health Care Programs

The federal, state, and local governments fund about 48% of US health care expenditures.[4] Voting records on health care issues may determine whether candidates are elected to local, state, and national office. All political parties carefully develop their platforms regarding health care to appeal to as many voters as possible. The adoption of Medicare and Medicaid in the mid 1960s gave the Democrats a major edge over Republicans concerning health care in the minds of many voters.

President Clinton's Administration invested a tremendous amount of political capital in its "Managed Competition" reform proposal in his first term. The Republicans adamantly opposed managed competition without offering a comprehensive health care reform proposal in its place. The Republican Party won this political

battle by defeating the Clinton plan and subsequently winning control of both houses of Congress in the midterm election of 1994 largely over this issue.

Remembering the managed competition disaster, neither major party has been subsequently willing to consider a comprehensive health care reform proposal. Both parties seek political advantage with various "incremental reform" proposals that are usually about spending more money—borrowed money—on government health care programs.

President Bush hoped to sway senior voters with his election year plan to spend $400 billion over 10 years for a prescription drug benefit for Medicare recipients. Conservative Republicans opposed the plan because of the high cost. Liberal Democrats opposed it because of the meager benefits to Medicare patients and massive benefits to drug companies, HMOs, and the drug benefit plans of Fortune 100 companies. Republican and Democratic centrists passed the legislation on a close vote. Weeks after President Bush signed the bill into law, Medicare's chief actuary, Richard S. Foster, announced that Tom Scully, then the Medicare and Medicaid chief, threatened to fire him if he told Congress that the drug benefit program would cost over $720 billion.[13] Medicare recipients now confront a confusing mess that will, hopefully, be repealed.

Health and Human Services Secretary Thompson's investigation confirmed that Mr. Scully threatened to fire Mr. Foster if he told the Congress the true cost of the benefit. However, neither the threat nor the withholding of information violated any criminal law, secretary Thompson reported.[14]

Mr. Scully now works as a well paid lobbyist for major drug companies and other clients that profit handsomely from the new Medicare law, which he helped write.[14] According to Political Money Line, a nonpartisan watchdog group, the health care industry spent $325 million in 2004 for lobbyists like Mr. Scully to influence Congress and federal agencies to favor various programs, medical products, and services. Drug companies led the orgy of influence buying by paying $86.9 million for lobbyists. Hospitals invested $55 million and doctors $35.4 million.[15, 16] Spending on lobbyists by major health care "stakeholders" (the new term for special interests) promises to increase in 2006 and 2007.

After the passage of the prescription drug benefit, the Social Security and Medicare trustees reported that Medicare would go broke by 2018. According to the Social Security and Medicare trustees, Medicare's long-term debt, based on a 75-year actuarial projection, is now estimated to be **$32.4 trillion**.[17] The public doesn't seem to blame either party for this crisis. Voters want immediate relief from outrageous health care costs. The year 2018 seems a long time away.

Legislators also play politics with private health care insurance. As of 2006, the Council for Affordable Health Insurance has documented 1,843 health insurance mandates by state laws in the 50 states.[18] A health insurance "mandate" is a legal requirement that an insurance company or health plan cover (or offer coverage for) health care providers (e.g., acupuncturists), benefits (e.g., prostate cancer screening), or patient populations (e.g., adopted and non-custodial children). At the behest of special interest lobbyists representing various health care providers, products, services, or populations; state government elected officials have decreed that private insurance must cover highly questionable health care services such as mammograms (Chapter 14), prostate cancer screening (Chapter 13), bone marrow transplants (Chapter 23), chemotherapy (Chapter 16), clinical trials (Chapter 1), colonoscopy screening for colon cancer (Chapter 2), diabetic supplies (Chapter 7), in-vitro fertilization, surgery for morbid obesity (Chapter 4), and off-label drug use (Chapter 19).

Arkansas mandates coverage for athletic trainers, Nevada requires insurance companies to cover hormone replacement therapy (Chapter 20), and Wisconsin is the only state to legislate the insurance coverage of AIDS vaccines. The number of mandates per state range from 13 in Indiana to 59 in Maryland. Although one mandate may only increase the cost of a policy by 1%, 40 – 50 such mandates will price many people out of the private insurance market. These state mandates will increase the cost of health insurance by an estimated 20% to 50% ($133 billion to $266 billion) in 2007.

To an increasing extent, special interest lobbyists and lawmakers rather than doctors are practicing medicine.

Money Driven Hospitals

Of the $2.3 trillion Amercians will spend for health care services in 2007, $709 billion (31%) will go to hospitals.[4] Reimbursement for different kinds of hospital services varies widely because of big differences in payment sources (Medicare, Medicaid, private insurance, out of pocket, etc.). The US has three kinds of hospitals: for-profits, nonprofits, and government hospitals. For-profits are most likely to offer relatively profitable medical services (e.g., joint replacement surgery and coronary bypass surgery); government hospitals are most likely to offer relatively unprofitable services (e.g., drug and alcohol detoxification); nonprofits often fall in the middle.[19] To maintain their favored tax status, nonprofit hospitals need to demonstrate that they provide services that benefit the entire community (e.g., training doctors and nurses, holding health fairs, providing emergency services, and conducting medical research). Prior to 1969, nonprofit hospitals also had to also provide a significant amount of charity care. The Internal Revenue Service no longer requires hospitals to provide charity care to maintain nonprofit status.

Because large insurance companies demand big discounts from hospitals, hospital bills for poor uninsured people are often much higher than insured people.[20] Many hospitals, including nonprofit and government ones, have been aggressive in trying to collect payment from the uninsured. New York Times reporter, Robert Pear, found that nonprofit hospitals may seek money more than providing charity care or community service.[21] For example, he cites an investigation of the billing and collection practices of nonprofit hospitals in Kansas by attorney general, Phill Kline, which found that some nonprofit hospitals have hired debt collection agencies that "harass the poor."

Lawsuits have been filed on behalf of low-income people around the country arguing that private nonprofit hospitals are required to provide free or reduced-price services to the uninsured. Most of the time, judges summarily reject these arguments, saying that Congress must act to fix the problem. In a typical case, Judge Loretta A. Preska of the Federal District Court in Manhattan ruled that Federal tax law does not give patients an enforceable right to affordable medical care. Making these inequities even more notable,

the commissioner of internal revenue, Mark W. Everson, said tax officials have often found little difference between nonprofit and for-profit hospitals "in their operations, their attention to the benefit of the community, or their levels of charity care."

While the poor are being gouged by nonprofit hospitals, hospital executives often make such exorbidant compensation that Republican Senator Charles Grassley, Chair of the Senate Finance Committee, and Representative Bill Thomas, Republican of California and the chairman of the House Ways and Means Committee, are investigating. For example, the president of NewYork-Presbyterian Hospital, Dr. Herbert Pardes, received more than $4.3 million in compensation in 2004, plus $1.2 million in contributions to his employee benefit plan. Dr. Spencer Foreman, president of Montefiore Medical Center in the Bronx, received $1.1 million in compensation and $712,000 in benefits.[21]

International Comparisons of Health Care Quality

For our anticipated $2.3 trillion in health care spending in 2007, how do we compare with other developed countries in health care outcomes? *JAMA* (formerly the *Journal of the American Medical Association*) published the following rankings of the US judged against the 12 other leading developed countries:[22]

- Low birth weight percentages—13th (last)
- Neonatal mortality and infant mortality—13th
- Over all years of potential life lost (excluding external causes)—13th
- Life expectancy at the age of 1 for females—11th
- Life expectancy at the age of 1 for males—12th
- Life expectancy at the age of 15 for females—10th
- Life expectancy at the age of 15 for males—12th

Barbara Starfield, MD, the lead author of the above study, said that the situation is worse in 2004 than in 2000 when the study was published. To begin to improve our health care outcomes, she calls for universal health care insurance coverage and the development of a first-rate primary care system.[23]

In 2006, Save the Children, a nonprofit children advocacy group, ranked the US next to last out of 33 industrialized countries in the mortality rate of newborns. While the infant mortality rate in the US was 7 per 1,000 live births, Cuba posted a rate of 6 per 1,000 live births.[24]

One explanation typically offered for the poor ranking of Americans in international comparisons is the greater degree of ethnic diversity in the US. However, in a comparison of middle age (age range: 50 – 64 years old) Caucasians from England and from the US (avoiding the ethnic diversity issue), Americans had twice the rate of diabetes as the English (12.5% versus 6%), more hypertension (42% versus 34%), and cancer (9.5% versus 5.5%). Americans also had higher incidences of heart disease, strokes, and lung disease -- findings that held true no matter what income or education level. Smoking rates were about equal and the English had a higher rate of heavy drinking. Americans exercised slightly less than people in England, but that did not account for the dramatically different health outcomes. [25, 26] The British payed less than half of what Amercians did for health care and all Britons were insured.

A survey in 2005 of 6,957 adults, who had recently been hospitalized, had surgery or reported health problems, compared the US, Australia, Canada, Britain, New Zealand and Germany. The survey, which is the largest to examine health care in several nations during the same time period, found that US residents were more likely to forego medical care than patients in other nations because of costs. US patients also had a higher medical error rate attributed in part to a lack of coordination among health care providers. The authors concluded that improved medical care would require a fundamental transformation of the system of delivering care in the US.[27-29]

The greater use of medical technology does not account for America's two and one half fold greater cost of medical care compared with Organization for Economic Cooperation and Development (OECD) countries (England, Germany, Canada, Australia, and Norway). We don't necessarily have more tests and treatments that don't work than other developed countries. The US has fewer physicians, nurses, and hospital beds than the median OECD country.[30] On a percapita basis, compared with OECD countries, the US has the same number of CT scanners; nine OECD

countries have more magnetic resonance imaging scanners (MRI machines); three OECD countries performed more heart transplants, and two other countries delivered more liver transplants. Health care costs more in the US because doctors, hospitals, and drug companies charge more than people pay in other countries.[30, 31]

Preventive Medicine Virtually Ignored

Echoing pronouncements of many US Government health care policymakers before him, former Secretary of Health and Human Services Tommy Thompson said, "To stem the epidemic of preventable diseases that threaten too many Americans, we need to move from a health care system that treats disease to one that avoids disease through wiser personal choices." Mr. Thompson noted that three-fourths of the money we spend on health care ($1.7 trillion in 2007) goes to treat chronic illnesses whose prevalence could be reduced through prevention.[32] In response to this urgent situation, the Secretary:

- Recommended that the Bush administration ask Congress for $125 million to help prevent diabetes, obesity, and asthma.
- Encouraged all Americans to make healthy changes in their lifestyles
- Told health insurance companies to change their attitudes and to get more involved in prevention
- Asked representatives of the fast food industry to help combat obesity by offering healthier food choices.

Unfortunately, former Secretary Thompson's remedies for health care are not up to the task.

Health insurance executives run cutthroat businesses with strong financial incentives to reduce costs. Preventive medicine interventions work in the long run but cost money in the short run. If health promotion services drive up insurance premiums, customers will switch to cheaper policies from companies that skimp on preventive medicine. The new insurers will then reap the financial benefits of the preventive health programs of the previous insurers.

The food industry pays about $36 billion to advertise and market its saturated fat and cholesterol-laden food while the federal government spends only $2 million to promote eating more fruits and vegetables.[33] The average North American child sees 10,000 food advertisements per year.[34] Asking McDonalds and other fast food companies to offer healthy food is a joke.

All US public health expenditures will amount to about $77 billion in 2007—3.5% of the $2.3 trillion American health care budget.[4] Former Secretary Thompson's proposal to add $125 million of government money to target preventing certain chronic diseases is like rearranging the deck chairs on the Titanic.

Even studies funded by federal grants exhibit little interest in exploring the effects of diet, exercise, and changes in lifestyle habits in treating and preventing diseases. For instance, the National Cancer Institute, which was established in the late 1930s, has never funded a randomized trial or other study in humans to determine if any dietary change will reduce deaths from any cancer at any stage. This is despite abundant evidence that diet plays a major role in causing many common cancers.

Alternative Therapies and Health Freedom

A potential benefit of stopping funding of ineffective tests and treatments by applying the principles of evidence-based medicine may be to allow for increased funding for some of these relatively inexpensive and popular alternative treatments. Is this consistent with my advocacy of the principles of evidence-based medicine principles to determine standards of care and funding? Yes. Most popular alternative treatments have not been proven ineffective. They have not been studied because there is no economic incentive to do so. I would not advocate funding alternative treatments for which there is clear scientific evidence that they do not work.

For example, many therapists and patients feel that massage and acupuncture are healing despite the absence of randomized controlled clinical trials to prove their usefulness. These therapeutic modalities are quite safe and relatively inexpensive.

An estimated 105 million Americans will use alternative medical therapies in 2007,[4, 35] functionally defined as interventions

(1) not taught widely in medical schools, (2) not generally available in US hospitals, (3) not documented to be safe and effective in randomized clinical trials, and (4) not generally reimbursable by medical insurance.[36] Most of these therapies have not been tested in randomized controlled trials to determine if they work. Proving that herbs, minerals, natural hormones, or other supplements are effective in treating a disease condition may cost millions of dollars and if proven effective may not benefit the practitioners or manufacturers. The benefit to the patient may be entirely subjective or real but impossible too measure.

For example, Dr. Larry Dorsey elegantly describes the importance of prayer in helping people cope with illness[37] and cites randomized controlled trials showing effectiveness in patients with AIDS[38] and heart attacks.[39] Although trials overall have not confirmed medical outcomes benefits due to prayer,[40-42] people of faith will continue to be comforted by prayer in ways the randomized controlled trials cannot measure.

Visits to alternative medical practitioners in the US exceeded visits to primary care physicians in 1997.[35] Based on recent trends,[4, 35] I estimate that out-of-pocket expenditures relating to alternative therapies for 2007 will be $81 billion, which is in the same range as the out-of-pocket expenditures for all US physician services. Insurance companies and HMOs will contribute about $25 billion for alternative therapies.

Undoubtedly, providing economic incentives to objectively study more alternative treatments is in the public's best interest and should be done.

Many states have laws regulating the practice of medicine in ways that inappropriately restrict or even prohibit alternative medical therapists from treating patients. For instance, a statute in Minnesota defined "practicing medicine" as "anyone who offers or undertakes to prevent or to diagnose, correct or treat in any manner or by any means or methods, devices or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person." This statute outlawed alternative practitioners. In 1998, when a naturopath was arrested and charged with illegally practicing medicine, his patients responded by mobilizing a successful campaign to change the law.

In addition, licensed MD's, dentists, and other practitioners who recommend therapies that are not in the medical mainstream, say homeopathy, may be prosecuted for not adhering to the standards of practice for the profession. Due to these infringements on health care choices for consumers, a "health freedom movement" has developed and gained momentum.

Health freedom advocates realize that the importance of honoring consumers' rights to make their own personal health care choices must be balanced with the need to protect the public from truly potentially harmful situations. The US Supreme Court has not yet decided whether it's constitutional for the state to deny health freedom to consumers.

Robert E. Moffit, Jennifer A. Marshall, and Grace V. Smith of the Heritage Foundation present another valid dimension of health freedom: Individuals and families should be free to control the flow of dollars in their health care plans and to make the decisions that will affect their medical treatment and health care coverage, including ethical decisions. They suggest allowing values-driven health plans (sponsored by religious and other organizations) to participate in public programs.[43]

Ideally, we can achieve a reasonable balance between health and religious freedoms and the protection of patients against exploitation and medical incompetence. This may be achieved best by having decisions about allocation of an individual's health care resources be made by that person's chosen primary care physician. When these decisions are made by someone you know and trust rather than by the fine print of a legal document or a distant government bureaucrat, the system would have few if any instances of regulators, attorneys, legislators, or judges making the decisions that affect the medical treatment of individuals.

Comprehensive Health Care System Reform

David Cutler, an economist at Harvard University, hits the nail on the head: "The ideal medical care system would encourage services with high value and discourage services with low value." We now have the opposite of the ideal system.[44] Comprehensive reform requires that we stop paying for expensive and dangerous tests and therapies which have become the "standard of care" but

which are not of proven effectiveness. Without a complete restructuring of financial incentives in health care, this will never happen. No incremental approaches to improving the medical system will be of use anymore, if they ever were.

This book does not advocate rationing. We do not need rationing of health care services, although we increasingly have a de facto rationing system of health care in the US. Instead, we need a more rational system of deciding coverage based on what benefits people's health, not on what saves the government insurance companies money or what makes money for private parties / companies that produce medical technology and interventions.

On two crucial points, I agree completely with J. Edward Hill, MD, President of the American Medical Association: (1) "Reform proposals fixated on cost will only exacerbate system problems. Reform proposals fixated on patient value-received are what we so badly need. (2) …..The days of one-size-fits-all health care coverage will be numbered."[45]

A national health care system run by the federal government, as in Great Britain and Canada, has been proposed by the Physicians for a National Health Program.[46] If implemented as proposed, the US would join Canada as the only industrialized countries that outlaw privately financed purchases of core medical services. However, outlawing the duplication of government provided medical services by private companies or individuals is not working in Canada. Faced with patients suffering and even dying on waiting lists, the Canadian Supreme Court ruled in June 2005 Quebec's provincial ban on private health insurance was unconstitutional. Technically illegal but openly operating private clinics are opening around the country by an estimated one a week.

We need more not less capitalism in health care, but it must be capitalism within an appropriately functioning system with the proper financial incentives. Health care professionals should work for patients and not for the government. I agree with the sentiments of President George W. Bush: "America needs a health care system that empowers patients to make rational and smart decisions for themselves and their families, a health care system in which the relationship between the patient and the provider are central, not a health care system where decisions are made by the federal government."[47]

However, market-based solutions thus far advanced by President Bush and conservatives—medical savings accounts coupled with high deductible insurance, tax deductions or credits for individuals buying insurance, limits on non-economic damages in malpractice suits, portable health care insurance, electronic medical records, and transparency in medical pricing[48]—may be useful baby steps but far from enough to address the crisis.

Health promotion, palliative care, and long-term care must also have more financial support. And the quest for quality health care, NOT the profits of the pharmaceutical industry or medical specialists, needs to drive medical research. These worthy goals can only be achieved by controlling insurance reimbursement and government funding for those tests and treatments that have not been shown to be effective and for new interventions and diagnostic tests until their effectiveness has been clearly demonstrated.

Reforming our health care system requires that we reconsider who should determine which tests and treatments are funded by public or private insurance and which are not. It would break the bank to allow patients to determine which medical services should be covered by insurance. Because of financial conflicts of interests, permitting medical specialists to determine who should receive insurance coverage for specialty treatments is also not feasible. Currently, Congress, state and federal government regulators, insurance company bureaucrats, managed care administrators, and the courts determine which tests and treatments are covered. This has led to major consumer dissatisfaction and quality of care problems. Yet someone must be entrusted with the responsibility of controlling health care spending for individuals.

Doctor Managed Care

True health care reform will require that every patient's primary care physician (PCP) be made responsible for determining the tests, treatments, and preventive medicine services that are covered under the universal health insurance plan. For this to work, the PCPs and their patients must have financial incentives both to provide state-of-the-art care and to control the costs of disease treatment.

We need to think about solutions that lie somewhere in between the two extreme scenarios of "privatizing medicine" with a totally market-oriented approach and a "takeover" of medicine by the government. This book recommends combining a patient-centered, market-oriented approach with government funding but minimizing the intrusion of the government in the practice of medicine.

Chapter 24 introduces "Doctor Managed Care," my proposal for comprehensive health care reform. It specifies how to shift money from ineffective tests and treatments, administrative waste, and fraud to evidence-based care determined by each person's PCP. Doctor Managed Care will also allow for meeting currently unmet medical needs, allowing preventive medicine to play a major role, reforming the dysfunctional medico-legal system, and eliminating problems with access to care. This proposal should be appealing to people from all points on the political spectrum.

The only losers in this proposed reform would be the special interests that profit from tests and treatments that don't work. Fundamentally reforming our system of care and the incentives that drive it will dramatically reduce bureaucracy costs, improve the job satisfaction of the remaining required medical administrators, and allow many administrators to move to other more fulfilling areas of health care.

The waste of 45% – 50% of our health care dollars on worthless tests and treatments and excessive administration requires fundamental restructuring of our health care system. The time for comprehensive health care reform is now.

Contents