Editorial

The American culture and health care

Edward D. Harris, Jr., MD, Editor

By focusing on the cost of delivering health care as a percentage of the gross national product of the United States and lamenting this large dollar number, economists and politicians ignore an important reality: Americans expect the most advanced and effective diagnosis and therapies for disease, no matter the cost. This is not a national weakness, but a consequence of our cultural evolution. If we accept this, our focus turns from lamenting our plight to devising a national health system that provides services to all citizens. The remaining challenge then becomes paying for health care while controlling excesses.

How did Americans come to expect only the most advanced and complete system of health care? Part of the answer could be our obsession with "fighting" disease.

At a recent Institute of Medicine conference, "Ending the War Metaphor," the medical war metaphor (e.g., against cancer, bacteria, etc.) was shown to be a sustained by-product of World War II in the United States. Barron Lerner pointed out that this war metaphor in medicine is a product of and a component of our culture, but does not exist in other countries. When we develop cancer, for example, Americans fight—we want as much surgery, as much radiation, as much chemotherapy as possible. Because of this, Americans are unlikely to ever accept less than the most advanced medical care. Despite cogent arguments, the case for arbitrary rationing of medical care has gained little traction in the United States. Quite the opposite. Look at recent examples of the standard of care:

- Zevalin and Bexxar, new radioimmunotherapy anti-cancer drugs, at the cost of $25,000 per treatment
- Hypothermia for survivors of cardiac arrest, administered at great expense to prevent apoptosis in re-oxygenated cells in the brain, projected to save as many as 100,000 lives each year
- The $20,000 to $100,000 annual costs for one-on-one therapy for our 500,000 (and increasing) autistic children.

But wait! Before botulinum toxin injections of the internal sphincter for refractory constipation in children becomes a mainstream standard of care, we must develop a system for assuring only appropriate therapy for all based upon an appropriate payment scheme.

Arnold Relman points out that commercialization and technological advances "coupled with a largely open-ended fee-for-service insurance payment system are primarily responsible for today's problems."[1] Ezra Klein, in the *Washington Monthly*, after describing the failed or failing attempts of individual states to achieve universal coverage for their citizens, concludes that, of our many states, only relatively affluent Massachusetts, which had only ten percent of its population uninsured at the outset, can achieve universal coverage without going bankrupt. Klein concludes that, as with national defense, universal health care can be achieved only by a massive federal effort. He writes, "On health reform, the light of reason is clear. We must merely be bold enough to follow it, and not settle for smaller, unsustainable victories because we fear the battle necessary for an enduring triumph."[2]

Competitive market forces, while desirable for drug and device makers, should not dictate how health care is paid for. This is an impossible dream. The most direct route to universal coverage is a single payer system funded by taxation and administered, as Relman suggests, by a public-private agency.

Once this is agreed upon the cost part of the equation must be addressed by tough measures. Polls indicate that Americans would rather increase taxes than deny a teenager a potentially lifesaving drug with minimal toxicity. In return, medical scientists working with health economists should be given authority to permit coverage of drugs and devices proven effective, while suppressing distribution of the redundant "me-too" therapies that have little demonstrated added value. Insurance companies must trim excess executive compensation, and strategies must be developed to convert them to not-for-profit entities in ways that do not bankrupt them. And, as Robert Moser outlined in the Fall 1999 issue of *The Pharos*, all the entities that comprise the "peripheral health economy" (i.e., those that make money from health care but are not physicians, nurses, or hospitals/clinics/nursing facilities) must be encouraged to have continued increases in earnings, while contributing a percentage of earnings to lower the gross national costs of health care under the single payer system.[3]

Compounding our problems are human elements. The same forces that shaped America's expectations for the best of therapy encourage specialization by physicians, leaving inadequate numbers in primary care and insufficient initiatives in preventive medicine. Current moves in the direction of cutting doctors' take-home pay are not the answer. As Uwe E. Reinhardt writes, "[We would save little money] in return for a wholly demoralized medical profession to which we so often look to save our lives."[4] The delivery part of health care must revised, suggests Relman, to development of a system of pre-paid medical groups in which physicians are paid largely by salary. The super-specialists would still be paid more, of course, but the primary care physicians could have adequate take-home pay, as well as an acceptable lifestyle.

Forget the health plans of Canada, Great Britain, and Germany—let's forge one appropriate to our very special culture.

References

1. Relman A. A Second Opinion: Rescuing America's Health Care. New York: PublicAffairs; 2007.

2. Klein E. Over stated. Washington Monthly 2007 July/Aug.

3. Moser RH. Mene, mene, tekel, upharsin comes to medicine. Pharos Fall 2007; 62: 15–19.

4. Reinhardt UE. What doctors make, and why. New York Times 2007 Jul 30: WK9.