Health policy

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The inadequacy of legislative procedures and the infirmity of physician organizations

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The United States has just commenced another in a century-long sporadic series of national health care initiatives with passage of the 2009 Senate Bill included in H.R. 4872, The Health Care and Education Affordability Reconciliation Act of 2010. This legislation represents the product of a highly turbulent politicized process driven by special interests. It is both expansive and expensive and will result in increased governmental and special interest control over approximately seventeen percent of our GDP at a cost of nearly a trillion dollars.

For the people of our nation the results will be mixed. The bill consists of well over two thousand pages of legislative language containing hundreds of line item issues addressing an impressive array of health and education related concerns. Some mandates will take effect immediately, others intermittently over the next several years extending through 2018. Presently no one can accurately predict the ultimate outcome of this reform effort, but there are two critical yet-to-be-addressed issues that bear directly upon the likelihood that increased government oversight will be successful in improving access to quality care for the public.

Legislative procedural inadequacy

While difficult for many in Washington to openly admit, it has become increasingly apparent that our national political processes are not up to the task of effectively dealing with the complex realities presented across our nation's health care landscape. Legislation driven by special interests is not capable of advocating for the overarching and ethically proper goal of universal access to quality care for our nation's inhabitants. What has emerged is a mishmash of legislative resolutions targeted at individual concerns. While almost all of the issues are legitimate, each section has been drafted against a backdrop of special interest agendas. The result is that many persons will gain access to care, others will see access more difficult to maintain or attain, and many will remain without access. The actual quality of the care accessed at the provider-patient interface has in large part been disregarded. Financial considerations have dominated the legislative product. Quality of care issues have been relegated to secondary status.

The more complex the issues addressed by our political machinery, the greater the opportunities for the agendas of special interests to trump the public good. Our political processes are inadequate in advocating for the public good when asked to effectively address the complexities of our health care economy. The emergence of calls for revision and repeal represent a predictable consequence of the procedural processes embraced by our political leaders in forging the legislative product. In the long run, major change in our political machinery will be a necessary element of effective advocacy for universal access to quality care. This will include replacing the business-as-usual deal-making by special interests, typically conducted behind closed doors, with open and transparent drafting of legislation guided by those who possess an understanding of the broad spectrum of issues that need to be addressed. The leaders of our nation's academic health

centers must be involved to effectively address the need for reform in the public interest.

Physician organizational infirmity

More participation by physicians is the second critical issue upon which ultimate success of health care reform depends. By education, training, experience, and professional mission our nation's physicians and physician associations represent the special interest that is best positioned to advocate for public access to quality care. Sadly, this cohort was neither afforded a seat at the table of reform, nor did it actively seek such a role. Indirect participation both as testifiers before committees and letter writers to those in positions of political leadership was not effective in realizing the goals advocated by physicians throughout the reform process leading up to the enacted legislative product.

The influence of our nation's physicians and the many general and specialty societies has been stifled as drivers of health care policy over the past half century. Because of the massive infusion of taxpayer dollars and increasing influence of state and federal governments generated by the Medicare and Medicaid programs introduced in 1965, potent special interests now dominate control of the national health care agenda.

In 1998 the Sustainable Growth Rate (SGR) formula was introduced to further control the reimbursement of physicians for services provided. As a result of the gradual increase to the currently proposed draconian twenty-one percent across-the-board cut in physician Medicare reimbursements, physicians have been further silenced by a top-down self-imposed policy of reticence regarding health care issues. Private payers use the Medicare reimbursement schedules as a base to determine how much they will pay for physician services. From the solo practitioner to the largest academic health centers, leaders of physicians and physician societies have become supplicants in health care discussions. The huge financial axe wielded by Congress threatens physicians who would otherwise openly and outspokenly advocate for the public good.

The powers, both governmental and special interest, that control these purse strings are not going to permanently loosen the manacles that bind physicians in servitude to the agendas of special interests. The increasingly burdensome overlay of financial considerations has decreased the influence of physicians, extending from bedside care of individual patients to national legislative agendas. The result is that the special interest best positioned to advocate for universal access to quality care has been muted.

Conclusion

If we as a nation are to achieve meaningful and effective health care reform, we must overhaul legislative procedural machinery and increase the ability of physicians to advocate to provide better access to quality care. Special interests have for too long trumped the common good. Absent the willingness to confront these two issues, the current legislative attempt to reform the health care landscape will be marginally effective at best, and will result in unintended adverse consequences. We remain a nation of tremendous potential and a profession with a great mission of service to the public good. If we willingly commit to an open-minded and vigorous approach to these two issues, we can successfully achieve better health care for our nation.

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Direct-to-consumer advertising

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Most of us in the United States are familiar with direct-to-consumer advertising (DTCA), in which pharmaceutical firms encourage patients to ask their doctors to write a prescription for their brands of drugs. This is accomplished by repeated enthusiastic television messages beamed directly into the living rooms of consumers. The technique is effective. Prescription drug sales grew sixty-eight percent from 1994 to 2004,[1] even though the U.S. population grew only twelve percent in that time. Similar growth has been occurring since 1985, when the Food and Drug Administration (FDA) relaxed DTCA regulations.[2] While only the United States and New Zealand allow DTCA now, it is possible that the practice will spread to Canada and European nations.[3,4]

The practice is harmful in several ways. Opponents of it argue that the ads mislead consumers and prompt requests for products that are not needed and are more expensive than

equally effective drugs or nonpharmacologic treatment. Many physicians are opposed to DTCA because they feel it leads to inappropriate use of expensive brand name drugs.[1,5] In one study, seventy-one percent of physicians reported inappropriate pressure from patients to prescribe unneeded drugs.

Physicians should not be influenced by patient pressure to prescribe certain drugs, but in the real world they clearly are. The Center for Disease Control and Prevention has noted that "tens of millions" of antibiotics are prescribed annually for viral infections,[5] and that physicians cite patient demand as one of the primary reasons.[5] Hope motivates sick people to believe that there is a "pill for every ill" and to overlook potential side effects or increases in bacterial resistance. Certainly DTCA has contributed to growth of prescription drug use and consequently to costs and side effects.[6]

We need to reconsider the distinction between selling soap or other consumer products and selling prescription drugs.[5] Poor judgment among soap brands may have few health consequences. The influence of DTCA on drug preferences is a much more substantial concern.

The enforcement of current and future laws rests with the FDA. At present, FDA regulatory action typically occurs long after an ad has begun airing on television. This should be remedied. DTCA is not in the best interest of physicians and patients. We should return to the regulations in force prior to 1985. Organized medicine and the public should make their feelings known with resolutions from groups and individuals to the FDA and the Congress.

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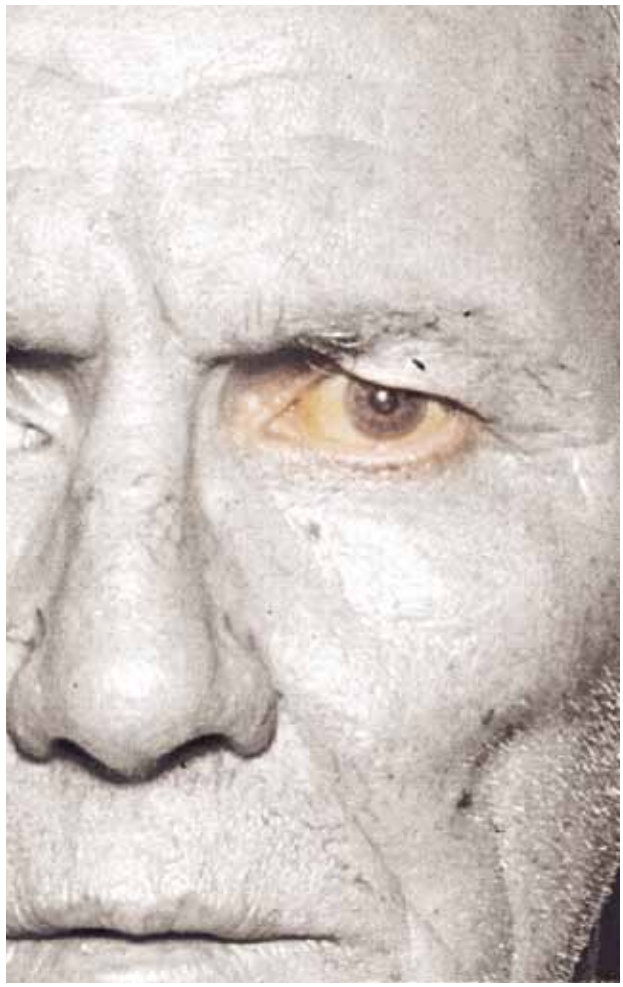

Ode to a Jaundiced Eye

Clinicians and Pathologists are most benevolent,
At a clinical pathologic conference are at times
malevolent,
The conference Pathologist practiced one-upsmanship
Through the medium of unilateral jaundiced-eyemanship.
The Clinician diagnosed the cause of a single yellow eye,
The knowledgeable Clinician had an eye for a yellow eye.

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