

reduction, adequate sleep, and realistic weight management—in other words, an urgent application of the preventive component of the integral-health medicine model, as detailed in chapter 9.

We are also at war against arteriosclerosis, which causes heart attacks, strokes, kidney disease, dementia, and peripheral vascular disease. Have you ever thought of how the term *heart attack* was coined? The word *attack* implies that a war is being fought and the heart is under attack from some outside enemy. This is another example of Pogo's famous statement, "We have met the enemy, and he is us!" Once again, we know that our chances of developing arteriosclerosis of the heart are related to lifestyle issues as well as to such factors as cholesterol and its subfractions—that is, HDL and LDL cholesterol—or to other independent biochemical risk factors such as homocysteine, apolipoproteins, fasting insulin, many coagulation factors, and iron levels. In fact, lifestyle, stress, social, and environmental factors are by far the most important factors. Remember that a hundred years ago, we had pretty much the same genetic makeup. Heart attacks were so rare in those days that they were a medical curiosity!

The complicated high-tech approach that underlies modern medicine's quest to triumph over nature ascribes a God-like quality to medical practitioners and researchers. This belief system has tended to erode the collaboration and partnership between physician and patient—and of the two of them with nature—and has led to the attitude of "We can take care of you, even if you don't take care of yourself" and "You can leave the treatment to us." We have become comfortable relying on an incomplete model of science and medicine to solve our health issues and have relinquished much of our personal responsibility to live a healthy lifestyle and build an ecologically sustainable world. A vast industry—sometimes known as the *medical-pharmaceutical-industrial complex*—has grown around this one-sided model of health care, with its questionable claim of being based upon genuine science.

Let us now examine how well it is serving us.



Four

How Well Is America's Health Care System Working?

Introducing businesslike practices, the theory went, would streamline health care and contain costs. But defying the collective wisdom of America's business schools, just the opposite happened: A massive bureaucracy has grown up to administer an ever-larger share of health care dollars in a paperwork factory that would be the dream of a 1950s Soviet bureaucrat.

—Donald Bartlett and James Steele, *Critical Condition*

The performance we get for what we invest in health care is probably the biggest business failure in American history.

—*BusinessWeek*, August 26, 2002

We've already alluded to another sad statistic: The United States does not even rate among the top 30 countries in the world in terms of overall quality of health care, according to a ranking by country done by the World Health Organization (WHO).¹ We are 37th, just after the great modern countries of Morocco and Costa Rica. America spends hundreds of billions

annually on health care, generates much of the most advanced biomedical research and technology, and attracts the finest minds into its practice of medicine, yet we are not ranked anywhere near the top as a nation. This is simply shocking.

These WHO statistics were reported on the World Health Organization website in June 2000 and represent the last time such a global study has been published. The study measured five elements: life expectancies, inequalities in health, the responsiveness of the system in providing diagnosis and treatment, inequalities in responsiveness, and how fairly systems are financed. Unfortunately, none of these areas have seen improvement in the U.S. since the year 2000.

Our dismal rating is a harsh pill for Americans to swallow—especially given that we also spend far more per capita than any of these countries just to get our mediocre quality of care. In fact, no country spends even half of what we do per person, and yet three dozen have better health care outcomes.

The WHO researchers found, for example, that Americans spent more per person (about \$6,000 at that time), yet ranked far below Great Britain, which spent about \$2,500 per capita but whose citizens have a greater life expectancy than Americans.

France was rated first in the world in the study. Its health statistics as of 2007 tell much of the story, according to a July 2007 *BusinessWeek* article that praised its system: “France’s infant death rate is 3.9 per 1,000 live births, compared with 7 in the U.S., and average life expectancy is 79.4 years, two years more than in the U.S. The country has far more hospital beds and doctors per capita than America, and far lower rates of death from diabetes and heart disease. The difference in deaths from respiratory disease, an often preventable form of mortality, is particularly striking: 31.2 per 100,000 people in France, vs. 61.5 per 100,000 in the U.S.”²

One piece of embarrassing data in the WHO study indicated that the U.S. was handily beaten by Oman, a tiny oil-rich country

on the Arabian Peninsula. The Omanis must be doing something right: They spent less than \$350 per person per year in 2000 and yet were ranked in the top ten in the world. Japan, whose lifestyle and economy are more comparable to ours, kept its costs to about one-third of U.S. costs but still ranked in the WHO’s top ten. What in the world accounts for such discrepancies?

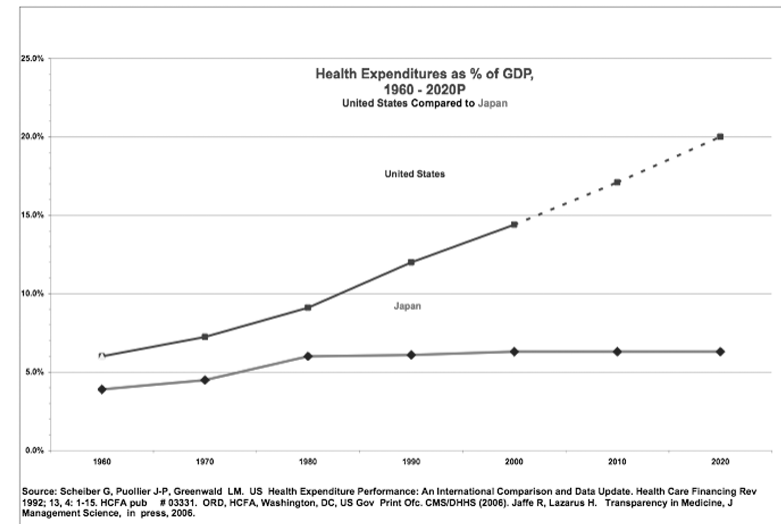


Figure 4.1. The percentage of gross domestic product spent on conventional health care in the United States compared with that of Japan, 1960–2020.

Our increased spending correlates with a chronic-disease epidemic

So, how did the United States get to be 37th in the world, just one notch above Slovenia? Right after World War II, most aspects of medicine were either run on a nonprofit basis or operated by physicians who saw themselves as professionals, not businesspeople. In those days, low-cost health insurance was available to virtually everyone, including people with existing medical problems; doctors had the time to understand your problems

and know you personally, and even make house calls. A hospital stay required only a few days' pay, rather than many months of income. Charity hospitals were available to take care of families that couldn't afford the low-cost hospitals. Regular hospitals rarely had a primary goal of maximizing income; since most were owned by voluntary boards of trustees, church-related groups, or the government, they were simply expected to serve the medical needs of the community. In his helpful book on the subject of the commercialization of the health care industry, *A Second Opinion*, Arnold Relman, MD, of Harvard Medical School explains that, as late as the 1950s, "Few people thought of health care as a market for investment. . . . It was not only an insignificant part of the national economy; it was not even considered to be a commercial enterprise."³

But since the 1960s, America has been in a rush to commercialize medicine. Doctors have had to turn into business entrepreneurs rather than pursue the role of compassionate healers; community hospitals that were once nonprofit have become publicly traded, profit-driven national chains; and hundreds of private insurance companies have arisen, competing with each other to make money on actuarial bets against each American's ability to maintain health.

What have been the fruits of all of this "market discipline"?

Contrary to what free-market theory would predict, the data on the ground shows that if the objective is genuine health care, market competition and the profit imperative operate in an *inverse* relationship to what we actually want to achieve. What an irony! We all aspire to maximize the social goods of health, healing, wellness, and longevity; instead, we find that the marketing of disease care correlates with a measurable deterioration in the health status of Americans.

Simply stated, *less* disease care is *better* disease care (provided that it is equitably distributed in the first place) in a rational health care system.

But to the marketers of disease care products and services, more disease—and especially more costly, chronic diseases—*that* is where the money is.

"The very core principle of the market system, that companies will compete by selling more products to everyone, is actually the last thing the health-care system needs," wrote Pulitzer Prize-winning journalists Donald Bartlett and James Steele (who are quoted at the top of this chapter) in their essential book, *Critical Condition*.⁴ "The goal should be to sell less, not more—that is, fewer doctor visits, fewer diagnostic tests, fewer hospitalizations, fewer consultations with specialists, and fewer prescription drugs." But try telling *that* to the marketing departments of our leading health care providers!

Consider this bar chart, which dates back to the beginning of the early period of the corporatization of health care:

**National Health Spending
as a Share of Gross Domestic Product**



Figure 4.2. The cost of health care as a percentage of America's GDP has more than doubled since 1970. It is now the largest sector of our economy. (Source: Centers for Medicare and Medicaid Services.)

This chart, compiled by the Centers for Medicare and Medicaid Services, clearly shows the extent of our “misspending” on health care as a percentage of gross domestic product (GDP). Starting at about 7 percent in 1970, the percentage had nearly doubled by 2000. It was 16 percent in 2008 and is at 18 percent at the time of writing in early 2009, almost matching the chart’s projection for 2015. At the 2009 rate, it should top *20 percent* by 2014, a nearly threefold increase in less than 50 years.

One might argue that these soaring expenditures on sickness care at least contribute to the economy. But why are we getting so much sicker as we spend so much more money? Consider this quick summary of the incidence of chronic disease in the last 50 years, pulled together from a variety of sources:

1. Despite vast expenditures, the cancer rate (now approaching one of every two Americans) has seen little or no improvement.
2. Obesity has increased fourfold overall and has tripled to 17 percent of children.
3. Diabetes has increased sixfold—a true epidemic.
4. Heart disease is down but remains officially our number one killer.
5. Medicine itself may be (unofficially) today’s leading cause of death.

What has happened to us? Nearly every family in America now has a member with a chronic disease. A prime example is obesity. The prevalence of obesity in the U.S. roughly doubled between 1991 and 2001 in all categories, to about 20 percent of the population, according to the Centers for Disease Control. And in 2008, approximately 127 million adults in the U.S. were overweight, 60 million were obese, and 9 million were extremely obese. This means that about two-thirds of all U.S. adults are overweight, and nearly a third are obese.⁵ This is alarming, for obesity has moved

into second place as the leading cause of preventable death in the United States. It is significantly associated with diabetes, high blood pressure, asthma, arthritis, and generally poor health.

Just how counterproductive is mainstream medicine?

The rise in our spending on disease care correlates with an increase in the incidence of disease over many decades; of this there can be no doubt. And this strange phenomenon will persist as long as we ignore such things as prevention, public health education, single-payer insurance, and the other reforms recommended later in the book—especially the cost-benefit ratio provided by integrative care with its more practical methodology of treatment. Compounding the irony are what might be called the secondary effects of mainstream medicine; because of their invasive nature, too many mainstream treatments are literally counterproductive.

Studies published by researcher Jason Lazarou et al. in *JAMA* in 1998 estimated that there are over two million adverse drug reactions in hospitals and more than 100,000 in-hospital deaths in the U.S. every year that are attributable to the *expected* “side effects” of pharmaceutical drugs.⁶ This number is likely to be higher today. Lazarou’s projection does *not* include deaths from the expected side effects of pharmaceutical drugs used on patients outside the hospital. This could become an even more frightening statistic! It also does not include the *mistakes and misuses* of pharmaceutical drugs. This number is difficult to predict, but one would expect it to be substantially higher.

Medical mistakes, known as *iatrogenic* errors, account for another enormous number of deaths. The Institute of Medicine in Washington, DC, estimates 98,000 such deaths each year. However, Dr. Lucian L. Leape’s December 1994 article in *JAMA* titled “Error in Medicine” cited some remarkable statistics:

- As far back as 1964, a previous researcher, Schimmel, reported that 20 percent of hospital patients suffered iatrogenic injury, with a 20 percent fatality rate.
- In 1981, Steel reported that 36 percent of hospitalized patients experienced iatrogenesis, with a 25 percent fatality rate, and adverse drug reactions were involved in 50 percent of those injuries.
- In 1991, Bedell reported that 64 percent of acute heart attacks in one hospital were preventable and were mostly due to adverse drug reactions.⁷

Leape went on to point out that the *Harvard Medical Practice Study* published in 1991, using a very conservative 4 percent iatrogenic injury rate for patients and a 14 percent fatality rate on data reported in 1984 from the state of New York, would allow one to project that 180,000 Americans would die each year at least in part as a result of iatrogenic injury. Had he chosen to use the higher percentage rates mentioned in the list above, this number could be increased to well over a million deaths. Such statistics sound more like the outcome of a global war than the benevolent efforts of a health care system.

A much more detailed exposé of the dangers of mainstream medicine is presented in *Death by Medicine*, a controversial research study published in 2003 by natural medicine crusader Gary Null et al.⁸ This much-quoted study claims that, based on data from different peer-reviewed journal articles, 783,000 to 999,936 deaths are caused annually by the medical profession, at a cost of \$282 billion to \$468 billion. In the abstract of the piece, the authors wrote: “A definitive review and close reading of medical peer-review journals and government health statistics shows that American medicine frequently causes more harm than good.” If they are correct in their analysis, the American medical system is itself the leading cause of death and injury in the U.S. By comparison, in 2007 the Centers for Disease Control

(CDC) reported that 652,091 Americans died of heart disease and 559,312 died of cancer.

Null's study also found that the annual number of people having in-hospital, adverse drug reactions (ADR) to prescribed medicine was 2.2 million. In 1995, the CDC's Richard Besser, MD, said the annual number of unnecessary antibiotics prescribed for viral infections was 20 million. Besser also reported that by 2003, tens of millions of unnecessary antibiotics prescriptions were written, that 7.5 million unnecessary medical and surgical procedures were performed, and that the number of people exposed to unnecessary hospitalization annually was 8.9 million.^{9, 10, 11, 12}

Some have disputed these conclusions, pointing out that the authors did not factor in how many lives are *saved* by modern medicine annually or consider the incidence of other *positive* effects that result in increased quality of life. For example, one set of critics of the study, a group of mainstream physicians, quite appropriately state on their website Science-Based Medicine: “Drug reactions? All effective drugs also have side effects. It's meaningless to count the side effects without counting the benefits. An insulin reaction counts as an adverse drug reaction, but if the patient weren't taking insulin he probably wouldn't be alive to have a reaction. Some of the counted drug reactions are transient minor annoyances like a rash. People have iatrogenic infections in the hospital, for instance post-op infections; but without hospitalization and surgery they might have been dead instead of just being infected. Iatrogenic deaths? How many of those were of people who would have died many years earlier without modern medical care? How many of those iatrogenic causes were high-risk treatments in high-risk patients who had no other option?”¹³

On the other hand, the Null study mightily challenges our assumptions about the status quo in medicine. True, thousands of medical journal articles provide fragmentary data showing

that the quality of life and life extension are the direct effects of some mainstream medical strategies. Yet there is no data showing an overall net benefit from the effects of medical practice—neither in increasing overall longevity nor in saving lives. And the numbers that Null has cited show, without a doubt, that the *cost–benefit ratio* of mainstream health care in America is poor in the extreme. Adding even more irony, there is some data documenting that when hospital physicians have gone on strike, mortality rates have decreased!

Given its posture of a war on nature, it is evident that modern medicine takes far too many risks for too much money. The obvious antidote is to adopt what may be called a *hierarchy of treatment modalities*. The methodology of integral-health medicine as I now practice it requires—for the sake of safety, effectiveness, and cost—that the least invasive therapy should be utilized first in all cases. Generally, the order of consideration should be as follows:

- Lifestyle strategies such as a healthy diet, adequate sleep, and exercise, stress reduction, weight control, avoidance of toxic exposures, and securing emotional and spiritual balance in life are the *first line of defense*.
- Noninvasive complementary and alternative (CAM) services such as acupuncture, herbal medicine, chiropractic, bodywork, homeopathy, and energy medicine are the *next line of defense*.
- Natural-medicine approaches based on the latest advances in orthomolecular medicine, functional medicine, and bioenergetic research—and inclusive of advanced forms of testing—are a *further line of defense*.
- Very careful and sparing use of pharmaceutical drugs, surgery, and other invasive strategies are the *last line of defense*.

What would it take to orient today's medicine according to this simple and reasonable protocol? As they say, dear reader, follow the money.

A health care system at the breaking point

It is increasingly evident that without radical reform of our health care system, we will have a system that not only delivers relatively poor health, but also cripples our national economy and federal budget.

We've reached the limit of how much can be spent before we begin to witness failures in various sectors of global business by American companies. The most salient example of the magnitude of this problem is our ailing automotive industry. General Motors (GM), for example, spent a staggering \$4.8 billion on health care in 2006, more than it spent on steel for building cars that year. At the time, many people joked that GM was actually a giant health insurance provider that happens to make cars. By comparison, foreign competitors to GM operate in countries that have comprehensive national health insurance, so they face a very minor burden. This is one reason why Japanese brands were thriving just as GM was approaching bankruptcy in 2008 before it had to be bailed out by the federal government. "These days," wrote the *New York Times* on May 19, 2006, "health care costs are causing enormous financial headaches for the Big Three. GM has an unfunded liability of \$85 billion in today's money to cover future health care costs for workers and retirees. That is seven to eight times the market value of the whole company. General Motors estimates that health care costs add about \$1,500 to the cost of each vehicle it makes in the United States. Chrysler claims a health care cost of \$1,400 per vehicle. Ford says its burden is \$1,100. . . . Japanese companies face little of this burden in Japan, where the government covers retirees' health care and pays a bigger share of workers' pensions."¹⁴

Numbers just like these can be found all across major American industries that compete internationally. No wonder our major corporations are beginning to favor comprehensive reform in the way we finance health care. A clear-headed businessperson in possession of the facts, and who is not encumbered by Washington politics, can

easily conclude that we must shift to a genuine health care paradigm with an emphasis on prevention, objective science, and integrative care, concurrently with a move toward national insurance for all workers and citizens. Such an insight gives new meaning to the old statement that, “What’s good for GM is good for America.”

Let’s look at some more numbers: Health care spending rose to \$2.4 trillion in 2008, a 9 percent increase over \$2.2 trillion in 2007, according to the Centers for Medicare and Medicaid Services. This was more than double the rise in GDP that year, which was 3.5 percent in 2008.

We’ve earlier noted that we easily spend twice as much per person as any other industrialized country, even though we slid to last place among these same countries in preventing deaths through timely and effective medical care.

The 2005 report of the Boards of Trustees for Medicare given annually to the Congress estimated that providing promised Medicare benefits over just the next ten years could require nearly \$3 trillion in new tax revenues; but raising taxes by that amount, it said, would eliminate over 800,000 jobs in each of those years.

We’ve noted the correlation of higher costs with more disease. What then are the factors *causing* these excessive rates of inflation?

According to a widely noted article in the September 2000 issue of *Archives of Internal Medicine*, our unsustainable health care costs are directly related to excessive administrative services resulting from a fragmented system, escalating malpractice insurance costs passed through to patients, uncontrolled use of expensive technologies, overtreatment at the end of life, lack of continuity of care, and excessive pharmaceutical drug use, among the leading causes. Yet, the authors claim, “the number of Americans with optimal health care has diminished such that they have become an ‘endangered species.’”¹⁵

Our own analysis pins the problem not only on a disconnected litany of issues, but even more so on the system that underlies and

produces each one: We lay in wait for symptoms to appear, and then focus on overkill treatments, and blend this approach with an irrational system of health insurance.

The proper charter of any for-profit health insurer is to maximize profit for shareholders—that part is “rational.” The best strategy for achieving this goal is to skim off, from the top of the pool of the entire population, only the healthiest customers—while leaving the rest of the population largely dependent on government or emergency services. Of course, the net social effect of this line of attack is irrational. It drives up costs because the poor or those with preexisting conditions lack access to prevention, education, and affordable routine care, forcing them to enter the system *only* when they have no choice but to resort to expensive acute care.

Structurally, our private health insurance system consists of hundreds of competing providers. Each one sells to a highly fragmented universe of purchasers of health plans—ranging from institutional buyers such as General Motors, to businesses of all kinds, and to ordinary citizens or families. Of course, such a fractured pool of purchasers puts all buyers not eligible for Medicare or Medicaid at a large disadvantage. Americans buying private insurance have far less power to negotiate for lower prices, compared with single-payer systems such as that in Canada, which buy on behalf of the entire population.

Aside from its negotiating advantage, each private insurer incurs higher costs—which it must pass on as higher premiums—to cover the cost of marketing to this splintered pool against numerous competitors. Other costs unique to this system include the expense of sifting out the less risky customers that are more profitable to cover, and dealing with billing disputes from doctors.

We pay two to three times more than other countries for health services—says former senator Tom Daschle, a leading health care policy expert—because of “the complexity, marketing costs, and insurance overhead that result from our market-oriented system,” including 31 percent alone for administrative

overhead—compared, for example, with 17 percent for Canada. Amazingly, America’s doctors and nurses, he says, “spend between one-third and one-half of their time completing paperwork.”¹⁶

In the final analysis, our commercialized health care system, including the way that insurance is managed, supports and profits from the assumption that virtually all health problems should be reduced to medical diagnoses of disease symptoms that are managed with prescription drugs or other high-tech solutions. This system’s potential for the greatest profit lies in treating symptoms and dealing with acute crises or chronic conditions only once they occur, and in seeing the costs and volume of this sort of business increase indefinitely. Can you see why, politically and in terms of profitability, the disease care system favors treatment of symptoms over curing or healing, after-the-fact care for acute illness over prevention, expensive drugs over simple nutrients and herbs, and a fragmented private insurance system over a national single-payer solution?

Hospitals, HMOs, and the central role of the insurance industry

Not *everything* in our current system militates against cost control. Given the spiraling inflation generated by the disease care system, it is no wonder that we’ve witnessed the emergence of cost-oriented managed care companies that are pressuring physicians to treat diseases as cheaply as possible within the disease care approach—if for nothing else, to leave room for their own profits. In this mentality, time is money, and this reality, coupled with the burgeoning cost of high-tech medicine, makes it difficult to justify paying for more than the bare minimum of expenses required to get people on their feet. To enforce this approach, many key health care decisions are no longer in the hands of highly trained physicians, as they were up until the last few decades; today, private insurance companies, HMOs (health maintenance organizations), or for-profit hospitals call the shots.

In most respects, insurance companies prevail. For example, as costs throughout the system have continued to soar out of control, insurers have found it necessary to dictate who gets hospitalized and for how long; thus, many conditions are now treated on an outpatient basis when years ago the patients would have been admitted to be on the safe side. To stay in business, hospitals must follow binding contractual agreements that have clear restrictions preventing hospitalization for certain conditions. Hours are often wasted on the phone in an effort to obtain permission from insurance companies to admit certain borderline cases. If patients are admitted but coverage is denied, the hospitals have to eat those losses themselves.

Hospital administrators are often thrust into an unfair position. Not only might they have to deny coverage to many people whom they know deserve more treatment than they are getting, but also they must explain this to the physicians and nurses who have to tell patients and their families that they cannot help them. Some of these situations lead to medical disasters, even resulting in lawsuits for malpractice.

It is not hard to imagine how difficult it must be for some physicians to deny certain patients admission to the hospital when they know that it is neither wise nor safe to send the patients back home for care. Doctors are often caught on the horns of a dilemma: While it is surely tough to say no to patients for some services, if physicians take matters into their own hands and override hospital policy, they must then answer to their employer. In many instances, physicians who have cared enough to jeopardize their jobs have been fired.

No wonder that the business contingent of our health care system is the only sector that seems to be happy with the present state of affairs. And why shouldn’t they be happy? They’ve achieved what they set out to accomplish—bringing “marketplace values” to health care—and they’ve made serious money in the process. They promised to make health care a profitable

business enterprise, and to “do what they could” for patients. They have largely succeeded in their mission.

One of the key objectives of commercialized health care was—for the sake of “efficiency”—to remove the independence of physicians. At the beginning of this process in the 1980s, many holdouts were determined to continue practicing in the style they believed patients deserved and good medicine required; they simply could not imagine practicing medicine HMO style. They would not sell out their patients to HMO conglomerates, simply because it was the wrong thing to do. But by the early 1990s, the already intense pressure on physicians to join HMOs had escalated to the point where it became almost impossible to escape their tentacles. Even the most well-intentioned physicians could not stand up to the severe economic pressure exerted by the lower prices for service and insurance offered by HMOs to individuals and organizations. As a result, doctors with independent practices simply crumbled. Yet for me, it was still a shock to witness the buyout of one medical practice after the next by the giant medical insurance industry, hospitals, and independent physician organizations.

Physicians are discontented with today's medical practice

As a result of this history, the discontent with America's health care system is widespread among physicians. You would know this for a fact if—like me—you were within earshot of daily conversations among physicians. I can assure you that the same set of complaints I routinely hear is being aired in thousands of doctors' hospital lounges throughout the country.

I can also testify to the fact that the nature of these conversations has dramatically changed over the past 30 years. Physicians used to spend most of their time sharing stories about patients' problems, looking for the best solutions for difficult situations, and socializing. This nurturing camaraderie kept spirits high.

Physicians experienced the satisfaction of working together to help their patients; there was great pride in being a physician on the frontlines of assisting patients on their way back to health. We also experienced a sense of intellectual freedom: Within wide guidelines, the type of medical practice applied was up to each individual physician. For the most part, there was no one to answer to other than patients, their families, and one's conscience.

But today's physicians have essentially become employees of large business conglomerates. Often there's not much they can do to influence how their patients are treated. The human element—the caring and healing, the attention to family needs, and the focus on service—has taken a back seat to profitability. While doctors still share with each other stories of interesting and difficult-to-manage patients, the hottest topics in doctors' lounges are now related to the increased volume of work, procedural administrative obstacles that must be hurdled before even beginning to address solving patient problems, the impracticality of finding sufficient time to help patients, and, of course, their ever-growing financial challenges. For many physicians, this state of affairs has led to utter discontent, frustration, and at times outright anger.

Compared with the good old days, an atmosphere of gloom and despair has descended. Sadly, many highly skilled and valued physicians have left their practices. They are “retiring early.” Only a few have been able to maintain a private practice and continue treating patients the way they used to—the way that they know in their hearts is the right way. Consequently, not only is there a growing shortage of physicians, but also we are losing some of our most treasured healers.

Several surveys measuring physician satisfaction with conventional medicine have produced shocking results. A 2002 Kaiser Family Foundation Survey of 2,608 physicians disclosed that over a five-year period, 60 percent had a decrease in enthusiasm toward their medical practice, 87 percent believed that physician morale had decreased, and 75 percent felt that managed care had had a

negative impact on how they were practicing medicine. The reasons for their displeasure included the following:

- Too much paperwork (74 percent)
- Not enough time for their families, hobbies, or friends (56 percent)
- Dissatisfaction with their lack of autonomy (54 percent)¹⁷

In a study of 4,500 women physicians regarding career satisfaction that was published in *Archives of Internal Medicine* in 1999, 31 percent stated that they would not choose to be a physician again, and 38 percent said they would prefer to change their specialty.¹⁸ Physicians such as Rachel Naomi Remen and Lee Lipsenthal now offer classes to help their fellow physicians avoid job burnout by addressing the subject of finding balance in their lives—courses for “healing the healer.”

Physicians have human needs as well

Physicians continue to be a special breed of human being committed to serving humanity. At the same time, it is important to remember that they have human needs, and are vulnerable to the value system of our culture just like the rest of us. Their apparent decision to put the financial security of their families before the welfare of their patients may seem unfair or wrongheaded, but it is what happened. And it is understandable.

Yet this was not a decision made with a great deal of foresight. Today, physicians are paying dearly for this poor choice made under duress. Sadly, the panic accompanying the threats implied by the giant HMOs scared them to either join or face the possibility of being financially squeezed out of clinical practice entirely. They became convinced that they had to choose between doing the right thing—staying in practice to provide quality, personalized care—or risk losing their patients to the lower-cost managed care providers. The choice amounted to almost certain financial

ruin—or joining the massive exodus from private clinical practice into HMO medicine and hoping for the best. I believe that most of them now wish they had done something collectively to prevent the catastrophe that has resulted.

What would you do if you had to make this choice? Had they been loyal to their patients rather than to HMOs, their ability to support their families in the style they had become accustomed to would have been compromised. The system was simply too big and too powerful for all but a few to seriously consider resisting.

As the transition from private practice to medicine driven by private insurance and HMOs deepened, it became relatively easy for large business conglomerates to bribe physicians with what appeared to be handsome prices to purchase their practices. It seemed too risky to go it alone and too easy to give in when they were guaranteed jobs for several years, where there would be plenty of patients and substantial up-front cash settlements to purchase their practices.

The acute problems of private health insurance

We all know that Medicare provides coverage for all citizens over 65, Medicaid covers the poorest of the poor and the disabled, and the Veterans Administration covers all the health care needs of our veterans. Let's look more closely at everyone else. Because of skyrocketing costs for medical care as well as other systemic problems, far too many Americans who do not fall within these three categories simply do not have health insurance. More than 47 million *working* Americans don't have access to health care, or about 16 percent of the population—up from 12 percent in 1980. This large sector of America represents the “working poor.” They make too much to qualify for Medicaid but too little to pay for private health insurance—or they work for small businesses that don't offer health insurance.

In addition, roughly 100 million are underinsured. As we learned from the outrageous stories narrated in Michael Moore's provocative film *Sicko*, Americans may have some sort of insurance, but it very often does not come close to covering the costs they may incur if they become sick or injured. It is almost never enough when a major illness strikes. We all know, of course, that the Byzantine, wasteful, and yet highly profitable insurance industry writes all sorts of restrictions into its policies. These loopholes, caps, and exclusions guarantee that most of the underinsured are vulnerable to disaster.

It may not be surprising to learn that the probability of being uninsured depends in part on one's race and where one lives. In 1997, *USA Today* reported that the percentage of uninsured people varied from a low of 8 percent in Wisconsin to 24 percent in Arizona. The percentage of uninsured was 34 for Hispanics, 22 for African-Americans, and only 11 for Caucasians. According to the U.S. Census Bureau, in 2007 these numbers improved very slightly to 32 percent for Hispanics, 19.5 percent for African-Americans, and 11 percent for Caucasians.

According to a study published by the Commonwealth Fund in 2007, the five top-ranked states for affordable health insurance were Hawaii, Iowa, New Hampshire, Vermont, and Maine. The five worst-performing states were Oklahoma, Mississippi, Texas, Arkansas, and Nevada. An article in the August 28, 2008, issue of the *Boston Globe* ranked Massachusetts first overall among states in the proportion of residents with health coverage, with only 7.9 percent not covered, and a report in the August 27, 2008, issue of the *New York Times* ranked Texas last among states, with 24.4 percent of residents having no health coverage. Where you live in the United States obviously matters.

Further, if all states reached the levels of the top ranked, the Commonwealth Fund estimated that 90,000 deaths could be avoided, 22 million people could gain health insurance, and the government's Medicare insurance program could save at least

\$22 billion. The report found a strong link between access to health care coverage, particularly insurance, and high-quality care.

According to the *Kaiser/Commonwealth 1997 National Survey of Health Insurance*, the underinsured are four times more likely to defer needed health care or medication than those who have health insurance.¹⁹ This report went on to further document which Americans did get guaranteed health care—congresspeople, the military, qualified veterans, criminals in prisons, Native Americans living on reservations, the indigent, the rich, and those over age 65 who qualified for Medicare.

The Commonwealth Fund's study *Gaps in Health Insurance: An All-American Problem*, completed in January 2006, documented that 41 percent of Americans with an annual income between \$20,000 and \$40,000 were uninsured for at least part of the previous year. In 2001, this number was only 28 percent.²⁰ Lower-income families remained the hardest hit, and 67 percent of the underinsured were in families where at least one person was working full-time. They discovered that one in five adults was paying off medical debt, and nearly 60 percent of uninsured adults with chronic illness could not afford their medications. Many of these people ended up in an emergency room or hospital because they didn't have access to a primary care physician. They were also more likely to go without preventive health care services such as screening for cancer, stroke, diabetes, hypertension, and heart disease.

It should be added, of course, that many working Americans who lack employer-provided coverage, would rather not rely on emergency rooms, and earn too much to qualify for Medicaid find themselves forking over the full cost of private insurance. This figure is astronomical if they have preexisting conditions.

The sad consequence of market-driven health care

Hillary Clinton's storied health care reform plan in the early 1990s had the potential to solve many of the cost-containment and

delivery problems we have outlined. But the largest stakeholders at the time each found aspects that were problematic, leading to its sound rejection. The underlying premise of the thousand-page report that resulted from this courageous effort was to provide *universal health coverage* for all Americans. The bulk of the coverage was to be paid for by employers through payroll taxes and was to be delivered through “carefully regulated” competition between large nonprofit health maintenance organizations such as the Kaiser Plan and Blue Cross, or by the for-profit prepaid plans that were springing up across the country. The government would cover the cost of membership in a health maintenance organization for the unemployed. The plan also proposed creating “regional alliances” of health care providers who would be subject to a fee-for-service schedule. And states would receive federal funding to administer the program.

Upon the failure of Hillary Clinton’s initiative, health policy leaders across the country became convinced that by setting up a competitive marketplace, for-profit managed care organizations and other major care organizations could solve our health care-related economic problems. This trend toward “market solutions” was long under way by the end of the 1980s, and it unfolded through a series of steps: First, medical costs were lowered to some extent by reducing hospital stays. Next, providers systematically reduced payments to physicians, physician groups, and hospitals. At the same time, services were reduced by making it difficult to access specialists and expensive tests, treatments, and medications. Finally, managed care organizations lessened their risks by offering *capitated care*. In this setting, each physician or physician group is paid according to how many patients they are willing to assume care for. If a particular group of patients happened to be especially sick, physicians would have to work harder to provide care but would receive no additional compensation. Needless to say, because this was a competitive business, many physicians and physician groups underestimated the costs

of providing health care services and were eventually forced out of business.

Physicians became increasingly squeezed, and, as you may have already guessed, the increased profits did not lead to a reduction in health insurance premiums for individuals.

So, if medical costs went down somewhat, who benefited from managed care if it wasn’t the patients or the physicians? You guessed right again: Stockholders and HMO executives made billions of dollars. According to the *1995 Crystal Report* on executive compensation, the total incomes and benefits of health care CEOs were staggering. The top incomes were \$14 million for Healthsource Inc., \$13 million for Foundation Health Corp., and \$6 million for United Health Care Corp. And it has gone up from there in subsequent years.

An article published August 23, 2007, by WebMD showed that the growth of CEO salaries of health insurance companies continued to soar, although the tough times that began in late 2008 have lessened the upward pressure somewhat. For example, it reported that the CEO of United Health Group, William McGuire, was paid \$124.8 million in 2005 and has a five-year contract for \$342 million. The CEO of Cigna, H. Edward Hanway, was paid \$13.3 million in 2005 and given a five-year contract for \$62.8 million. Larry Glasscock, CEO of WellPoint, earned \$23 million in 2005 and was given a five-year contract for \$46.8 million.²¹

Medicare may be the prime example of the slaughter of health care services. Its medical expenses in 1999 were actually cut, and many governmental agencies were bragging about the accomplishment. You might ask yourself how this was possible in an era of increasingly expensive technology and treatment, along with a steadily growing population over the age of 65, all of this occurring against the backdrop of an epidemic of chronic diseases. Something didn’t add up.

The only way Medicare costs could be held in check was to cut reimbursements to physicians, other health care providers, and

hospitals. Unfortunately, when physicians and other health care providers are paid less, they generally feel the need to see more patients in order to continue generating the income they are accustomed to living on. Inevitably, this results in less time for patient visits as well as more mistakes, because there simply isn't enough time to be with patients or weigh important decisions that could lead to serious errors.

This problem is even worse in the hospital setting, where hospital staffs are often cut to reduce costs, so that fewer nurses, technicians, social workers, psychologists, and specialized services are available for patient care. It seems that while we've contained costs to some extent, we've forgotten what it was that we set out to do in the first place, which was to help the sick.

The result is clear: Managed care cut costs by reducing services, and neither consumer nor physician benefited. Physicians have been put into a conflict-of-interest predicament. They are now frequently being rewarded for seeing more patients in less time, making fewer referrals, and spending less money. What would you expect, given that HMO medicine is above all profit driven—and service oriented only when it is not too much of an economic burden?

Ask yourself once again: How could a country that spends more per person on research, pharmaceutical drugs, technology, insurance, and hospitalizations than any other country in the world offer quality of care across all classes of Americans that is not much better than that of Cuba? The only way this could happen would be if delivery of the best health care in the world were not the primary goal. On the other hand, the dire condition of American health care reported in this chapter makes perfect sense if the primary goal is to keep this sector of the economy profitable, while enriching the businesses, financiers, and major stockholders who own or run health care companies.



Five

The Karma of Big Pharma: Questioning the Drug Industry

It's hard not to note the irony: the generation of Americans who rebelliously experimented with drugs is now a generation upon whom drugs are experimented, with barely a squeak of protest. . . . Has managed care, with its stingy allocation of resources for face-to-face medicine, made pills the de facto primary care physician, Dr. Merck, M.D.?

—Greg Critser, *Generation Rx*

Even in my earliest days as a doctor, I would become aware now and then of the perils of medical fundamentalism—that is, scientific reductionism based on the objectification of nature, detachment from our patients, and a narrow focus on symptoms of the body. But as I developed a thriving practice, I slowly realized how dependent I was on tools derived from this model of medical science—techniques and technologies for diagnosing and treating diseases, and especially pharmaceutical drugs that only temporarily relieved my patients' symptoms, when they worked at all. I was gradually beginning to