

Trends That Will Affect Your Future . . .

# An Appraisal of The Illness Profit System

| By Stephan A. Schwartz |

*The SchwartzReport tracks emerging trends that will affect the world, particularly the United States. For EXPLORE, it focuses on matters of health in the broadest sense of that term, including medical issues, changes in the biosphere, technology, and policy considerations, all of which will shape our culture and our lives.*

Once, years ago, walking across Louis Kahn's magnificent campus designed for the Jonas Salk Institute, Jonas Salk answered my question about how he had seen so clearly what others had not seen. He said, "The answers are not the hard part. It is the questions. Asking the right question. That's hard."

We are about to enter yet again into the great debate over American healthcare, and the discussion once again will be mostly couched in financial terms. I want to suggest money is the wrong question, and it leads us to the wrong debate. Here's what I think we should be asking: Is the health of the American people an essential part of our national security and prosperity? Is America better equipped to deal with the challenges of the 21st century when it has a healthy population more capable of working at its full potential? If the answer is yes, then the next question to ask is: why is our healthcare system so very bad—37th in the world according to the World Health Organization?<sup>1</sup> To answer that, we need to accept this reality and start fixing it by telling the truth to ourselves about money.

The Center for Defense Information estimates the cost of the Iraq and Afghanistan wars will total over \$1 trillion by the end of fiscal year 2010.<sup>2</sup> We have almost nothing to show for these wars and the

sacrifices made by young men and women motivated by honor, duty, and a call to serve. Yet we have made these wars such a priority that in the midst of the worst economic downturn in two generations, we continue to fund them at a cost of tens of millions of dollars each and every day. It's not about the money.

We have a defense budget that is larger than the defense budgets of every other nation in the world *combined*—\$683 billion, going to \$743 billion in 2015.<sup>3</sup> It's not about the money.

As Senator Bernie Sanders forced the Federal Reserve to reveal, "we found 3.3 trillion" to bail out our financial sector—to the benefit of a tiny percentage of the population.<sup>4</sup> How can anyone say that when the priority is there, the money can't be found? And, anyway, we already spend more on our healthcare system than any other nation on earth.<sup>5</sup>

If we believe a healthy nation is a national priority, why aren't we getting results? Because, measured in a dozen different ways, our healthcare system is not about health. What we have in the United States is an Illness Profit System. The illnesses and traumas of human beings are just the mechanism by which the money taps are opened. It is part of the human condition that everybody gets something that requires medical attention some time in their life, and the Illness Profit System is structured to exploit this. If you get well, it makes money on your treatment. If you don't get well, it makes even more money on your treatment. The system is profitable at either end but is weighted toward illness. It's more profitable. To hide its rapacity, the Illness Profit System relies on the humanitarian face presented by the health professionals who administer the treatments. It understands and exploits their calling to the service of healing, and our natural deference to the men and

women who care for us, even as the system is constantly and cynically trying to corrupt them.

The Project on Government Oversight is an independent nonprofit that "investigates and exposes corruption and other misconduct to achieve a more effective, accountable, open, and ethical federal government."<sup>6</sup> On November 29, 2010—just a few days ago—they wrote Francis S. Collins, MD, PhD, director of the National Institutes of Health (NIH), urging the NIH to curb "the practice of ghostwriting in academia. As the Director of the world's largest and most prestigious funding source for biomedical research, you must set policies that require NIH-funded academic centers to ban ghostwriting to strengthen scientific integrity."<sup>6</sup>

Why did they make this request? Perhaps because the medical world has been increasingly challenged by ghostwriting—medical studies ostensibly written by the named authors that are, in fact, written under for a pharmaceutical company by a contract writing group.

This is a problem so pervasive that it has developed its own literature. I will cite one, this by Jeffrey Lacasse of the School of Social Work, College of Public Programs, Arizona State University, Phoenix, and Jonathan Leo of Lincoln Memorial University, Harrogate, TN. They recently published in the peer-reviewed journal *PLoS Medicine* an assessment of medical ghostwriting, citing particularly two drugs and the published studies that got them on the market. One concerned rofecoxib, a Merck & Co nonsteroidal anti-inflammatory drug sold under the brand names Vioxx, Ceoxx, and Ceeoxx, that was taken off the market in 2004 when, in contradistinction to the published studies, it was withdrawn over safety concerns. The other concerned paroxetine, an anti-depressant marketed by GlaxoSmithKline (formerly

known as SmithKline Beecham) under the brand names Aropax, Paxil, and Seroxat. Lacasse and Leo describe the role of medical ghostwriting using these drugs to illustrate their point this way:

Medical ghostwriting, the practice of pharmaceutical companies secretly authoring journal articles published under the byline of academic researchers, is a troubling phenomenon because it is dangerous to public health. For example, ghostwritten articles on Rofecoxib probably contributed to ‘... lasting injury and even deaths as a result of prescribers and patients being misinformed about risks.’ Study 329, a randomized controlled trial of Paroxetine in adolescents, was ghostwritten to claim that Paroxetine is ‘generally well tolerated and effective for major depression in adolescents,’ although data made available through legal proceedings show that ‘Study 329 was negative for efficacy on all 8 protocol specified outcomes and positive for harm.’<sup>7</sup>

Lacasse and Leo conclude: “The practice of ghostwriting explicitly violates the usual norms of academia. We are not aware of any other academic fields where it is acceptable for professors to allow themselves to be listed as authors on research papers they did not write, or to purposefully conceal the contributions of industry coauthors in order to mislead readers.”<sup>7</sup>

Why would pharmaceutical companies, a major component of the Illness Profit System, be interested in ghostwriting? Profit of course. Before it was withdrawn, sales revenue from Vioxx totaled US\$2.5 billion.<sup>8</sup>

To fully understand the implications of ghostwriting, however, one has to place it in its larger context, which Donald Bartlett and James B. Steele do very well in the January *Vanity Fair*:

In 2009, according to the Institute for Safe Medication Practices, 19,551 people died in the United States as a direct result of the prescription drugs they took. That’s just the reported number. It’s decidedly low, because it is estimated that only about 10 percent of such deaths are reported. Conservatively, then, the annual American death toll from prescription drugs considered ‘safe’ can be put at around 200,000. That is three times the

number of people who die every year from diabetes, four times the number who die from kidney disease. Overall, deaths from F.D.A.-approved prescription drugs dwarf the number of people who die from street drugs such as cocaine and heroin. They dwarf the number who die every year in automobile accidents.<sup>9</sup>

Can one overemphasize the importance of ethical accurate medical literature? I don’t think so. And why don’t we read a constant litany of reports in all the media concerning these deaths? Could it be the advertising, the dubious grant funding, and sponsorships the Illness Profit System can marshal?

Another wrong question you will hear in the debate: is it all the fault of the bad health choices Americans make? As it happens, at the Mailman School of Public Health at Columbia University researchers Peter A. Muennig and Sherry A. Glied asked just that question. They compared the healthcare systems of 13 first world nations, including the United States, Australia, Austria, Belgium, Britain, Canada, France, Germany, Italy, Japan, the Netherlands, Sweden, and Switzerland.<sup>10</sup>

Their study, which covers the years 1975 to 2005, is particularly important, not only because it is recent and well designed, but because in addition to healthcare expenditures in each country, it focuses on 15-year survival for people at 45 years and for those at 65 years. As they say in their report published in the journal *Health Affairs*:

Many advocates of US health reform point to the nation’s relatively low life-expectancy rankings as evidence that the health care system is performing poorly. Others say that poor US health outcomes are largely due not to health care but to high rates of smoking, obesity, traffic fatalities, and homicides. We used cross-national data on the fifteen-year survival of men and women over three decades to examine the validity of these arguments. We found that the risk profiles of Americans generally improved relative to those for citizens of many other nations, but Americans’ relative fifteen-year survival has nevertheless been declining. For example, by 2005, fifteen-year survival rates for forty-five-year-old US white women were lower than in twelve comparison countries with

populations of at least seven million and per capita gross domestic product (GDP) of at least 60 percent of US per capita GDP in 1975. The findings undercut critics who might argue that the US health care system is not in need of major changes.<sup>10</sup>

Nicholas Bakalar, writing in *The New York Times* said:

In 1975 the United States was close to the average in health care costs, and last in 15-year survival for 45-year-old men. By 2005 its costs had more than tripled, far surpassing increases elsewhere, but the survival number was still last—a little over 90 percent, compared with more than 94 percent for Swedes, Swiss and Australians. For women, it was 94 percent in the United States, versus 97 percent in Switzerland, Australia and Japan.

The numbers for 65-year-olds in 2005 were similar: about 58 percent of American men could be expected to survive 15 years, compared with more than 65 percent of Australians, Japanese and Swiss. While more than 80 percent of 65-year-old women in France, Switzerland, and Japan would survive 15 years, only about 70 percent of American women could be expected to live that long.<sup>11</sup>

Muennig and Glied<sup>10</sup> concluded: “We found that none of the prevailing excuses for the poor performance of the US health care system are likely to be valid. On the spending side, we found that the unusually high medical spending is associated with worsening, rather than improving, fifteen-year survival in two groups for whom medical care is probably important.”<sup>10</sup>

The Commonwealth Fund in its State-by-State Look at Health Insurance Costs reveals just how truly bizarre that “unusually high medical spending” has gotten:

Health insurance premiums have risen three times faster than incomes, according to a new Commonwealth Fund state-by-state analysis of employer coverage. In 2009, total premiums—including employee and employer contributions—equaled or exceeded 18 percent of the median household income in 26 states, up from three states in 2003.

The analysis of state trends from 2003 to 2009 finds family coverage in

employer-sponsored health plans increased 41 percent across states, ranging from a 21 percent increase in Delaware to a 59 percent increase in Louisiana. The report found that by 2009, premiums were highest in Alaska, Connecticut, Massachusetts, Vermont, Wisconsin, and Wyoming, with family premiums in those states exceeding \$14,000 a year. Annual family premiums in the lowest-cost states—Alabama, Arkansas, Hawaii, Idaho, Kansas, Montana, North Dakota, Ohio, Oklahoma, South Dakota, and Utah—were also high, ranging from \$11,000 to \$12,000 per year by 2009.<sup>12</sup>

Now let's take it down to individual procedures where the grotesqueness of the Illness Profit System's reality becomes even clearer. The International Federation of Health Plans has just released its *2010 Comparative Price Report*: "The survey data showed that average U.S. prices for procedures were once again the highest of those in the 12 countries surveyed for nearly all of the 14 common services and procedures reviewed."<sup>13</sup>

Here are some results:

- delivery of a baby: \$2,147 in Germany, \$2,667 in Canada, and an average of \$8,435 in the United States;
- hip replacement: \$9,637 in the UK, \$20,069 in Australia, \$75,369 in the United States;
- appendectomy: \$3,456 in the UK, \$4,624 in the Netherlands, \$25,344 in the United States;
- cost for a typical hospital stay: \$1,679 in Spain, \$7,707 in Canada, \$14,427 to \$45,902 in the United States.<sup>13</sup>

And through the entire weave of health-care runs the pharmaceutical component of the Illness Profit System. It's hard to ignore, if you're one of the millions of Americans on a prescription drug regime. Its drive for naked profit is breathtaking: Nexium (brand name for esomeprazole), commonly prescribed for reflux conditions, is \$30 in the United Kingdom, \$186 is the average cost in the United States. One could go through the entire pharmacopoeia and see this differential, or worse, for almost every drug. It is enormously profitable, but is it consistent with health as the first priority?

And there is this reality: the Illness Profit System has not proved capable of designing a system of universal coverage, because when health is made the first priority, although it may be profitable, it cannot be as profitable as it could be.

As the Centers for Disease Control and Prevention frames it:

In the first quarter of 2010, an estimated 59.1 million persons had no health insurance for at least part of the year before their interview, an increase from 58.7 million in 2009 and 56.4 million in 2008. Of the 58.7 million in 2009, 48.6 million (82.8%) were aged 18–64 years. Among persons aged 18–64 years with family incomes two to three times the federal poverty level (approximately \$43,000–\$65,000 for a family of four in 2009), 9.7 million (32.1%) were uninsured for at least part of the preceding year. Persons aged 18–64 years with no health insurance during the preceding year were seven times as likely (27.6% versus 4.0%) as those continuously insured to forgo needed health care because of cost. Among persons aged 18–64 years with diabetes mellitus, those who had no health insurance during the preceding year were six times as likely (47.5% versus 7.7%) to forgo needed medical care as those who were continuously insured.<sup>14</sup>

The data of the past three decades also tell us that just being a participant in the Illness Profit System can damage your life. Medical bankruptcy is a concept almost unknown in the rest of the world. In the United States it is quite common. In 2001, Harvard's Medical and Law Schools teamed up to look at this and discovered 1.458 million American families filed for bankruptcy.<sup>15</sup> A research team led by David Himmelstein surveyed 1,771 personal bankruptcy filers in five federal courts and subsequently completed in-depth interviews with 931 of them, and published the results of the study in 2005 in the journal *Health Affairs*.<sup>16</sup> Their report noted that "about half (the bankruptcies) cited medical causes, which indicates that 1.9-2.2 million Americans . . . experienced medical bankruptcy." As if this were not cruel enough, about 700,000 of those affected were children.

One of the sure signs a system is working against the national interest is that it

continues its destructive behavior even in a time of great stress, and that is exactly what we are seeing. In the midst of the worst financial environment since the Great Depression, as people are dropping from the insured ranks by the thousands, hospitals and pharmaceutical companies in the spring of 2009 began raising drug prices. As *The Wall Street Journal* reported, the profit illness industry has "been pushing through hefty price increases aimed at bolstering earnings, even as government and private insurers are struggling to rein in healthcare costs."<sup>17</sup>

Good health and good healthcare are national assets that increase a nation's functionality, giving it a much better chance to prosper. The data on this are quite clear. Viewed from this perspective, the Illness Profit System damages national security, because its priority is not national health—but profit. This is not an argument against profit, categorically. There may be a place for profit, but the first question we should be asking is: how can we design a system that produces the healthy citizenry essential to our national security and prosperity, a healthcare system that is designed with that priority—and not profit—as its goal?

We need to ask the right questions. I think Jonas Salk was right.

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