Who Puts Patients First?

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In the debate over how health care in the United States is organized, financed, and delivered, we see the influence of a number of particularly important constituencies. Among the constituencies wielding the most influence are elected officials, health insurers, pharmaceutical manufacturers, the news media, and the health professions, especially medicine. None of these groups is completely selfless, and each operates with somewhat divided loyalties. On one hand, each feels compelled to look out for its own security and financial interests. On the other hand, it also wants to do what is best for patients and communities. This being said, which group offers the best prospect of putting patients first? The health care debate is incredibly complex. Which of these groups can patients and communities most count on to look out for them?

This article provides a brief overview of the motivations and practices of each of these sectors, highlighting in each case some well-documented examples that should give pause to anyone who would like to believe that everyone puts the interests of patients and communities first. The purpose in doing so is not to lambast any particular group of people but to present physicians and other health professionals with a challenge. In view of the fact that other important parties to the health care debate sometimes seem to put self-interest above the interests of patients, what ethical standpoint should physicians adopt? Recognizing that others may not put the best interests of the health professions foremost, do physicians need to devote most of their energy to promoting them themselves? Or can and should physicians hold themselves to a higher standard of trustworthiness?

ELECTED OFFICIALS

The federal government is by far the largest health care payer in the United States, so it is no surprise that other constituencies spend a great deal of time, effort, and money attempting to influence federal health care policy. In 2009, lobbying in the health care sector totaled more than $3.96 million, more than in any other sector, including finance, energy, transportation, and defense. In the 2008 federal elections, contributions from the health sector totaled $1.67 million. These contributions were split almost evenly between the two major political parties, with 54% going to Democrats and 46% to Republicans [1]. Such expenditures have been rising for a number of years and at the moment show no signs of abating. Many elected officials now feel that they must devote a substantial amount of their time and energy to getting reelected, which means raising contributions.

The imperative to get reelected and raise the funds necessary to do so raises the concern that public service may be reduced to influence peddling. For example, tens of millions of people in the United States who lack health insurance tend not to vote or to contribute much money to political campaigns, which can mute their influence in the health care debate. A similar point could be made about infants and young children, who exercise even less direct political influence. By contrast, other groups, such as retirees and the elderly, tend to vote at a relatively high rate and also contribute much more aggressively to political campaigns. As a result, retirees and the elderly have tended to enjoy much better health care benefits through federal programs such as Medicare than either the uninsured or children, two groups that overlap to a substantial extent.

There is another reason to be concerned about the extent to which both elected officials and their appointees will think first of the interests of patients. In many cases, government officials enter into employment by firms and industries that they regulated while in office, acting as well-compensated lobbyists on their behalf. For example, in 2003, the chief administrator of CMS sought a waiver from the secretary of Health and Human Services to allow him to negotiate employment with firms financially affected by his office. This waiver was granted. The office subsequently acted as a lead negotiator on the Medicare prescription drug bill, legislation with major implications for the 5 firms with which he was negotiating possible employment. Later that same year, this official announced that he was joining 2 of the 5 firms affected by the bill [2].

PRIVATE HEALTH CARE PAYERS

It would come as a surprise to few patients to learn that the executives of health insurance companies and other private health care payers are compensated not primarily on the basis of quality of care or the access they provide to health care services but on the financial performance of their companies. Such corporations need to satisfy their customers, but

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they are hired, fired, and compensated primarily on the basis of the evaluations of their shareholders. And shareholders have a variety of choices about how to invest their money, many entirely outside the field of health care. Thus, the leaders of such corporations are under continual pressure to improve their firms' financial performance, which can produce perverse incentives that do not dovetail well with the interests of patients.

In some cases, they adopt practices that conflict directly with the interests of patients. Consider the congressional testimony of one former senior executive of one of the nation's largest private health insurers concerning the practice of rescission, the retrospective review of a customer's policy after the customer becomes ill, seeking grounds to cancel it. The executive testified [3],

> They confuse their customers and dump the sick, all so they can satisfy their Wall Street investors . . . . They look carefully to see if a sick policyholder may have omitted a minor illness, a pre-existing condition, when applying for coverage, and then they use that as justification to cancel the policy, even if the enrollee has never missed a premium payment . . . . Dumping a small number of enrollees can have a big effect on the bottom line.

Such practices reveal a callousness toward the sick that many patients and health professionals would likely find disturbing, yet if there is an inaccuracy in an insured person's enrollment forms, the practice can be legal regardless of whether the misstatement was intentional. In some cases, only public outcry has managed to persuade insurers to honor commitments that legalities would have enabled them to ignore.

Another method that some private health care payers have used to increase their profit margins is to construct confusing, arcane policies; promote equally arcane changes to such policies over time; and make payment schemes as complex as possible, shifting financial responsibility to patients without making them aware of it. The same former executive stated in his congressional testimony that some firms rely on "deceptive marketing practices" to sell "what is essentially fake insurance," which consumers are unable to detect thanks to "notoriously incomprehensible" policies. Another former health insurance employee stated that the CEO of his corporation told him that the goal in restructuring benefits plans was to "give them less and make them think it's more" [4].

THE PHARMACEUTICAL INDUSTRY

Pharmaceutical corporations play an important role in US health care by developing, marketing, and distributing medicines on which patients and health professionals rely. Such a mission is not incompatible with terrific financial performance. For example, giants Merck, Pfizer, and Roche were among *Fortune*'s 50 most profitable corporations in the world in 2009 [5]. Pressed to explain such performance, pharmaceutical firms often point to their high research and development costs. It takes a long time and costs a substantial amount of money to bring a new drug to market. However, throughout the 1990s, the top 10 pharmaceutical corporations spent about 11% to 14% of their budgets on research and development but 35% on sales and marketing [6]. There have been some notable cases in which the pursuit of profit seems to have overwhelmed concerns with the best interests of patients.

Consider, for example, the story of Vioxx, a painkiller introduced by one of the largest of the pharmaceutical firms, Merck. The drug's mechanism of action raises the possibility of hazards for the cardiovascular system. Like any other new drug, it went through extensive safety testing. On the basis of the data and analysis supplied by the manufacturer, the drug was approved by the US Food and Drug Administration, and soon after going to market in 1999, it generated annual sales of $2.5 billion. Yet in a 2008 article in *JAMA*, the authors asserted that despite Merck's own data suggesting an increase in mortality from the drug, when the Food and Drug Administration raised safety questions in 2001, the company did not bring the issues to an institutional review board and revealed that there was no data and safety monitoring board for the protocol [7]. One case against the firm involving 27,000 patients claiming harm by the drug was eventually settled for $4.85 billion.

THE NEWS MEDIA

One might suppose that the news media would serve as ultimate guardians of the best interests of patients and communities, but in fact their coverage of health issues can be ill informed, misleading, and downright sensationalistic. Consider, for example, the 2009 influenza season, in which some news outlets performed less than admirably. One national television network featured a large North American map depicting the number of reported cases in different locations. As 6 "mild" cases were reported in Canada, Canada's color on the map changed from beige to red, leading comedian Jon Stewart to quip, "For 6 mild cases of flu, you are going to turn 4 million square miles bright red? Seems to me we are in for a good old-fashioned scare-off." Why would news outlets have a bias toward overstating threats? In part because startling

and frightening news reports can, and often do, raise ratings.

Such tactics can harm patients in very tangible ways. For example, after some alarming news accounts regarding seasonal flu, patient volumes in some New York City emergency departments doubled overnight [8]. This can threaten the welfare of seriously ill and injured patients in urgent need of medical care. Said one critic [8],

> The impact is clear: lives were lost. High-quality studies have shown repeatedly that when [emergency departments] experience crowding, patients in need of rapid, high-intensity care are identified later, treated more slowly, and devoted fewer resources. Mortality goes up during crowding in virtually every condition that has been studied, including [myocardial infarction], sepsis, and others.

There is no question that the news media have an important role to play in educating patients, but the imperative to generate revenue can at times take precedence, leading to journalistic approaches that boost returns in the short term but ultimately undermine trust and lead to ineffective and inefficient allocations of health care resources.

PHYSICIANS

In whom can patients place the most trust? Most physicians would hope that the answer is the profession of medicine, yet 81% of physicians report that changes in the health care system over the past decade have diminished physicians' commitment to an ethic of undivided loyalty to patients [9]. It is impossible to design a health care system or a society that would be completely free of conflicts of interest, and recent policy changes regarding such conflicts have probably reduced the temptation that some physicians face. Yet the ultimate bulwark against conflicts of interest cannot be rules, regulations, and the threat of litigation. Ultimately, it must reside in the sense of professional responsibility and conscience of every physician, for whom the suffering patient is the physician's very reason for being. If physicians ever begin to think that patients exist for doctors, instead of the other way around, medicine will have ceased to be a profession and become merely another means of making money.

Are we businesspeople whose first calling is to profit, or are we health professionals whose first calling is to protect and promote the welfare of our patients and communities? Where possible, we need to promote high standards of conduct toward patients throughout our society and partner with elected officials, health care payers, pharmaceutical firms, and news media to ensure that patients' interests come first. There are very good people and organizations in each of these fields who genuinely have the best interests of patients at heart. However, we must also recognize that none of these other groups has sworn to uphold the kind of trust to which the Hippocratic oath aspires, and in this sense, it is incumbent upon physicians above all to put patients first. No one knows patients as well as their doctors, and the responsibility to put them first is both an immense privilege and a sacred trust.

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