A Report Card On the American Healthcare System

By Josh Bloom — November 26, 2016

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As an ancient Chinese curse would have it, we live in “interesting” times. Even the most casual reading of news and popular literature must convince us of the premise of a fascinating movie from a few years ago: “The Gods Must Be Crazy.” Nowhere, I think, is this more evident than in American healthcare.

American public commentary on health care in 2016 seems dominated by “Obamacare” (the US Affordable Care Act), and its impacts on rising health care cost. Politically conservative voices would repeal the act (or “replace” it, without defining what they actually mean), despite its inclusion of millions of formerly uninsured and under-served citizens. Political liberals hope to “fix” such problems by tinkering with the system at the margins. But both sides in this debate ignore the elephant in the room: American healthcare is the most expensive in the world despite its many failures. This isn’t going to improve without major structural changes to both our health care delivery system and our personal behavior as citizens.

It is undeniable that American life expectancy has risen sharply in the last century. In 1900, half of all American white males could expect to live from birth to age 47 or older. Expectancy for black males was 33. In 2000, the numbers had risen to 75 and 68 years respectively.

There have obviously been major medical advances during this time, not least of which was effective antibiotics that mostly eliminated pneumonia as “the old man’s friend” and influenza and whooping cough as killers of children. But in the larger scheme of things, individual medical treatment could not have had much of an impact without public health measures that reduced infectious disease. Widespread water and sewage treatment eliminated illnesses like typhus,
typhoid, cholera and amoebic dysentery. Public health testing and inoculation made tuberculosis and polio third-world diseases.

In the 21st century, the leading US causes of death are heart disease and cancer, followed by cerebrovascular disease. We also recognize diseases that were unknown a century ago: diabetes, Alzheimer's disease, and a host of genetic disorders which in the aggregate affect more people than the top two killers combined.

What seems truly ironic is that a large fraction of our deadly disease is preventable. We literally smoke ourselves to death with tobacco, drink ourselves to death with alcoholic beverages, and eat ourselves to death with processed drinks and foods too high in sugar and salt. We don’t get enough dietary fiber or daily exercise to maintain health, despite an abundance of food and the means to transport it internationally. Consequently, we spend most of our health care dollars in the last five years of life, in “heroic” measures that cannot correct for decades of self-abuse. Likewise, we suffer from an epidemic of obesity that in turn causes other conditions of poor health.

American health care suffers from many distortions which contribute to its high expense. A third of our health-care dollar is spent on collection – insurance company labor, for-profit hospital overhead, and malpractice law that generate no benefit to actual care. But any time “single payer” is mentioned in our public discourse, we hear a chorus of complaints about “socialized medicine”. We conveniently ignore the fact that much of this chorus is funded by insurance and pharmaceutical companies in their own self-interest. Such companies have bought themselves legislative advocates with tens of millions of dollars yearly in so-called “campaign contributions.” It is small wonder that profiteering, price-fixing and outright fraud run rampant in our pharmacies.

The mess which is our health care system has more than just physical medicine at its core. The mess is also evident in our mental health “system” (if one could call it that). Psychiatry and psychology have promised for the past 75 years to explain us to ourselves and cure our emotional distress – but they have uniformly failed in that effort.

A revolution occurred in the 1970s in public consciousness of the abuse of the mentally distressed. Most of our locked wards were eliminated in favor of community out-patient care – which we then refused to fund. Today our most deeply distressed often find themselves homeless or incarcerated in the US prison system, when their behavior becomes too disordered for their families or communities to tolerate.

Advances in treatment for the mentally compromised that were promised 30 years ago simply haven’t happened and likely won’t. The brain-disease model for schizophrenia, psychosis and depression has provided little or no benefit to people who suffer with uncommon perceptions or who wrestle nightly with the black dog. Pharmaceutical companies continue to market psychoactive medications whose side effects are known to be disabling, while seeking to suppress data gathering or scientific reexamination of published “trials” influenced by cherry-picking and deliberate misinterpretation of outcomes.

The state of professional psychology is no better. A recent “replication study” attempted to repeat 100 widely-published studies of social and individual psychology and therapy, employing new investigators from academia. Nearly two-thirds of the claimed outcomes of these studies could not
be duplicated, and the significance of remaining outcomes was significantly less than originally claimed. The current state of both psychological and psychotropic drug research is simply abysmal.

Meantime, some Americans are vastly over-medicated even as others are under-served. We are daily bombarded with advertisements for new or “improved” (aka “patented and expensive”) prescription medications. Millions of us take anti-depressants, usually after a 10-minute office consult with a general practitioner who has little specific training in psychological assessment. Millions more kids are taking powerful stimulants for “ADHD”, which might more honestly be called “disruptive behavior in school.” But long-term outcomes in both of these drug epidemics include disabling side effects and little benefit beyond placebo. Both are arguably medical fads that need to pass from the scene.

The American consumer is not the only victim of these distortions. Doctors too are damaged. Run a Google search on “doctor suicide” and you’ll generate thousands of references. But even this does not tell the whole story.

Multiple factors are involved in high rates of physician and nurse self-harm. Not least of these in the US is the situational stress imposed by for-profit hospital management teams and insurance company refusal to adequately reimburse the protracted care necessary to manage patients with chronic disorders. Doctors see far too many patients and are professionally penalized if they do not meet case load expectations. Many of the same factors are likely involved in the 440,000 deaths per year due to errors in US hospital care.

A further factor in younger health care professionals who have just graduated from med school (along with hundreds of thousands of dollars in student debt), is the abuses of the internship system. Doctors just entering the health professions are subjected to unrelenting stress in 100-hour or longer work weeks, often involving 24-hour shifts. Sleep deprivation is well known to harm our practicing young physicians. But hospital managements turn a blind eye to that harm — continuing to do so after a doctor dies by suicide. Nobody listens.

It is understandable that Americans want solutions for the conditions summarized here. But we must realize that such solutions will involve changes in our own behavior as well as our access to health care services. Change will be fought tooth and nail by the present financial beneficiaries of our failing system.

As a minimum, it is time to legally ban US radio and television advertising of prescription drugs; they should have never been permitted in the first place. The US is one of only two countries in the world that permit such advertising. Likewise, our research standards need substantial overhaul. Voluntary disclosure of individual doctor financial interests isn’t enough to overcome the flood of pharmaceutical company money into both professional and political circles. When a corporate entity is found to have engaged in price gouging or factual misrepresentation of its products, then entire Boards of Directors need to be jailed for fraud. Some companies may need to be broken up.

Medicine must also move toward community preventative assessment and care, sometimes by paraprofessionals (nurse practitioners, physician assistants). We must learn to do without expensive technology and interventions that aren’t proven to extend or improve quality of life.
Some patients may have to be discharged from care if they will not change their self-destructive life style habits.

Funding of health care services must place less emphasis on the for-profit model. Malpractice law, which financially rewards litigants must yield to professional Boards of Review focused on the elimination of negligent practitioners or quacks.

None of these changes will come easily, and many will require changes in public law or policy. Inevitably, patients now ill-served will need to organize in order to exert pressure on politicians who will otherwise neither listen nor care. Some of our political class must be turned out of office in favor of people with a higher vision of public service. Term limits must be enacted by more States, and dark-money bribery eliminated after overturning “People United”.

I wish us well in these shared endeavors. There is no single “one size fits all” magic bullet.

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