Return to a Semblance of Sanity

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We live in the richest country on Earth. Every day many of our fellow citizens, most of them among the aging or aged, must decide between the purchase of food and that of prescribed medications. The majority of these individuals are covered under Medicare, but Medicare does not cover any part of the cost of drugs.

When Medicare was established four decades ago, the cost of prescription drugs was established inconsequential. The armamentarium of drugs physicians had at their disposal was a mere fraction of today's vast array of pharmaceuticals. Patients saw physicians when they felt ill and had not yet recognized the social aspect of visits to the doctor's office. Pharmaceuticals houses were marketing their wares to physicians only, because it would have been considered highly inappropriate and unethical to make a direct pitch to patients via the print media, radio and television.

How did we get from there to here? It has been a gradual, insidious change. Over there years, healthcare changed from a privilege to an absolute right in the perception of the public. Enactment of a variety of laws confirmed that perception. The truth lies somewhere in the middle: healthcare is a necessity, much like food, water, and shelter, but it does not come free. The perception that healthcare is an absolute right caused patients or their relatives to legal action in the court when they felt that their right was curtailed, or the care they received from their physicians was sub optimal.

"For some time now, some patients have judged their physicians' medical acumen by their prescribing habits. Having to leave an office without a prescription or samples of a drug has often been considered gauche."

Malpractice litigation flourished, and is even today a major contributor to the escalating cost of healthcare, not only because of rapidly rising claims expenses, but also – and perhaps more importantly – because of the unnecessary expenses generated by physicians who often yield to patients' demands against their better medical judgment as a result of their not unfounded fear of litigation.

Pharmaceutical houses have added fuel to the fire by marketing their high-priced, proprietary panaceas directly to patients in the hope that they, in turn, will pressure their physicians to prescribe whatever they are currently promoting.

To a large degree, this stratagem has worked. The patient of yore believed that aging brought along with it certain physical discomforts, and that death was an inevitable consequence of life. Today's society's quest for near-immortality requires a remedy for all ailments and a postponement of death to a point where the quality of life remaining may well be worse than death. Pity the physician who fails to deliver on both accounts; he or she may soon make the acquaintance of a legal system that encourages the notion that if something went wrong, someone had to be at fault.

What can be done to effect a return to a semblance of sanity in the world of healthcare? The solutions ae difficult, cut there are solutions. With respect to the high cost of drugs for the elderly – the topic of most of this letter – the solutions are more tangible. First, Medicare must institute a drug benefit for its beneficiaries. Such a benefit should be on a sliding scale based on the actual income of the beneficiary. Current government proposals are inadequate in many ways. Forcing Medicare beneficiaries into HMOs to receive a drug benefit is clearly not a solution.

Next, tort reform is essential if the defensive practice of medicine and its concomitant high cost is to be stopped. President Bush's initiative toward tort reform is a step in the right direction, albeit too small a step. Steps must be taken, laws enacted that punish initiators of frivolous lawsuits. Discontinuance of the contingency fee concept would discourage many enthusiastic litigators. Legislation to give those without means access to an attorney would counteract the argument that the contingency fee concept allows those without means to seek remedies under the law. Only when the constant and imminent threat of unreasonable litigation is removed, can we expect physicians to relinquish fear-based behavior and return to rational, science-based decision-making.

Direct marketing by pharmaceutical firms of drugs to patients should be prohibited, and physicians should be encouraged to prescribe generic drugs where true therapeutic equivalence has been demonstrated. Such

encouragement could, and sometimes already does, take the form of differential co-payments for generic and proprietary drugs on the part of the patient.

As physicians, we must familiarize ourselves with the cost of drugs and prescribe those drugs, proprietary or generic, that have therapeutic equivalence and the lowest price.

Finally, pharmaceutical firms must discontinue inappropriate pricing practices. No American citizen should be forced to purchase essential medications in Canada or Mexico because he or she cannot afford to buy the same drugs at significantly higher prices at home. Many have argued that the costs of research and development with respect to new drugs are very high and must be recovered. That of course, is true to a large degree. The patent system, however, protects the originator of new drugs for lengthy periods of time from competitors in the generic market and allows recouping of most of the R&D costs. Canadian government price controls have kept drug prices at 30 to 40 percent below prices charged for the same drugs in the United States, and US drugs ae cheaper in Europe as well. Canada has established a national formulary, and some drugs are not available. Closer scrutiny of those drugs that are not available, however, indicates that most of the drugs not available either have other, less expensive equivalents, or are “convenience” variations of drugs, such as time-release versions that sell at higher prices.

It is clear that we as Americans should not have to bear the full brunt of the R&D costs. No one forces US pharmaceutical firms to sell their patented drugs at prices controlled by Canada, or any other country. Obviously, even at the controlled prices, these firms continue to make a profit. Price controls are not the answer, but neither is the practice of charging what the market will bear.

Many of the current sales practices by pharmaceutical representatives are expensive and go far beyond the ethical purpose of informing physicians about new drugs and the appropriate uses. Such practice should cease.

The most difficult change to accomplish will be the re-education of society with respect to healthcare. The current distance between patient and physician must be bridged. Somehow we must find ways to re-establish the old patient-physician relationship based on trust, respect, and confidence, unimpeded by interventions of intermediaries whose interests do not often coincide with those of patients and physicians. But that will also require re-education of some of our colleagues.

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