

THE PURSUIT OF HEALTHCARE

By Christopher W. Bryan-Brown, MD, and Kathleen Dracup, RN, DNSc. From the Department of Anesthesiology, Albert Einstein College of Medicine, Bronx, NY (CWB-B), and the School of Nursing, University of California, San Francisco, San Francisco, Calif (KD).

In the United States, all people are constitutionally awarded the inalienable rights of life, liberty, and the pursuit of happiness. In the past few years, our political leaders have assailed these rights in the name of a “War Against Terrorism,” and they have done little to establish the public’s assumed right to have even basic healthcare. This right should be undeniable, even if it is not promulgated in the Constitution of the United States of America or in the United Nations Charter. Most countries and the United Nations are redolent with healthcare agencies, but self-centered political agendas, poor funding, and pitiless protectionism too often thwart their good intentions and plans.

The Right to Healthcare

The axiomatic concept that healthcare should be a right, and not a privilege, makes more sense when the ravages of unchecked disease are considered. A typical health problem is shown up by the AIDS epidemic that has ravaged Africa and parts of Southeast Asia, and has had an obvious impact in the Americas and Europe. The reduced immune status of individuals with AIDS has rendered them very susceptible to tuberculosis; with inadequate healthcare, the infection is inadequately treated. The result is that vicious drug-resistant strains of *mycobacterium tuberculosis* have begun to spread throughout the world, killing people who have been successfully treated for, or avoided, AIDS. Healthcare workers are at a significant risk, as most of us are treating HIV patients who may have contracted diseases from other virulent organisms.

Patients with severe respiratory failure and atypical pneumonias are frequently admitted to intensive care units (ICUs). By effectively treating AIDS, the risk of atypical pneumonias could be reduced, which most likely would decrease the incidence of resistant tuberculosis and obviate some of the need for the admission of patients who have a labor-intensive course in the ICU and high mortality.

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Healthcare Providers

If healthcare is to be adequate, then someone has to provide it. This means that community resources have to be budgeted to support the necessary personnel, facilities, and materials. There has been a tradition of altruism and self-sacrifice in the healing professions, which has been traded on and eroded by the entry of a marketplace morality into the delivery system. In the United States, we accept it as a norm that medical students will incur between \$100 000 and \$200 000 in interest-accruing debt. This sizable debt serves as an incentive for graduating doctors to specialize in one of the more remunerative branches of medicine and to become specialized as soon as possible. Procedures are a major source of remuneration and make up a large part of the expense for patient care. These circumstances create an environment that is not financially favorable for the primary healthcare provider.

The Nightingale tradition of nursing as a vocation rather than a means of earning a decent living has put the profession at a considerable disadvantage during the last century. As pay scales become competitive with other professions, insufficient nursing recruitment during the last few decades has resulted in a terrifying worldwide nursing shortage. In the United States, where the nursing profession is growing in age faster than in numbers, many nurses are projected to retire in the next 10 to 15 years, which will further diminish the supply of nurses to care for an increasing aged and needy population. Furthermore, the better paying field of administration pulls nurses away from direct hands-on care. There is a chasm between direct caregivers and institutional administrators that is difficult to bridge; the former tend to be advocates for patient-centered care, whereas the latter often are strongly pressured to endorse the establishment no matter how much they may desire to or actually support the staff and patients in their charge. The administrative sensitivity to the “bottom line” as a marker of institutional survival, although fiscally correct, may lead to an apparent insensitivity to the needs of patient care. It also may have led to the burgeoning numbers

of healthcare professionals seeking advancement by obtaining higher qualifications in business, hospital administration, or public health.

Healthcare as a Commodity

It is problematic to treat healthcare as a commodity, and yet it is irresponsible to give it an open-ended budget. In the current political climate, the lack of discipline and fiscal restraint in the medical manufacturing and insurance industries ensures that healthcare is delivered with considerable shareholder profitability. Medicare, the most efficient US system, operates with a 3% overhead, but does not have to compete with insurance companies for business. The idea of a single-payer system seems too radical and upsetting to the insurance industry, which expends substantial effort and funds to prevent it from happening. Major medical organizations also oppose such a system. Medical centers spend a great deal of money to promote their individual superiority to the public in order to compete for patients. In the end, healthcare money is used for all of this activity, which shortchanges our patients. We also have the ticking time bomb of 40 to 50 million people who do not have healthcare insurance, and many have no means to pay for it. In addition, a large percentage of the population are not entirely certain what their policies cover.

Ultimately, the prevention of disease is far less expensive than its treatment, but the dividends are realized at a slower pace. We are a nation invested in curative medicine primarily because we have an aging population suffering from the ravages of time and self-negligent lifestyles. Many of the advantages of preventive health measures will not become apparent until long after the lifetime in office of many of our elected leaders, and certainly not before their next election. Opening a new community hospital has a much higher political return than making people healthier so they don't need a new hospital.

Intellectual Property

The material rewards for original endeavor, discovery, and invention are protected in most civilized communities by a variety of copyright and patent laws. Apparently, there is little legal differentiation between music, movies, computer software, a better mousetrap, and the manufacturing process of a new life-saving drug. The upside is that the original artists, producers, discoverers, programmers, or inventors can be rightfully rewarded for their work in developing intellectual property. However, there is a difference when the intellectual property results in a drug that can cure or arrest an otherwise fatal disease that is far beyond the

purchase of millions of patients. It is hard not to sympathize with governments that have a large-scale AIDS problem when they could offer infected patients adequate therapy for \$250 to \$400 a year with generic drugs, but the cost would be closer to \$7000 under recent free trade agreements that are protecting various US products from generic competition.

In the words of Rachel Cohen of Doctors Without Borders, a nonprofit emergency-relief organization, "Medicines are treated like a commodity, the same as Barbie dolls or computer software. Essential medicines should not be treated simply as products needing protection, or else poor people pay the price."¹ The standard reply by the pharmaceutical industry spokesmen proclaims the well-worn saws concerning costs of development and investment in research. While we should all recognize that we are best served by a thriving pharmaceutical industry, there seems to be enough surpluses for a little moderation. Major drug company stocks maintained or increased their value and dividends during the recent worldwide financial downturn. This is a highly complex problem, as cooperation between industry, governments, and healthcare agencies is needed to keep all in a good state of health.

Even in the United States, the many retirees living on fixed incomes have a difficult time paying for medications that delay or alleviate medical conditions that would otherwise require hospital or even ICU admission at far greater expense to the community.

Personal Responsibility

One way to reduce the strain on the healthcare system is to promote healthier living. Smoking tobacco is still a major cause of poor health and premature death. Nicotine addiction has a reputation for being harder to beat than that of heroin, yet our political leaders consider the sale of cigarettes to be an unfortunate but necessary evil. There are too many smokers who expect the healthcare community to treat their smoking-related bronchitis and emphysema, cardiovascular disease, lung and bladder (and possibly other) cancers, and underweight newborn babies. Many nonsmokers who inhale secondhand smoke also require medical treatment.

The expanding overweight segments of the community look to the healthcare system to cure them of the ravages of obesity. New joints, gastric stapling, expensive blood pressure and cholesterol lowering therapy, treatment for diabetes mellitus, management of cardiovascular disease, and a greater incidence of some cancers seem far easier to promote than a healthy diet and regular exercise. Obesity is now overtaking smoking as a cause of preventable morbidity and mortality.

Envoi

Who is really responsible for healthcare? Perhaps the imaginary "they"—the "they" who ought to do something about anything not working properly—might be invoked when people do not want to take responsibility themselves. This is a Pogoesque cop-out, because the "they" are "us"! We are all responsible for healthcare.

REFERENCE

1. Chase M, Lueck S. In new trade pacts, U.S. seeks to limit reach of generic drugs. *The Wall Street Journal*. July 6, 2004:A1.

CORRECTION

In the article titled "Documentation on Withdrawal of Life Support in Adult Patients in the Intensive Care Unit" (*Am J Crit Care*. July 2004:328-334), the authors were sorry to discover that they misquoted Campbell et al. The authors were looking for time to death following withdrawal of life support so they could develop an intervention to prepare families who wish to be present during withdrawal of life support. They misinterpreted Campbell and colleagues' statement, "The average length of time required to complete the terminal wean was 14.9 \pm 1.24 minutes" to mean that was the time it took from beginning of withdrawal until the patient died. Later in that same article, Campbell et al stated that the average duration of patient survival after weaning was completed was 24.20 \pm 9.34 hours, with 2.3 hours as the median; their point was that these patients continue to require care after withdrawal of life support. The authors regret any confusion caused by their error.

Karin T. Kirchhoff, Prashanth Reddy Anumandla, Kristine Therese Foth, Shea Nicole Lues and Stephanie Ho Gilbertson-White