

The main reason healthcare costs are high is because that's what everybody in healthcare wants them to be, regardless of what they may say for the record.

Actions speak much louder than words, and the actions of absolutely everybody in healthcare since 1993 have taught me that the healthcare system no longer want to eliminate diseases. Everybody, in effect, acts to preserve the highly lucrative, hospital-based status quo, including public health authorities at the CDC, non-profits like the National Kidney Foundation, academic medical centers, especially the more prestigious ones, and Medicare itself.

Bureaucrats at the British and Canadian National Health Services are as guilty as bureaucrats at Medicare. Single-payer or private pay, the entire system has become corrupt.

The evidence for this disturbing accusation is at http://www.genomed.com/images/guyot_dec09nl.pdf

Patient outcomes, which aren't even reported now, are the most important thing in any healthcare system. They're what matter most to patients. They should be what matters most to Congress. Medicare has just begun a voluntary program to record a few patients' outcomes, but it is desultory, underfunded, and will clearly fail, like many other attempts to improve on the current system (cf. the recent Disease Management demonstration project presided over by Sandra Foote of Medicare).

I would mandate that anybody getting federal money (Medicare, Medicaid, VA, IHS, etc.) to take care of a patient be required to report one or two simple things about each patient at least once a year. Is the patient alive or dead at the end of the year? How many times has the patient been in the hospital, to the physician's knowledge?

(Additional outcomes are easy to imagine. For example, if the patient has a chronic condition, how fast is the patient progressing? If chronic kidney disease, what are two representative serum creatinines during the previous 12 months? If COPD, supply a pulmonary function test result [FEV1] within the past 2 years. If congestive heart failure, what is the patient's left ventricular ejection fraction within the past 2 years?)

After anonymizing the patients' data, I would post the outcomes for every physician, hospital, and outpatient surgery facility that had any interaction with that particular patient. I would pool all the patients with the same ICD-9 (or ICD-10) codes for whom the same physician claimed reimbursement for a global outcomes measure. Computers can do this easily enough. How did Dr. Fitzgerald's type II diabetic patients do as a whole? What was their mortality? How many had their limbs amputated during the previous 12 months? How many went blind from diabetic retinopathy?

I would post this summary data for each physician and inpatient/outpatient facility receiving federal healthcare funds. This data would have two purposes:

1. It would allow patients to vote with their feet, selecting physicians with the best outcomes in their region.

2. Somebody within the Dept of Health and Human Services would be responsible for looking at the data and following up on it.

Amongst the hundreds of thousands of physicians, and tens of millions of patients covered in this database would be some with unusually good outcomes. I would ask these physicians what they did for their patients. I would ask in sufficient detail to understand why their outcomes were so good. I would then try to get every physician to do the same thing.

Physicians who continued to have terrible outcomes would stop getting paid with federal dollars. Physicians with good outcomes, if they could be easily replicated, would achieve clinical fame.

In other words, I would expect physicians to take seriously their oath to constantly try to improve clinical outcomes.

In this way, I would use the entire database of federally supported patients to improve quality and lower cost at the same time. The best outcomes are the cheapest.

Every physician could theoretically discover a better way to treat a given disease, not just the favored few who had been getting NIH grants since they were junior faculty at elite medical schools, and who will be getting President Obama's CER (clinical effectiveness research) grants in the future.

Medicine needs to be more democratic, not less so. Physicians in practice seeing 3,000 patients themselves know best how to practice, not academics who let residents and fellows care for their 200 patients. Why do we let the academics with the least direct experience tell everybody else how to practice medicine?

Once outcomes are finally reported, it will be impossible to continue the nonsense that's currently going on. (The nonsense essentially consists of prestige substituting for actual patient outcomes). Clinical breakthroughs will get noticed, and publicized. People will finally get what they want, and what they've been paying for. Physicians with better outcomes, and cheaper prices, will get more business. Those overcharging for worse outcomes will go out of business.

Healthcare will finally resemble a market.

Finally, I would charge the Medical Director for each federally supported patient population--e.g. Medicare, the VA, the IHS--to try to improve the outcomes of his/her patients while lowering the cost of their care. Let academic medical centers try to lead the way, if they can.

Furthermore, I would charge the Secretary of HHS to use all the resources of the Department, especially the NIH and the CDC, to fund clinically useful research so as to improve the outcomes of American patients paid for with HHS funds, i.e. Medicare patients. Instead of letting the NIH go its own way, as has been the practice for the past 50 years, yoke the country's research engine to solving clinical diseases. This was why the NIH was founded after World War II. But in

the 1960s, the NIH essentially stopped studying clinical diseases, preferring sub-human model systems instead.

The theory was that only by thoroughly understanding model systems could we hope to solve disease. The reality is that no model system is simple, and that we still don't understand even the simplest bacteriophage virus.

It takes a particular combination of attributes--courage, the willingness to engage in clinical research, comfort with science, and dissatisfaction with the current mostly pathetic state of affairs in clinical medicine--to drive this change in HHS. If the Secretary of HHS can't do it herself, then I'd suggest she appoint somebody, along with sufficient power, to do it for her. I'd love to volunteer.

Genomics, especially genomic epidemiology, makes humans the study system of choice. The NIH no longer has any reason to be spending money on model systems when clinical diseases can be addressed directly at a molecular level using genomic epidemiology (1). Let the National Science Foundation fund sub-human model systems in the interest of understanding "mechanism," the NIH's mantra since the 1960s. Restore a human focus ("health") to the National Institutes of Health.

Finally, the nation's public health establishment needs to become interested in taking care of patients again, instead of offering laughably unhelpful advice. The CDC needs to encourage treatments for West Nile virus encephalitis (2), not simply acting like the Hanes lady to say who has and who hasn't died of WNV. The Institute of Medicine needs to encourage academic medicine to solve diseases, not conduct a witch hunt for the 100,000 patients a year it claims die from physicians' accidents.

What about the millions of patients dying from disease? How about the 100,000 patients dying from end-stage renal disease each year, simply because the media hasn't publicized my 2002 paper (<http://tinyurl.com/healthcrime>)?

Public health needs to get real. Telling people to lose weight is insufficient; tell them to take the right blood pressure pill, too. It may counteract their obesity (3,4).

This took more than 4 minutes to read. I hope you'll have the good sense to ask me to explain it to you at your leisure. Otherwise, you'll have done nothing to prevent Medicare from going bankrupt in 2015, and for private health insurance to follow suit.

Yours sincerely,
Dave Moskowitz MD