

# Medical partnerships for improved patients' outcomes— are they working?

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## Necessary medical partnerships

To improve patients' outcomes, ICC believes that there must be effective partnerships between the four key medical groups whose efforts are needed to benefit patients (*Figure 1*). The first group includes patient organizations. Patients should let people know what they need, and they need to be represented by patient organizations and patient advocates when decisions are made that affect patients. We should remember that the main reason that medical companies and organizations exist is to improve the welfare of patients. It is a point that is sometimes neglected.

The second group in the patient partnership is health care professionals. They are the ones who can provide care for patients, and their partnership and commitment to patient health is essential. The third group—suppliers—includes the medicine, device, and health care management companies. They work to improve patients' lives by providing the resources they need. Finally, governments and their health ministries, which are responsible for the health of patients and oversee the health care delivery systems in their countries, must be supportive partners for patients.

ICC believes that establishing successful partnerships with each of these groups is a priority for every country's COPD patient organizations, and we believe that each of the medical groups should demonstrate an active commitment to patients and their outcomes. This commitment should not be dominated by the financial interests of these groups in the care of patients.

The most important priority for patient organizations is to promote the best possible care for patients and to call attention when appropriate care is not being provided and attempt to improve it. To assess the success of respiratory

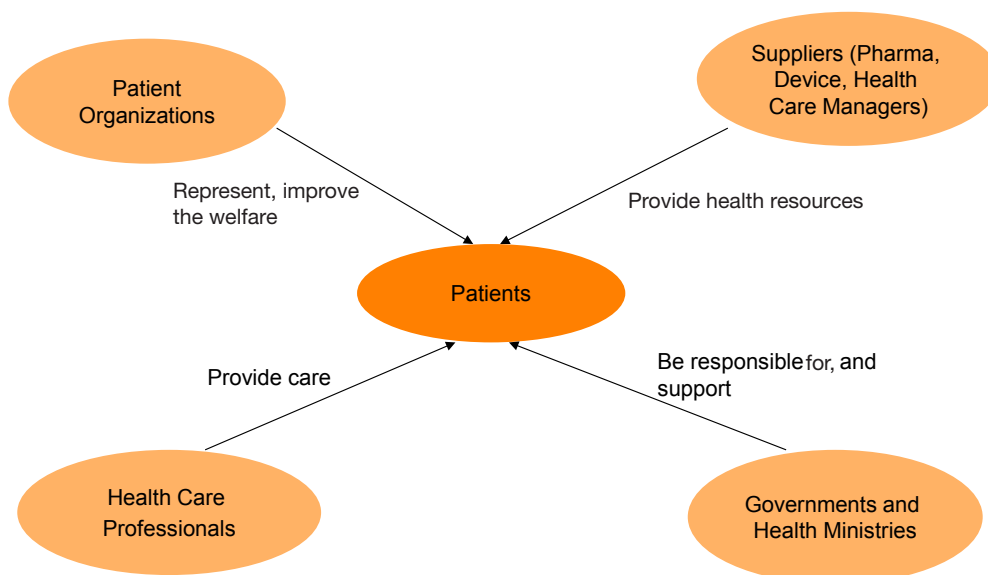
patient groups and their partners in health care, ICC surveyed its 125 member organizations and asked how well the health care professionals who cared for COPD patients in their countries were doing in providing needed care. *Figure 2* shows a luke-warm response to this question worldwide. According to COPD patient group leaders and patients worldwide, physician carers for COPD patients are doing an average job, neither good nor bad.

We also asked the ICC member organizations about how well they thought their national health ministries were doing in providing for COPD care in their countries. The response (*Figure 3*) was similar to the responses for physician care: there is room for considerable improvement in the opinion of patient organizations. In the case of the efforts of health ministries on behalf of patients, the rating in developing countries was significantly more negative than in developed countries (*Figure 4*). It appears that the global relationship between respiratory patients and their provider and governmental partners in health care is not perceived as satisfactory.

ICC believes that when a COPD patient needs care, governments should have a system by which they can receive it. Suppliers should work to make their drugs, devices, and services available to those who need them at a price they can afford. Finally, health care professionals should make sure that health care is, in fact, available to COPD patients who need it. When physicians lose their sense of responsibility toward their patients, health care is bound to be bad.

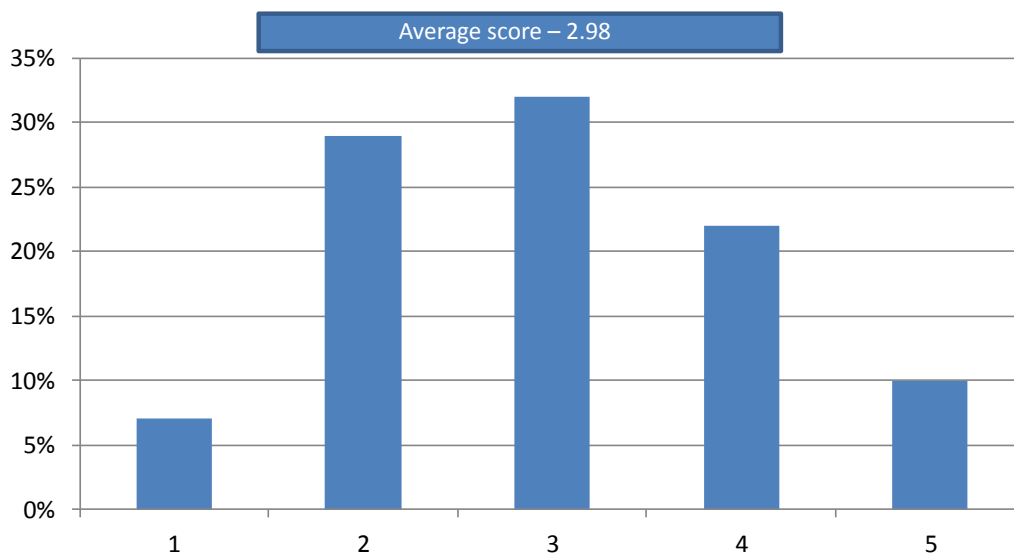
## Patients or profits?

A great battle that concerns all patients is occurring



**Figure 1** Partnership of four key respiratory organizations.

Do you believe that the **health care professionals** in your country are doing their utmost to help COPD patients?  
 Rate from 1 (completely disagree) to 5 (completely agree)



**Figure 2** Rating of HCPs.

globally in medicine, and it dramatically affects the relationship of patients and their advocacy groups with their health care partners. At issue is whether or not basic health care is a human right. Obviously, ICC believes that it is, as do most of the populations of both developed and developing countries of the world, which are working to achieve universal health care. Because of limited resources

and, in some cases, lack of concern about patients, many countries have not yet achieved this goal.

Opposing the desire for universal health care is the global rise of for-profit health care providers and insurers for whom profit is the primary goal and patient benefit and patient outcomes are a secondary or even a non-existent concern (1).

Do you believe that the **national health ministry** in your country is working to improve COPD prevention and care? Rate from 1 (completely disagree) to 5 (completely agree)

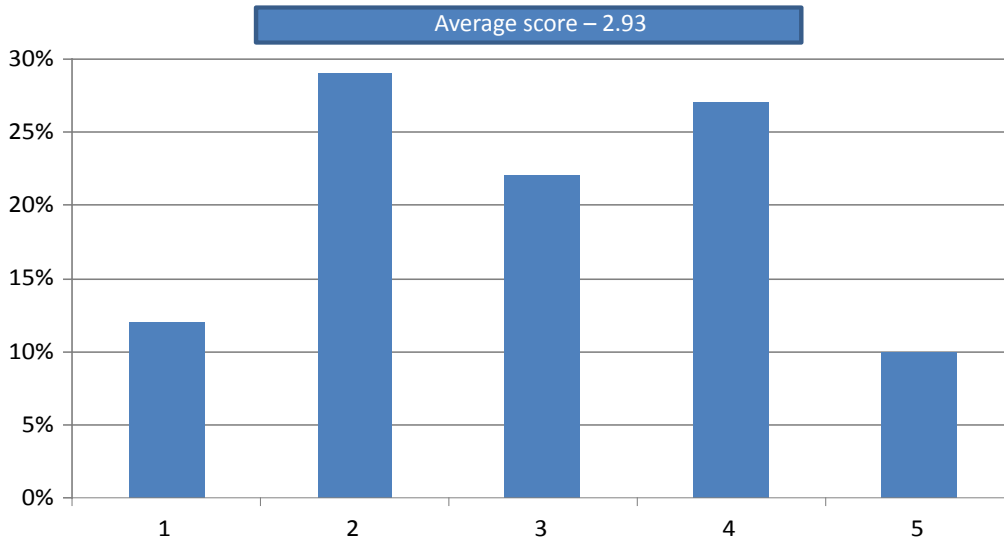


Figure 3 Rating of health ministries in all countries.

Do you believe that the **national health ministry** in your country is working to improve COPD prevention and care? Rate from 1 (completely disagree) to 5 (completely agree)



Figure 4 Rating of health ministries in developed and developing countries.

### Physicians' ethical principles

Physicians and other health care professionals, ICC believes, have the most important role in ensuring that patients receive care. Since the time of Hippocrates, physicians

have taken an oath to commit to the ethical principles of medicine. It is what makes them professionals. There are four major medical ethical principles: *primum non nocere*-the duty of health care providers not to harm patients; *beneficence*-the obligation of health care providers to help

people in need; autonomy—the right of patients to make choices regarding their own health care, and justice—the concept of treating all people in a fair manner. To deprive patients of health care violates all the ethical rules of the medical profession. Corporations cannot be held to these rules. They will violate them whenever they can. Neither can governments, but health care professionals and patient groups should be committed to these ethical principles for patients and should fight for them.

Worldwide, patients experience serious problems in obtaining health care because of the combination of overpricing, overtreatment, and inappropriate treatment by for-profit healthcare providing companies, health insurance plans, and pharmaceutical companies. The situation is better in countries with universal health care, but with the current economic problems in many parts of the world, needed health benefits are being withdrawn even in countries with universal health care programs.

### **Criminal abuses of patients' rights**

There are many examples of criminal abuses of patients' rights as well as other actions on the part of health care providers, service organizations, and health ministries to maximize their profit in the health care business to the detriment of patients' welfare and outcomes. A recent example of such criminal abuses in China involves pharmaceutical companies giving bribes to physicians to prescribe their expensive, and often unneeded, medications (2). In addition, there is an increasing concern that clinical trials conducted by pharmaceutical companies to submit to national and regional regulatory agencies in order to gain approval of their products for licensing are falsified by the companies (3). Many companies' failures to allow the release of patient-level data from the clinical trials to be used by regulatory bodies to decide on whether or not their drugs can be approved, indicates that favorable results with new drugs in some cases are based on falsified data, and that negative results are concealed (4). Since trials of this sort are seldom repeated by independent investigators because of the expense, it is likely that falsified trials will not be discovered and that serious unreported side effects and lack of efficacy of the treatments are damaging patients.

In one instance of falsified clinical trial data in Japan, Novartis employees provided falsified data that made it appear that their antihypertensive agent Diovan was beneficial for strokes and heart attacks. However, the actual data did not support these conclusions (3). As a result of

this fraud, Novartis was expelled from membership in the association of ethical pharmaceutical companies in Japan. In China, Novartis representatives reportedly paid physicians bribes to prescribe more than five dosages of medications such as Sandostatin. Some observers of these illegal activities recommended that the company change its name from Novartis (New Arts) to Noveritas (No Truth) because of their activities in these scandals. Authorities in China are also investigating bribes paid by Sanofi for prescribing their products.

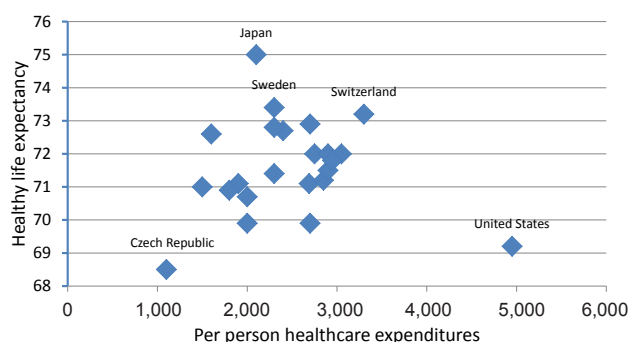
### **Influence peddling damages patients**

Payments by pharmaceutical companies to expert physicians to influence their recommendations for their products in clinical practice guidelines and for their recommendations in advisory committees of regulatory agencies have led to inappropriate recommendations for expensive new drugs in place of well-established medicines that are less expensive (5).

Because wealthy pharmaceutical, health insurance, and private health provider companies make large donations to political parties and politicians in countries where they market, the laws that they pass and the regulatory authorities' actions favor the welfare of the companies and allow them to financially exploit patients (6). As a result of these and other conflicts of interest that harm patients, in most countries the amount of confidence that people have in their national governments is very low and sinking. In the US, only about 30% of the population has confidence in their government; the people in most European countries have the same or slightly higher confidence levels. The highest confidence globally of people in their national government is in China (75%) and one of the lowest is Japan (15%) (7).

### **US pro-profit and anti-patient laws may spread globally**

The US is bad model for how countries should provide health care, but with many countries expanding their for-profit industries and others with financial problems it is likely that they will develop the same policies that harm patients that are seen in the US. As early as 2004, the US had health care costs that were several times higher than most other developed countries while having markedly inferior mean years of healthy life for their citizens (*Figure 5*) (8). The situation in the US has only gotten worse since that time as its percentage of GDP resulting from health care expense



**Figure 5** Healthy life expectancy and per person medical expenditure for 23 OECD countries.

has increased and the years of healthy life for its citizens has decreased.

In the US, the windfall profits for health care providing companies, health insurance plans, and supplier organizations have led to deficient, unmanaged health care throughout most of the country, and the high costs of health care have damaged many businesses and have driven many middle-class workers into poverty and led to their deaths.

In the US, more than 57,000 people die each year because they do not have access to basic health care. A total of 32,000 people die in hospitals as a result of preventable medical errors. A total of 20,000 people die unnecessarily each year as a result of high hospital mortality rates that result from deficient care in many hospitals. Millions of other patients suffer unnecessarily because of limited access to health care and from staggering health care costs (9). This is a disgraceful situation for one of the wealthiest countries in the world. The turmoil over the Affordable Care Act in the US as well as over budgetary deficits in the US is in large part the result of the battle over whether or not health care should be available and how it can be paid. A recent article in *The New England Journal of Medicine* profiles a typical case in which the lack of access to health care led directly to a patient's tragic death, a situation that occurs hundreds of times each day in the US (10). Health care is not just another commodity in the market place where one has a choice of whether or not to buy.

Until the US alters its health care system and adopts universal health care and curtails the unrestrained profit taking by physicians, hospitals, health insurance companies, healthcare management companies, and pharmaceutical and device companies, the US economy and population will continue to suffer. As an example, physician salaries are extremely high in the US for most of the procedure-

dominated specialties, with an average of about \$400,000-500,000 per year and many of the procedures that are performed are overpriced compared to other developed countries (11). In the developing world, few physicians make more than the equivalent of \$20,000-30,000 per year (2). Opportunities for high salaries for physicians in the US have prompted substantial immigration of foreign-born and foreign-trained physicians who now make up about one quarter of practicing US physicians. This "brain-drain" of physicians can be detrimental to the public health of countries that train the physicians.

In spite of more expensive health care in the US, many patients are no better off than they were 40 years ago. For example, the care given 40 years ago for COPD was not much different than today's therapy. Short-acting beta agonists, long-acting bronchodilators, antibiotics, oxygen, and corticosteroids were used, as was respiratory therapy with IPPB delivery of medications. Why haven't there been more fundamental improvements in COPD therapy in the last 40 years? The cost of health care for COPD over these past 40 years has tripled in the US but with no evidence for improved outcomes (12). In fact, patients have more YLDs (years lived with disability) (13). Instead of improving the understanding of the pathophysiology of COPD, only the health care system's profit for COPD care has improved!

The out-of-control cost of health care in the US has become so destructive that articles in medical journals are demanding that excessive cost be included in the side effects profiles of drugs since it can do more damage than most biological side effects to patients and their families (14)!

For elderly patients in the US who incur a large part of their lives' health care costs in end-of-life care, the medicalization of death often deprives patients of a peaceful death in their homes with their family without providing any extension of healthy life but definitely resulting in massive expenses. All this overtreatment achieves is to confiscate the life savings of patients. Instead of passing on an inheritance to their children, they are bankrupted by health care costs and are forced to become dependent on their children's financial and custodial assistance! The high cost of health care in the US is contributing to poverty among its elderly population and diminishing resources for lower and middle class people.

In US urban areas such as New York City, those people whose income is in the top 1% receive more than 40% of all the wealth that is generated in the country (15). This increasing concentration of wealth damages the freedom, access to education, and employment opportunities of

most Americans. Many people believe that the US is no longer a democracy, but an oligarchy in which the elected politicians are puppets controlled by wealthy individuals and companies. The enormous healthcare costs in the US fuel these political realities.

There are few voices of morality in the US, which is increasingly secular rather than religious. It is of interest that the Roman Catholic Pope Francis has recently attacked the “idolatry of money” that results in countries with unrestrained capitalist economic systems. He pointed out that these “economies kill” people by depriving them of work, education, and health care by their exclusion and inequality (16). Patients, with their illnesses and inability to protect themselves, are the ideal prey for predatory and unethical health care systems in such countries.

The conflicts of interest that suppliers, providers, and governments have in maximizing their own revenues at the expense of patients have proved too powerful to resist in the US. Hopefully, patients and patient organizations in other countries can learn from this situation and prevent it from occurring in their countries.

The partnerships of patient organizations in the US with providers, service organizations and governments are not effective. Other countries’ patient organizations are more successful in working with their partners. Patient organizations worldwide need to protest and advocate against these abuses against humanity when they occur.

### Acknowledgements

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