

and publication, scientific papers began piling up at a rate of 25 to 30 per week. Scrambling for a replacement, the CMA turned to Bruce Squires, the journal's former editor-in-chief. The 71-year-old Squires meant to help, but under pressure from editors of other journals, he, too, left, urging the CMA to agree to Choi's demands.

The editors were unable to speak about the matter publicly owing to the CMA's confidentiality policies, so the editorial board contacted the media. Journalists have characterized the story as a battle over editorial independence, despite the publisher's claims to the contrary, and press coverage has been widespread; leading international scientific and medical journals have run sympathetic editorials. The sense of a battleground was heightened by frequent postings on the CMA and CMAJ Web sites, including several "Messages from the Publisher" and editorials by CMA officers,<sup>3</sup> the Kassirer committee,<sup>1</sup> and the remaining editors.<sup>2</sup> For two weeks, the 95-year-old journal was at a standstill. Anita Palepu, a Vancouver-based associate editor who resigned in early March over the CMA's plans for the journal, said of the CMA leadership, "I don't think they expected how strongly most of the editors would feel about this. . . . I think they underestimated that severely."

On March 7, a resolution appeared to be in sight: the CMA announced that a former chief justice of Canada's Supreme Court would lead a panel to examine the journal's management and make recommendations within 90 days. Until then, the CMA pledged to honor several rules proposed by Choi, including granting the editor-in-chief total responsibility for editorial content and requiring editors to report to the publisher only with regard to business and financial operations. As interim editor, the CMA named Noni MacDonald, former dean of the medical school at Dalhousie University in Halifax, Nova Scotia, and Squires agreed to serve as editor emeritus.

Yet the CMAJ's future remains uncertain. The CMA president, Ruth Collins-Nakai, said that the CMA board doesn't believe there was editorial interference, but she declined to say more about why the editors were fired, citing "legal and personnel constraints." Kassirer resigned from the editorial board, accusing Collins-Nakai of hiding "behind a veil of bureaucratic legalisms" and of putting "a gag order" on the editors. Other board members said they also planned to resign, and a professor at the University of Ottawa called for authors, peer reviewers, and advertisers to boycott the journal.

The underlying fight within

the CMA between those who want control over "their" journal and those who favor the complete independence that characterizes major medical journals is likely to continue. Organized medicine is a political and social entity, and Canada has emphasized its political functions by doing such things as giving provincial medical associations the authority to negotiate all fees for physicians' services under universal health care. So it shouldn't be surprising that Canada is now the epicenter of the ongoing struggle over the scope and limits of editorial freedom at association-owned journals.

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## Part "D" for "Defective" — The Medicare Drug-Benefit Chaos

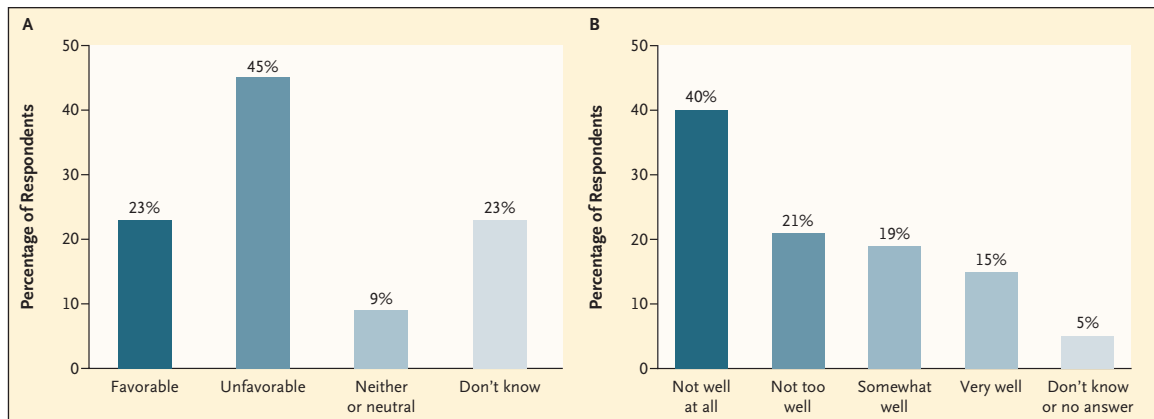
Jerry Avorn, M.D.

A recent survey by the Kaiser Family Foundation quantifies what many of us have seen firsthand: the new Medicare drug benefit is having a troubled infancy (see bar graphs). The data reflect the experience of elderly people who were well enough to partici-

pate in a survey; other reports make clear that matters are far worse for those with medical or cognitive disabilities.

True, the program provides drug benefits for some Americans who previously had none. But because of its strange design, enroll-

ment is falling far short of expectations. Officials in the Bush administration boasted that 25 million people are receiving benefits through Medicare Part D. But the government's data reveal that about 20 million of them already had adequate drug coverage



**Impressions of the Medicare Drug Benefit (Panel A) and Level of Understanding of the Benefit (Panel B) among Respondents Older Than 65 Years.**

Data are from the Kaiser Family Foundation *Health Poll Report Survey*, conducted February 2–7, 2006. ([www.kff.org/kaiserpolls/upload/7463.pdf](http://www.kff.org/kaiserpolls/upload/7463.pdf).)

through Medicaid, their employers or unions, or health maintenance organizations; as of late February, the new benefit was providing only 12 percent of the elderly with coverage they did not already have.<sup>1</sup>

In many cases, the program worsened patients' situations, with a particularly heavy burden falling on indigent Medicaid enrollees. Before the new entitlement, most had virtually all their medications covered fully by the states. But on January 1, 6.2 million of these vulnerable elderly were reassigned to one of the private insurance companies designated by Medicare to run its program. Word of these arrangements didn't always reach the patients, insurers, or pharmacies accurately, and tens of thousands of indigent patients were told to get prior authorization, pay a large initial deductible, or make substantial copayments for regularly used medicines they previously received at no cost.<sup>2</sup> Thousands discovered that the drugs they had been taking for years were not covered by their new insurers. Clinical crises ensued, and 37 states had to provide emergency payments for frail citizens.<sup>3</sup>

Despite its youth, the Medicare

drug benefit is already chronically ill. But with extensive rehabilitation, it could go on for years, albeit with impaired functional capacity. Debate continues over whether its early spasticity was caused by inept management of its birth or a genetic disorder present at its creation. Proponents of the first explanation suggest that Medicare and its private insurers were not ready for the millions of applicants and hundreds of millions of prescriptions that poured in early in January, in a flood that they were ill prepared to handle. The layer of insurance companies inserted into the process in the name of efficiency exacerbated the confusion. An administration and Congress guided by Ronald Reagan's principle that "government is not the solution to our problem; government is the problem" put his vision into practice in a chillingly convincing way.

Alternatively, the lethal flaw may not have been in the implementation of the program but in its conception. The program's poor functioning may result from mutations at multiple loci: the reliance on private companies to shape a public program and contain use of costly medications; the

expectation that most older Americans would readily choose among myriad competing plans, making necessary comparisons on the Internet; the right granted insurers to require patients to switch to the companies' "preferred drugs"; and the vision that millions of disabled patients — many cognitively impaired, chronically ill, poorly educated, unable to speak English well, or all of the above — would successfully work the new system as enlightened consumers. Instead, the new public-private partnership expressed the worst traits of each parent. The government was ill equipped to coordinate the complexity it created, and the companies were too fragmented and bottom line-driven to fulfill this vital public health function.

As with other nature-versus-nurture debates, the correct answer to the question of causation is "both." The drug benefit was defective from its conception and then malnurtured at birth. Its legislative history was marked by heavy input from the pharmaceutical and insurance industries, with predictable results. Previous experience with companies that manage prescription-drug benefits indicated that many did not improve

the quality or contain the cost of medication use. Some had hidden contracts with drug companies to move market share to their products, and savings were not always passed along to patients.<sup>4</sup> The new law prohibited the government from negotiating with pharmaceutical manufacturers for lower costs, though nearly every country that guarantees drug coverage to its citizens does so. Lobbyists argued that it wouldn't be fair for drug companies to have to negotiate prices with such a powerful buyer. Yet Medicare has different rules for less influential vendors: it sets the prices it pays physicians, hospitals, laboratories, nursing homes, and essentially every other recipient of Medicare funds.

Another design element heralded as a bold innovation turned out to be a congenital anomaly. Patients had to shop around among plans that offered different selections of covered drugs and prices, as well as various copayment requirements, deductibles, and available pharmacies. Many plans offered variations on the notorious "doughnut hole" — the legislated interruption of coverage between \$2,250 and \$5,100 in annual drug expenditures.

Several of these concepts were drawn from the "moral hazard" culture of the insurance industry. In auto insurance, a deductible discourages claims for small dents, and copayments provide a disincentive to overuse of coverage. But does it make clinical sense to transfer these values directly to a drug-benefit plan? Do we really want to force patients to think twice before starting an antihypertensive regimen or create disincentives to fill each prescription for warfarin? (The doughnut-hole idea had a different source; it was a shortcut inserted by Congress to make the benefit less costly to the government.)

The implications of the debacle extend far beyond the current program. This is the largest rollout so far of the vaunted consumer-directed approach to medical insurance. The concept is based on the assumption that the health care system (in particular, we physicians) cannot or will not address cost-effectiveness or quality assurance, so patients must take decisions into their own hands to make care affordable and reliable. To the first part, we should plead guilty: we have a poor record of containing costs and maintaining quality. But it doesn't follow that a Hobbesian all-against-all marketplace solution will produce better results, and the Medicare drug benefit demonstrates clearly that it will not.

The program also casts doubt on the wisdom of another trend: the carve-out, which is based on the belief that expenditures and outcomes are best managed when costly problems are "carved out" for management by separate caregivers (usually nonphysicians) working for payers — hence, mental health carve-outs, diabetes carve-outs, congestive-heart-failure carve-outs, and increasingly, drug carve-outs. In Medicare Part D, decisions about which drug in a class to use are made by each insurance company, often requiring prescriptions to be rewritten. The concept abandons the expectation that a doctor will choose the most appropriate and cost-effective drug and reassigns that decision to an insurance company that has its own agenda. The current infatuation with this solution is a stinging indictment of our profession; the encroachment on our prerogatives flows from our failure to address these responsibilities ourselves.

Medicare Part D lives on, responding semiappropriately to noxious stimuli by flailing its

limbs as best it can. It even shows some limited capacity for learning, and one important learning opportunity is just seven months away. Elderly citizens vote in droves, and many of them will have hit their "doughnut hole" by early November. At that point, they will let their legislators know how they feel about the program.

A better solution would be for physicians (and consumers) to make drug choices solely on the basis of evidence about efficacy, safety, and economic value and not on the basis of marketing campaigns that so often distort these decisions. Getting there will require reforms in medical education, health care organization, and regulation of the pharmaceutical industry.<sup>5</sup> We will need to build appropriate prescribing into the structure of clinical practice, so it won't have to be imposed on us from outside. Only then might we expect government to provide universal drug coverage without relying on intermediaries to second-guess doctors and patients. If we can learn from this debacle and move in that direction, not all the chaos will have been in vain.

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