**UNIVERSITIES IN THE MARKETPLACE: THE COMMERCIALIZATION OF HIGHER EDUCATION**


Why should this book about the commercialization of higher education, written by a former president of Harvard University, be reviewed in a medical journal? And what relevance does his thoughtful analysis of the corrosive effects of big-time athletics and profit-oriented education and research in our leading universities have for the medical profession?

The answer should be obvious. Medical schools and teaching hospitals resemble the major research universities in being not-for-profit institutions that are entrusted with essential public responsibilities and that are now endangered by commercial incentives. As part of this carefully balanced yet compelling description of how financial rewards are increasingly tempting universities to compromise their educational and scholarly standards, Derek Bok also exposes the ethical crisis now facing academic medicine and the U.S. medical profession at large.

Whether describing the scandals in the athletics programs at major colleges, the consequences of universities’ pursuit of profits from the licensing of patented discoveries, or the conflicts of interest among faculty scientists who have financial ties to industry, Bok shows that he knows his subject well and that he has done his homework. Moreover, he marshals the relevant facts with an even hand and unsparing candor. He seems as familiar with the medical academy as with the rest of the university scene. Unlike many university presidents, he fully understands the risks inherent in the growing liaison between medical schools and the pharmaceutical and biotechnology industries. Although he acknowledges the social usefulness of the enhanced collaboration between academic and corporate research that followed the passage of the Bayh-Dole Act in 1980, he also is clear about the risks to the integrity and independence of research in medical schools that results from industry sponsorship and about the need for stronger policies to protect these values. Bok says that corporate influence on research involving human subjects needs particular attention because of the threat to the welfare of patients, but he also says that the involvement of businesses in the education of practitioners is no less problematic, since the practitioners’ education will determine how they treat their patients. He is right on both counts.

Bok is also correct to emphasize the growing danger of the corporate subsidization of continuing medical education. By allowing pharmaceutical companies to support and thereby influence programs for the continuing education of practitioners, medical schools and teaching hospitals are surrendering their own professional responsibility for education. In so doing, they risk losing the public’s trust in the objectivity and reliability of medical teaching and in the professional advice that is based on this teaching. He fears that this trend may no longer be reversible because medical schools and teaching hospitals already depend on corporate support, but I think he is too pessimistic. Continuing medical education does not need to be nearly as costly as it is, and it could be financed without corporate handouts. Professional medical educators could easily regain full control if they were determined to do so and if they worried less about the loss of their corporate subsidies.

Despite similar concerns about the reversibility of much of the current commercial tide in higher education, Bok thinks that university leaders still have the power to develop policies that could effect change. He urges collective action by the trustees and presidents of our universities and hopes that senior faculty can be persuaded to join the effort. I believe the same should be said about our medical academic leadership. If a handful of the most prestigious and influential medical schools were to adopt new guidelines that drew clear and reasonable limits to protect research and education from the worst effects of corporate influence, we would be well on our way to a solution. Without such action, it is hard to see how the values of most medical professionals can be sustained in a climate that is now so heavily dominated by investor-owned corporations.

The medical profession, like the rest of higher education, will be greatly challenged by the need to develop a common vision for the future of medical education and research that is consistent with its professional standards and that is not compromised by commercial incentives. Bok’s book provides an excellent basis for the debate that must follow.
education, is too important to society to allow its future to be determined by market forces. One can only hope that this book will help the public understand what is at stake and will generate support for the needed reforms. Derek Bok has sounded a warning that ought to be heeded. I suspect his book has already become required reading for college presidents and trustees and other leaders in higher education. It deserves just as careful attention from the deans of medical schools and their faculty — and indeed from all physicians who care about the soul of their profession.

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CRITICAL ISSUES IN GLOBAL HEALTH

Global approaches to health began to be conceived as rich nations embarked on the exploration and colonization of poor nations in the tropics. For much of the first half of the 20th century, these approaches were focused on gaining an understanding of the pathophysiology of infectious diseases endemic to warmer climates and devising the means to cure them. In the latter half of the 20th century, the use of airplanes increased international travel, allowing the import and export of various infectious agents with increasing ease. Other factors contributing to the spread of disease were the mass migrations caused by war, civil strife, hunger, and natural disasters. Such migration has influenced the changing face of global health. The past century also witnessed the industrialization of previously nonindustrial countries and the globalization of trade. In some regions, these trends have led to economic improvement, the control of many infectious diseases, and a shift toward a focus on chronic diseases. But these epidemiologic transitions have also drastically affected some countries by requiring less sophisticated societies to face modern health challenges.

Global health today has a much different face from the one it had in 1902, when Sir Ronald Ross won the Nobel Prize in Medicine for his work linking malaria and mosquitoes. Today, the field of global health encompasses infectious and chronic diseases, environmental and occupational health, injury prevention, war, and hunger, as well as research and the implementation of health care programs. And it involves politics. In order to achieve success in combatting poor health, the international community has come to appreciate the need for partnerships, both among countries and international organizations and between public agencies and private industry.

In Critical Issues in Global Health, Koop, Pearson, and Schwarz have assembled contributions by prestigious leaders in the area of public health who here share their insights into what they see as the most pressing issues in global health. The editors have grouped the essays into three main parts, covering countries, continents, and the world; organizational landscapes in global health; and organizations, management, leadership, and partnerships. The relatively short chapters address past successes, current challenges, and possible future advances in public health.

The first essay, by Gro Harlem Bruntland, the former director general of the World Health Organization, establishes the tenor of the book. Bruntland points to the tremendous gains in life expectancy that were made over the past few decades; however, she also points out that severe poverty hinders more than a billion people from reaping the rewards of the “health revolution.” Bruntland lists four challenges for the 21st century: “first and foremost,” a reduction in poverty; second, the need to address threats that arise from economic crises, unhealthful environments, and risky behavior; third, the development of effective health care systems; and, fourth, the expansion of the knowledge base related to health. Throughout subsequent chapters, after discussing experiences with various topics in health care, the contributors delve into areas that, in essence, revisit these four challenges.

Critical Issues in Global Health is an excellent overview for those with an interest in improving global health. It is expansive in its coverage, which is both a strength and a weakness. Although the book provides an overview of many important topics in global health, each chapter is only that, an overview. Readers will use the book as an introduction to the subject of global health, but they will need to search for other works that provide more coverage in depth. The pressing health issues of today are covered, but the challenge is to predict what influences — the
Severe acute respiratory syndrome is a recent example—will affect the world’s health in the future.

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A Shared Destiny: Community Effects of Uninsurance


Insurance inherently involves collective destinies among members of a community—a sharing of the risk of loss from untoward events. The fourth report from the Institute of Medicine’s Committee on the Consequences of Uninsurance, A Shared Destiny: Community Effects of Uninsurance, explores a mirror image of the communal fortunes of those who are insured: the implications for a community of people who share geography and health services when not all of them are insured. It highlights the critical question of what happens to the broader community when the health insurance risk pool is highly fragmented and exclusionary.

The report identifies an array of potential societal consequences of uninsurance, beyond the well-known implications for individual persons, families, and uninsured persons as a group. It reviews data on the association between uninsurance levels and community-wide measures of access to care, economic and social conditions, and overall health status; its sources range from sophisticated commissioned studies on uninsurance, hospital services, and financial margins to case studies and anecdotes. The Committee on the Consequences of Uninsurance finds that the adverse effects of uninsurance on the uninsured and the associated financial strain have spillover effects on health care institutions and providers. The committee concludes that indicators of access for persons with low and moderate incomes and those without insurance get worse as rates of uninsurance rise. It finds suggestive evidence of adverse consequences on the availability of primary and preventive services, specialty services, emergency care, and certain hospital services. The committee hypothesizes that uninsurance may also raise health care costs, increase the public tax burden, and hurt the overall local economy. Finally, higher numbers of uninsured persons add to the level of disease and disability within a community, and the provision of care to the uninsured may undermine public health and preparedness activities.

Surprisingly, the report skirts the problem of the community-level consequences of personal debt and bankruptcies from sticker-price charges levied and often vigorously enforced on the uninsured, although it acknowledges that the uninsured pay out of pocket for a sizable part of their care. Thus, it sustains the widespread misperception that uncompensated care has adverse consequences mainly for providers and not for the uninsured themselves and their role in the local economy.

The committee’s own critique of its efforts is that “the picture of community-level impacts . . ., although tentative in some respects, is an important starting point for developing more definitive evidence” and “the picture is clear enough to inform some policy choices now.” My conclusion is that the report does indeed provide a well-considered starting point but provides little direction for current policy choices. Reluctant to draw causal connections without teasing out the extraordinarily complex effects of uninsurance on communities, the report provides few answers to these pressing questions and no specific policy recommendations. Rather than providing guidance for policy, which is generally informed by much less rigorous evidence, the report largely calls for the collection of more data and for more research.

In the face of a worsening national crisis of uninsurance, one must ask whether our country really needs, or has time to conduct, as the committee suggests, research such as “well-controlled, longitudinal stud[ies] . . . to tease out the difference between the effects of the uninsured population as . . . an aggregate influence” and their effects in terms of “ecological impact.”

Apparently, the committee shared this frustration, explaining its repeated calls for more research by saying that “as long as we as a nation tolerate the status quo, we should more fully understand the implications and consequences of our stalemated national health policy” and ending the report with a clarion call to action: “[I]t is both mistaken and dangerous to assume that the prevalence of uninsurance in the United States harms only those who are uninsured.” Unfortunately, it requires a triumph of optimism over experience to hope that scien-
Epidemic of Care: A Call for Safer, Better, and More Accountable Health Care


Health care costs are out of control, the quality of health care is frightfully low, and far too many people are uninsured. The solution, according to George Halvorson and George Isham, is managed care. This is not your father’s managed care. It is the new managed care, in which health plans focus more on improving the quality of care and less on rationing care. Halvorson and Isham worked together doing just that at HealthPartners, a Minnesota-based health plan. Halvorson now heads Kaiser Permanente.

After exploring the behaviors of providers, consumers, and health plans that led to the current state of affairs, the authors lay out a seven-point national plan for increasing the value of health care. Not surprisingly, health plans have a large role. Improving the quality of care and patient safety tops the list. Other items include improving the efficiency of health care markets, addressing population health, developing a workable plan for the uninsured, and supporting research. Along the way, Halvorson and Isham correct some misperceptions about health maintenance organizations. The authors’ focus on the value of health care is refreshing. Increasing value demands a delicate balance of frugality and innovation. The right mix of these elements is an equation that needs to be solved for each new advance in medicine, with what we gain in health weighed against the opportunities we give up to achieve those gains.

Improving health outcomes is the most interesting part of Halvorson and Isham’s plan for increasing the value of health care. The authors believe that automated record keeping is a prerequisite for any widespread improvement in quality. Automated medical records make information instantly available to doctors when they need it and provide a platform for real-time education about the latest treatment guidelines, possible drug interactions, and other features that can improve the quality of care in the increasingly complex and harried world that physicians inhabit. The possibilities for innovation seem almost limitless. The idea of automated record keeping, coupled with other strategies, gives a clear direction for improving treatment outcomes. Not so clear is who will pay the cost of these improvements or how they can be implemented nationwide.

On the cost side, Halvorson and Isham turn to the strategies economists typically use in failed markets: enforcement of antitrust laws to make markets more competitive, improvement of information on the quality and outcomes of health care, and creation of incentives for patients and employers to shop for the best value. But their assertion that “it generally costs less to do care right,” which is a pillar of their plan for increasing value, seems more wish than fact. For example, they cite a newspaper article as evidence that counseling for obesity will reduce the incidence of diabetes and its concomitant costs. A study reported in the Journal by Tuomilehto and colleagues (2001;344:1343-50) showed that counseling-based intervention to help prevent diabetes was neither simple nor inexpensive. Better health care often requires an initial investment, and the promised savings do not always materialize.

There is much to like about this book. Health care providers and those who administer health plans will find many examples of what can be done to improve the quality of care by working together. Employers and others who purchase health insurance can learn how to get more value for their health care dollars. Policymakers may learn a thing or two about how insurers can help solve problems in health care. Everyone can have a role in Halvorson and Isham’s plan.

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