William C. Hsiao (Healt economics 1994;3:351)

Propelled by a declining faith in government, many developing nations have searched for a "magic pill" to cure the ills of their underfunded and inefficient public sector dominated health systems. Allured by the success of free market mechanisms in promoting economic growth, conservative politicians and economists, starting in the early 1980s, pushed many developing countries to turn to the free market to finance and provide their health services. Marketization, defined as the idea of using market forces to finance and provide health services, was seen as an effective means to pursue efficiency only. (...)

According to neoclassical economic theory, an optimum level of social welfare can be achieved by emphasizing consumer sovereignty. Consumers choose health services, constrained only by their budgets, relying on their own preferences to trade off the prices that we have to pay for health services versus other goods. Under this model, there must of course be competition among providers to yield optimal social welfare, including little restriction on who can practice medicine or sell drugs. Therefore, a simple market system emphasises consumer demand to generate price competition and contain the cost of health services. (...)

Health systems are rather complicated. Economists often think in terms of supply and demand in a marketplace, but a health system from a market perspective, consists of a series of interconnected markets: insurance, physician services, hospital care, factor supplies such as health professionals, pharmaceuticals, medical equipment and finally capital and medical education. (...)

Lasting a credible macro-theory of health systems, we can only rely on empirical evidence to tell how successfully market forces can improve efficiency and control cost inflation. (...)

National experiences teach us that neither pure centrally-planned not free market health systems can achieve maximum efficiency. A complex mixed system seems to be the answer. (...)

Marketization, then, is not a simple pill whose magic can be harnessed easily for the benefit of all the people. Instead, it is a complicated system of regulated markets. Fortunately, the past two decades of marketization in the health sector of many nations has also revealed many useful principles and practices as to how a State can structure a system to bring out the positive market forces.

Jeromek Kassirer, Marcia Angell (New Engl. Med. 1995; 333: 449)

Nobody is well served by practice of reporting the same study in two journals a review of the same subject nearly simultaneosly in two journals, or splitting a study into two or more parts and submitting each to separate journals. (...)

The reasons for preventing redundant publication are not arbitrary. As earlier editorials have pointed out, multiple reports of the same observations can overemphasize the importance of the findings, overburden busy reviewers, fill the medical literature with inconsequential material, and distort the academy reward system. (...)

Two years ago we accepted a paper on bone lesions in patients with cronic renal failure. We asked a distinguished nephrologist to write an editorial to accompany the paper. While preparing the editorial, the nephrologist came across a study published in a specialty journal several months earlier. It was written by the same authors, described the same patients, and reported virtually the same end points. The authors had not told us they had published similar data elsewhere. (...)

We will continue to rely on the honesty and judgment of authors in informing us of any work of theirs that is related to a manuscript they submitting to the journal.