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Fractured Healthcare

By Jane Orient, M.D.
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With the party of HillaryCare in the ascendancy, the drive toward "universal healthcare" in America may succeed, after more than a half century of effort. This time, we are told, it's "*not* socialized medicine"; it's "equitable healthcare" or "single-payer healthcare." It's about providing a "human right." Whether or not one believes that it is a proper role of government to regulate individual medical care, is it safe to assume that a government takeover would make medical care less expensive, more accessible, or of higher quality? How well is government medicine likely to succeed?

For a sneak preview of the result of implementing a system under the control of the federal government, let's look at another "human right" that was implemented in American law and that began receiving federal aid a few years before Medicare was enacted: the "right" to a basic education. The results: the performance of American students is nearly the worst in the industrialized world. With SAT scores plunging so much that the test was revised to bring the scores back up, per-pupil spending by state and local governments has doubled in real dollars over the past 30 years.

At the same time, there has been an increasingly intrusive presence of government in the curriculum and oppressive, costly measures designed to produce "equality." The welfare of the children is the pretext for ever-heavier demands on the taxpayer. But the system takes on a life of its own. If there's a conflict between the needs of public education in America and what's best for your individual child, the system — that is, its entrenched bureaucracy — wins every time. Maybe you can escape, but only if you can afford to pay twice for your child's education — once through taxes, and once through private tuition.

There's ample evidence indicating universal healthcare will travel that same high-cost, poor-quality road if enacted.

Unfair Equality

By listening carefully to the proponents of universal care, it becomes clear that "universal healthcare" is code for "uniform healthcare," not "optimum care of the sick." Proponents say that we need to accomplish "fairness" and to eliminate "healthcare disparities." In fact, this is a very popular topic in establishment-approved medical journals such as JAMA, the American Medical Association's journal. To ensure fairness, we are told, we need to "weed out" doctors who deviate from the "standard of care."

The harsh penalties to be meted out against doctors who don't follow to the letter government directions for care should clue us as to the rigid system that is being proposed and the type of care we can expect: any care that bureaucrats feel is financially worthwhile and "equitable." But good medicine means treating each person in a manner best suited to him. Presuming that research into promising medical endeavors is not shut down owing to bureaucratic string pulling, what happens when new discoveries mandate that each person be treated differently; will the discoveries be ignored? A whole new field of genomics is opening up, in which patients could receive treatment optimized to their own genetic endowment. But would this be considered fair under universal healthcare? Would it be allowed?

Even whole races of people vary in their responses to certain treatments. Consider past guidelines for high blood pressure. In blacks, hypertension usually has a different physiologic mechanism than in whites. Blacks usually respond better to diuretics and salt restriction, while whites respond better to drugs such as ACE inhibitors. In fact, doctors are now realizing that long-accepted recommendations for treatment of hypertension, including diet restrictions that might prove beneficial to blacks, are actually harmful to some Caucasian patients. Similarly, recommendations tailored for men may be much less suitable for women, and treatments helpful for young adults could be very dangerous for the elderly. Remember that the words "do no harm" are no longer part of the trendy substitutes for the Oath of Hippocrates. In any event, under universal healthcare your doctor would not decide your treatment; government bureaucrats would.

And how far would equability be taken? Would government care providers follow the lead of school equality and bus white patients or doctors to inner city hospitals, and black patients or doctors to the suburbs for their care? Would they deny doctors a required government permit to open an office in an area where there are already "too many" doctors of a certain type or race, or force them to work in an "underserved" area? They do it in Canada.

Avoiding Costly Care

Though used on both sides of the political aisle, the very term "healthcare" speaks volumes. Most proponents of universal healthcare spout rhetoric that American medicine is too "disease oriented." This tells you where the emphasis of a new system will lie and where future monies will be spent — on the healthy. They ask, "Wouldn't it be better to focus on keeping people healthy?" This theme plays out in various iterations, often in the context of statistics and money. Over and over, we hear negative commentary about the supposedly over-large amounts of money being spent on people during their last six months of life. Not voiced aloud but obviously implied are other questions about cost, such as, "Why should society waste money giving your child a 10 percent chance of surviving his cancer, when for the same amount of money we could buy obesity education for thousands?"

Of course, proponents of universal healthcare aren't so crass as to admit that they're against giving care to certain groups of people, but that *is* how universal healthcare

lowers the cost of care. The Fraser Institute, which does a yearly analysis of the wait times in Canadian healthcare, found that in 2005 over 782,936 Canadians were on waiting lists. If Canada had the same population as the United States, that would mean almost seven and a half million people would be on waiting lists. (In the United States, our waiting list would likely be vastly greater because of our aging population.) In fact, eye surgeons in Toronto, Canada, were allowed in operating rooms only one day a week while Canadians often went blind waiting for cataract surgery, a relatively minor procedure in the United States.

Undeniably, "universal access" means months of waiting for "elective" procedures. In Canada, a new industry has even emerged for managing the waiting lists. The average waiting time across "12 specialties and 10 provinces surveyed" was 17.7 weeks, according to the Fraser Institute. (This number is probably skewed low because some provinces do not readily release data about waiting times.) This is a worsening problem: "Compared to 1993, waiting time in 2005 is 90 percent longer." And as Paul Krugman, a *New York Times* editorial writer who is for government healthcare, has admitted, Canada's waiting times are still shorter than Britain's. Yet, when comparisons between the systems are made, the cost of pain and disability from these delays is never counted. Long-suffering Canadians are beginning to lose patience. Only 65 percent of Canadians still say they get good care, and only 53 percent of Albertans said they were satisfied with recent emergency care. The government's response: hire more social workers, open a 24-hour "suggestions" hot line — and conduct a high-profile campaign to reduce waiting times for cancer surgery by cannibalizing resources from other types of surgery.

But when the citizens of countries with national healthcare programs get treatment, it's better than ours, right? An article critiquing Paul Krugman's commentary on healthcare cites the book *Lives at Risk: Single-payer National Health Insurance Around the World* as saying: "Consider breast cancer. In the U.S., the mortality ratio — the percentage of people with the disease who die from it — is 25%. The breast cancer mortality ratios for Canada, the U.K. and New Zealand are 28%, 46% and 46% respectively. The U.S. prostate cancer mortality ratio is only 19%. In Canada, it's 25%, in France, it's 49% — and in the U.K., over half — 57% — of men diagnosed with prostate cancer die from it!"

But if Canadian healthcare is so poor, why don't they scrap the system and get a better one? Because supplying "free" routine healthcare is still a great vote-getter from the healthy population that is worried about paying off emergency trauma care, rather than paying for quality-of-life care (knee and hip replacements). And the healthy out-vote the sick by a huge margin. Moreover, healthy people may enjoy going to the doctor frequently for minor complaints, without charge at the time of service, without thinking about the *true* costs of those doctor visits.

Universal Rationing

In actuality, universal *health*care discriminates against the sick by design. Read the Vision Statement of the Archimedes Movement, the mission of John Kitzhaber, M.D., former governor of Oregon and architect of the Oregon Health [Rationing] Plan, which

went into effect in the early 1990s: the stated goal is to "maximize the *health of the population* by creating a sustainable system which reallocates the public resources spent on health care in a way that ensures universal access to a *defined set of effective health services*." (Emphasis added.) That is "*care that is effective in producing health*," Kitzhaber clarifies. Under such a plan, medical care that would effectively prolong *your* life, relieve *your* pain, and reduce *your* disability, but cannot restore you to a state of health, may not have resources allocated to it because the resources would be commandeered for measures that can benefit more people. Say, for the treatment of thumb sucking, actually one of the highest priorities of the Oregon Health Plan until people started ridiculing it.

Advocates of universal access downplay the rationing aspect, attributing it to insufficient funding of the system. The United States, they argue, spends so much on healthcare that we could have everything for everybody if only we allocated the money efficiently as in Canada, or in our own Medicare. Administrative costs here, they say, are only two to three percent when government is the payer.

But what they say doesn't ring true. Medicare has tens of trillions of dollars in unfunded liabilities and is on pace to devour the entire federal Treasury in a decade or two, if present trends continue. This is true despite the fact that Medicare "saves money" by only paying, as George Quinn, senior vice president of the Wisconsin Hospital Association, told the House Committee on Ways and Means, "pennies on the dollar for actual costs incurred taking care of patients," thereby transferring the costs of Medicare patients to patients who have private medical coverage. And Medicaid is already bankrupting state treasuries.

Ironically, because the government cannot control costs on its own, to try to staunch the hemorrhage of money, it is turning to the dreaded HMO, a public/private collaboration! Nearly one-third of Medicaid recipients are now in HMOs. The government pays an HMO seven to eight percent less than it expects to spend by managing payments itself. And the HMO, after providing all "needed" care, still has enough cash left over for corporate jets, stockholder profits, generous endowments to the arts, and stadium-naming rights.

Because government accounting makes Enron look like the model of probity, nobody really knows the cost of government administration. Certainly, billions of dollars vanish without a trace. For years, the Government Accountability Office (GAO) has been unable to render an opinion on consolidated government financial statements. Reportedly $462 billion was looted from trust funds in 2000 and 2001. Many costs are simply excluded from estimates of government expenses: tax collection, regulation writing, and interest on government debt. If these are included, the administrative overhead of public programs amounted to 27 cents per dollar of benefits, compared to 16 cents for private programs, according to a 1994 study by the Council for Affordable Health Insurance. Government also shifts huge administrative costs — such as complying with more than 100,000 pages of regulations — onto doctors and hospitals. If a claim worth less than $65 is denied,

many doctors do not bother to refile it because the administrative cost is greater than the payment that might be collected.

"But," proponents of universal healthcare say, "the present system of care in the United States is private now, and it is failing. Better to let the government try to improve the situation; otherwise, only the rich will be able to afford medical care." Almost unbelievably, the undeniable problems in American medicine are blamed on the 15 percent of expenditures paid directly by patients, not the 85 percent that involve a third-party intermediary, whether government or private insurer. And by the way, government already pays about half of all medical bills. There has been no free market in American medicine for around 60 years. We have disconnected the natural regulator of prices paid by actual users of the services, the only valid measure of worth. Patients can no longer bargain for care in a system that permits competition on quality and price.

Ruining Routine Care

Most "health insurance" in effect today does not pay the beneficiary (which is supposed to be *you*) an indemnity to compensate for a financial loss. Instead, it pays "providers" to render medical services or, increasingly, *not* to render them. And that's the number-one problem. It's what people dislike most about our medical system today — managed care.

The heart of the matter is that we don't have "sickness insurance"; we have something called "health insurance," even though it doesn't protect your health, any more than life insurance protects your life. And even though it generally isn't really insurance.

With *real* insurance, the insurance provider profits by collecting premiums and investing them. It *loses* by paying claims. If actuaries are competent, and premiums can be priced according to risk, and there are no extraordinary disasters, then the insurance company prospers while the subscribers get what they pay for: in return for a small, predictable premium, the company promises reimbursement for an unlikely but catastrophic loss.

With true insurance, subscribers hope that the only interaction they ever have with the insurer is to pay the premium. They don't want their State Farm agent to be a check-writing service. Then he'd know about all their affairs; would keep a cut of each and every payment; and would soon be trying to tell them what to buy, where to buy it, and how much to pay for it. Of course, the company might favor expanding its coverage to include payment of routine medical bills because the more money flows through, the more they make — as long as they have the power to determine what's covered, and what isn't.

Strangely, Americans have accepted having Blue Cross, or Aetna, or Medicare as their bill-paying or check-writing service, for medical bills only. They don't like the worry or the bother of paying doctors or hospitals. They're afraid of medical encounters (often for good reason!) and of the high anticipated costs. Most importantly, they believe that *somebody else* is paying the bill, primarily the government or the employer. They don't seem to understand that (1) they are really paying the bill themselves through taxes or

reduced wages, and that (2) their access to sickness care is under somebody else's control.

Insurance has morphed into managed care. In other words, it has been turned upside down. Subscribers don't get money that they can use, as they see fit, to make themselves whole after a loss. Instead, they get case management — that is, whatever medical service providers (who basically work for the insurer) decide to render under whatever terms the insurer decides to set.

Americans are angry about how billion-dollar companies (and their CEOs) profit from denying care to the sick. But unfortunately, this outrage is often translated into a demand for a takeover by the biggest HMO of all — the U.S. federal government. They fail to realize that our system is not privatized; it is a private/public conglomeration that combines a few of the good aspects of privatization with much of the bad of socialized medicine.

Ultimately, there can be no peaceful coexistence in an economy that is half government-funded and controlled, and half free. The contrasts are too stark. Socialists, of course, always blame continuing problems on the remnants of the private sector. And no matter how good private medicine may be, it will have always one irreparable defect in the eyes of utopian reformers: inequality.

Watch the heart-rending images the utopian reformers present: old people who can't manage their complicated medical regimes; fat diabetics who face future blindness, amputations, and renal failure because they can't lose weight; children whose parents don't have health insurance. The implication is unstated: how can you justify your prompt, state-of-the-art total body scan when others are lacking basic healthcare?

But are the poor better off in a system that has lots of well-motivated, well-paid, excellent physicians; sophisticated scanners on every street corner; some excess hospital capacity; and a vibrant, free-market economy where doctors compete to give the highest-quality, lowest-priced care? Or are the poor better off in a system that is a zero-sum game, where any person's gain is another's loss, and where all decisions must be implemented by strict rules and laws because they are not accepted voluntarily, a system that demands quality, equality, compliance, and health — or death?

These are questions that proponents of "evidence-based medicine" do not want put to the test of a controlled experiment. Nor do they want Americans to look too closely at the historical controls, like the Soviet Union, nor the concurrent controls in Europe or Canada, where the welfare state, more advanced than in the United States, is imploding.

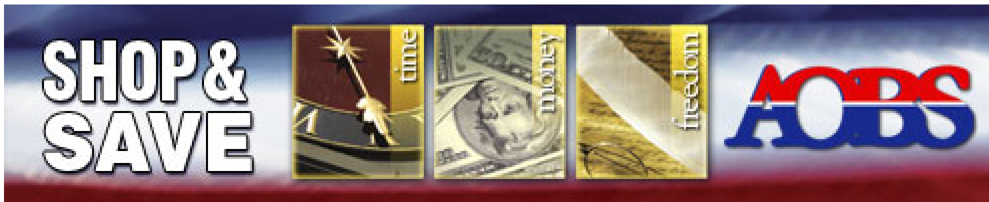
As Pope Leo XIII noted in the encyclical *Rerum Novarum*, the Marxist ideal of absolute equality results in the "levelling down of all to a like condition of misery and degradation." Suppressing economic initiative and the right to private contract, argued Pope John Paul II, puts "everyone in a position of almost absolute dependence."

If we get a true "single payer" system in the United States, there will be no escape, except by leaving the country, as about 90,000 Canadians a year already do to seek care elsewhere. That's what single-payer advocates mean when they say "everybody in, nobody out." There must be no escape from paying for other people's healthcare (no "free riders") or from rationing (no "two tiers").

We are hurtling toward what is, by definition, a fascist system in medicine. In fact, we're halfway there. Momentum builds as costs and dissatisfaction mount. The utopian reformers are certainly right about one thing: American medicine is in serious need of reform — but not the "reform" they envision.

"So what's your solution?" is always the next question. "And what about the poor?" To paraphrase Euclid, there is no royal road to reform. There is no Utopia, no One Plan. There will, however, always be the poor as long as there is inequality, and there will always be inequality because some will always produce more than others and there will always be a lower end of the distribution function. But universal healthcare is not the answer. Managed care is concerned with allocating scarce resources. Only steps toward truly competitive, free-market care, will get us to where we want to go because free-market care will expand the resources — with the result that even those who get smaller slices of the pie would be better off.

Jane Orient, M.D., is an internist in solo practice in Tucson, Arizona. She is also executive director of the Association of American Physicians and Surgeons.



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