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THE STRENGTH OF A REALLY BAD IDEA

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For any problem, there is a solution which is simple, neat, and wrong.

H. L. Mencken

The fact that I have no remedy for all the sorrows of the world is no reason for my accepting yours.

It simply supports the strong probability that yours is a fake.

H. L. Mencken

Is there a right to health care? For about the past 50 years, this question has been the subject of an ongoing debate in America. It begins with the premise that no one, in a wealthy and just society, should lack health care. This is hard to disagree with. In fact, as a physician, I agree wholeheartedly. I'm probably biased. Health care is a basic need. Most of us feel that no one, save by their own choice, should be hungry, or homeless, or unable to obtain health care for illness or injury.

But... is it a right? It's very different from most other rights. Most of us know what rights are. The Bill of Rights lays down most, and we've defined a few others. We have a right to free speech. We have a right to practice our own religion. We have a right to bear arms. (I know, there's a bit of debate on that one.) All these are in the Bill of Rights. We have a right not to be discriminated against on the basis of race. These rights are all basically protections against someone else – individuals, groups, government – encroaching on our liberty.

Health care is something different. Let me go back 60 years, before the start of the debate about health care, to Franklin Roosevelt's "four freedoms" – "Freedom of speech; freedom of worship; freedom from want; freedom from fear."^[1] Notice that the first two are conventional rights. The last one is less conventional, but easily understood in the context of World War II. Freedom from want, however, raises a serious question about the duty of a society towards its members. After all, up until the 20th century, the idea that society had an obligation to prevent people from starving would have been regarded as... quaint? Idealistic? Unreasonable? Probably all of the above. Even today, it's not a universal idea, although it is accepted in America and Europe. But the principle of freedom from want raises a question of resources, which the other freedoms and rights did not. If you are hungry, and you show up on my doorstep, do I have an obligation to feed you? Perhaps I might as a matter of ethics, but I have no legal obligation. Nonetheless, few if any people have to go hungry in America. We maintain that desirable state by an intricate network of subsidies and services, governmental and private. We can do that because food is very inexpensive, and because our society is very wealthy.



What about other kinds of “want”? What about medical treatment, to be specific? If you’ve suddenly come down with appendicitis, and you show up on my doorstep, do I have a legal obligation to operate on you? I’m a surgeon, so that’s not as far-fetched as it might sound to most people. Still, as an individual, I don’t have to take you in and remove your appendix. But the hospital where I work does, by Federal law. Because it’s an emergency. But... what if you have diabetes, and you need ongoing care for a lifetime? Well, the hospital may have a legal obligation, or it may not. That depends on the status of the hospital, on whether Hill-Burton funds were used to build it - a lot of things. And it depends on whether someone can pay for the time and effort which it takes to treat you. Unlike food, health care is expensive, and the cost is not trivial even for a wealthy society.

Now, we come to the basic problem with calling health care a “right.” For if we call it a right, then you can demand it of me, or at least of society. But that’s different from someone demanding that I not interfere with free speech, or free worship. If it’s a right, then we’re obligated to give it to you. But then, who pays for it? A right that’s conditional on payment isn’t really a right. It’s something else. Perhaps we should call it a moral imperative, or something equally vague. In the end, the debate about health care as a right comes down to an argument over who should pay for the health care of those citizens who cannot afford to pay. And there are, unhappily, a lot of them.

About 30% of Americans – excluding the elderly - do not have private health insurance. About half – 15% of Americans – are on Medicaid, or some state variant such as MediCal or TennCare. The other 15% are “uninsured.” These latter are, in general, the working poor, who make too much money to be eligible for Medicaid, yet too little to afford private insurance. Medicaid in most areas – including Kansas and Missouri – pays less than the cost of care.

The care of both Medicaid patients and uninsured patients must be partially or completely subsidized from other government monies, from surplus gained from private insurance, and from overloading our health care personnel and facilities.

What that means in practice is that many health care professionals are overloaded with patients who are either totally uninsured or who have inadequate Medicaid insurance. It is universally recognized that we have a shortage of nurses. Many people have observed that we now have a shortage of physicians. People wonder why this should be so, yet is it any mystery? If GM had to give away a third of its cars, we’d probably have a shortage of GM dealers.

And so we arrive at a conclusion which has dominated our discussions for this past half-century. Specifically, many have concluded that because the private health care system will not reliably pay for the poor, the unemployed, the disabled, and the elderly, government should do so. And in fact, this is exactly what is done, although neither completely nor effectively. But this creates inequities. In particular, the poor do not get the same level of care as wealthier or insured people, or even the elderly on Medicare. Many health planners, politicians, economists, and physicians have argued that, in order to fairly allocate health care resources, everyone should be treated the same way. They say that the best way to do this is for health care to be paid from tax revenues which are allocated by the Federal government. We can call these proponents, for lack of a better term, the True Believers. The idea isn’t new. Harry Truman figured it out in 1950. He just couldn’t get it through Congress. A lot of True Believers still regret that he could not.

In the 1950’s, this idea was known as socialized medicine. In the 1990’s, it was the Clinton health plan. The Clintons couldn’t get it through Congress, either. Today, it is known as the single payer plan, or as universal health insurance. It assumes that the health care system can be kept more or less intact, but that its funding can be changed from employment-based insurance to tax-based allocation. Its proponents seem to have something in mind like Medicare for all. Its opponents fear Medicaid for everyone. Or even worse.



Canada uses a single-payer system. It spends less on health care per capita than we do, although its rate of increase in spending is similar. It doesn't have a terribly bad system, but it's not as good as ours, either. A lot of Canadians come to the US for elective procedures, rather than wait for months in Canada. Physicians and hospitals in Canada are held hostage to the winds of politics. Because it isn't pleasant to practice medicine in Canada, there are a lot of Canadian physicians practicing in the US. More to the point, the Canadian system generates shortages, waiting lists, and discontent. There are a lot of anecdotes about patients being poorly treated, and about essential treatments being delayed. However, the legal system is very different in Canada, and there are very few medical liability lawsuits.

A group of physicians from Harvard have published a paper on a single-payer proposal for National Health Insurance (NHI) in the Journal of the American Medical Association (AMA).^[2] They call themselves The Physicians' Working Group for Single-Payer Health Insurance. Any semblance of an unbiased consideration has been carefully expunged from the article. Just in case anyone misses the point, an accompanying editorial by Rashi Fein, PhD, also from Harvard, presents an equally biased assessment.^[3] Dr. Fein, in referring to the possible dangers of this approach, puts "dangers" in quotation marks. He says, with a perfectly straight face, that any abuses by the government - cutting reimbursement, starving the system of capital, and so on - can be dealt with at the ballot box. Right. This from a citizen of Massachusetts. I should point out that Senator Hilary Clinton has weighed in with a long article in the New York Times Magazine, as well.^[4] The True Believers are beating the drums.

Well, it's probably true that Harvard faculty members and Senator Clinton have more faith in Big Government than most of us. But does the proposal have merit?

The President of the AMA, Dr. Donald Palmisano, said, "Long waits for health care services, a slowness to adopt new technologies and maintain facilities, and development of a large bureaucracy that can cause a decline in the authority of patients and their physicians over clinical decision-making are all hallmarks of the single-payer system."^[5]

There was an interesting quote from Great Britain last August. Dr. Liam Fox, a physician/politician, commented, "Four years ago, Tony Blair pledged in his party conference speech that everyone would be able to see an NHS (National Health Service) dentist within two years. Four years later this government is still failing patients."^[6] Ignore the partisan tone. Dr. Fox is on the other side of the aisle. The significant thing about this quote is that the British prime minister made a promise that dental access would improve to allow appointments in less than two years, and then nothing happened. Granted, dental work isn't as urgent as appendicitis, but still... two years??? Most Americans think an appointment wait of two or three months is something to be worried about. Two years? The (London) Sunday Telegraph cited government statistics, and said that surgical operations on 67,000 were cancelled less than 24 hours before surgery, often after having reported to hospital in the morning and receiving their preoperative medication. That was just in the first three months of 2003.^[7] That calculates to 270,000 per year, if you're interested.

Supposedly, the British public is happy with the NHS, just as the Canadian public is happy with their long waiting times, antiquated technology, and miserable service. But would Americans be as happy? Can you imagine the frustration of getting care in a system like that? And remember, in any equivalent American system, any patient who had a bad result because of delays in the system could simply sue the physician. How many docs would be left after a few years?



That raises an interesting point. It has often been noted that neither England nor Canada has a malpractice problem. Perhaps that would be a trade-off to consider - but nobody is offering it. Any single-payer system will necessarily include the present tort system, if only because there is no politically viable way of linking single-payer to tort reform. Of the two parties, it is the Democrats who tend to favor universal health insurance, and who also oppose tort reform. Today, some insurance companies, such as Blue Cross Blue Shield of Kansas City, strongly support tort reform. Some will even raise premiums to cover part of the malpractice insurance costs. The government programs, Medicaid and Medicare, are still lowering physician payments, regardless of how much physicians have to pay for malpractice. It would be no different under a single payer program. The article cited above goes through a litany of problems with the current health care system, and only once mentions the word "malpractice." The authors say that the present system would be expected to continue, albeit with somewhat lower judgments because future medical expenses for each patient would be zero. [8] Huh? In their world, any medical services for which the NHI won't pay will be illegal.

To digress a bit, medical liability isn't just an incidental problem. It's a crisis in itself. The rising costs of liability for failures of medical treatment presently threatens our ability to maintain the health care system. The costs of liability are largely met by physicians as individuals, and not shared across the entire health care system. As they rise, they have a disproportionate impact on physicians. But it is acknowledged by its advocates that a single payer plan will – like Medicare – simply ignore those costs, or deny that they exist. We need to ask how many physicians will be left in practice in a few years, if they have to bear the entire burden. Perhaps physicians will go to work for hospitals and health plans. Is that desirable? Well... not if you want your doctor to exercise independent judgment. "Got to do a few more cardiac catheterizations this month, Doc. The bottom line needs help." Can't happen?

Well, it has happened, when physicians and hospitals get too cozy. Force physicians to work for hospitals, and it will happen a lot more often.

The hidden agenda of the single payer proposal seems to be control of the whole system. Actually, it's not all that hidden. The Harvard authors make a strong point that the system will allow all resources to be allocated by the government, rather than the undesirable "investor ownership." The tone of the article is stoutly socialist. "...Investor-owned firms have defrauded Medicare and been implicated in other illegal activities." Charming. All those "investor-owned" hospitals would just be bought out by the government. Nationalization was the old term. I'm not sure what the current euphemism is.

Non-profit hospitals wouldn't be bought out. If you're a non-profit, like a majority of hospitals today, your operating expenses and your capital equipment budget will be controlled by the government. Every health care facility would have to submit its operating and capital budget for approval, because all of its patient care income would come from the NHI. Need a new x-ray machine? Nope. How about starting a new cancer program? No money. Want to build a new hospital? Well, maybe. Representative Cash is facing a tough re-election campaign. If you put the new facility in his district, we'll approve it. You say that's not where the facility is needed? Too bad. Denied.

Practicing physicians would have their choice between capitation and fee-for-service. The latter would be something like the present Medicare system, in which fees are set centrally. There would be no room to adjust them for increased expenses. The article refers to "the inflationary potential of fee-for-service practice," including "limiting the supply of physicians, monitoring for extreme practice patterns, setting overall limits on regional spending for physicians' services." There is a lot of talk about "global budgeting" and the like. It sounds like a bureaucrat's dream. And a physician's nightmare. As noted above, most docs would just wind up working for the hospitals.



It's challenging to defend the present system against the sort of all-out ideologically-based attack that the folks at Harvard want to make. But consider this. For the great majority of patients, who have private insurance or even Medicare, things work pretty well. The system is a long way from perfect. It's too impersonal. We – physicians and hospitals both - should be more responsive to patients' needs. We could deal better with quality issues. Medical liability suits are killing us economically. There's too much paperwork, especially in that part of the system that the government already runs. Doctors and patients are being systematically excluded from decision-making. And on and on. The system definitely needs work.

Above all, we badly need a better way of paying for care of the uninsured. What are our options? Do we even have any options? States all over the country are spending as much as they can on Medicaid, and trying to get more money out of the Federal government. The Feds are pushing back, to reduce their spending. Half of the working poor are still uninsured, and the ones that are on Medicaid are so poorly insured that most doctors and many hospitals won't take care of them. Makes you want to run around in circles, and scream in frustration, it does.

Well. That's out of my system. Actually, the problem is solvable. It's just that it's neither simple nor easy to understand. Let's consider the cost drivers in the system. Let me discuss legal barriers, insurance barriers, new technology, and system problems.

The biggest legal barrier is the medical liability system. We literally cannot estimate the amount of money wasted on unnecessary tests, procedures, and drugs that are carried out or prescribed simply to make the chart look good enough to stand a lawsuit. We call it defensive medicine.

The reason people file medical lawsuits is because they have bad results. These cannot be entirely prevented. Any given illness may turn out badly, even if treatment is entirely appropriate.

Medicine is not an exact science. But by holding doctors personally responsible for every bad result, we make each patient encounter into a possible lawsuit. Missouri has been a nightmare for physicians. Kansas is somewhat better. But even tort reform isn't enough. As long as the present system exists, it will be a major economic drag on the system. We have to find a better way to deal with bad results – and with inept physicians and careless hospitals. Some speak of a "no-fault system", sort of a workman's compensation for health care. Workman's comp isn't the world's most outstanding model, but perhaps a no-fault system would allow people who are legitimately hurt by mistakes to be made whole. It would cost a lot – but then, our present system costs a lot, as well.

It's too expensive to buy health insurance. Employer-based insurance for a family of four costs \$4,000 to \$5,000 a year. If you make less than, say, \$20,000 a year, you cannot afford it. But that's an income far above the poverty line. Even worse, if you're a small businessperson, you can't afford the time, trouble, paperwork, or expense to set up your own program for you and your employees. Individual policies are priced out of sight. We need simpler insurance, and we need association insurance. If you're a bar owner with five employees, you need to be able to go the restaurant association, and sign up for insurance.

We need to shift the burden for the small stuff back to the individual. It won't happen overnight, but we need to wean the public from first-dollar insurance, and go to better cost-sharing, with catastrophic insurance to cover the big losses. Nobody has any problem with paying the first \$200 of their auto repairs, but they scream bloody murder if we ask them to pay the first \$200 of their doctor or hospital visits. There's got to be some individual responsibility put back into the system, else health insurance simply becomes a big entitlement program, and patients don't know or care how much things cost.



New technology – and by that I include new drugs – is a major cost driver. We do things routinely today that weren't dreamed of 20 years ago. And all of them cost money. Yet, we want those new treatments, and that new technology.

Senator Clinton says disparagingly that it takes 17 years for a new development to reach practice, and she's probably correct. Yet if we speed up innovation, we may make it less expensive to develop, but we also make it more dangerous. All of us remember thalidomide, which was introduced too quickly in Europe. We can surely remove some of the bureaucratic barriers that make it cost \$800 million to develop a new drug. But some of those barriers keep us safer, as well. We have to adopt new treatments, yet we cannot do so too quickly. And quickly or slowly, new treatments cost new money. The best we can do is to recognize that health care will continue to get more expensive, and insist that the rise in cost is matched by a rise in benefits. Cancers that used to require mutilating surgery are now treated with smaller operations, x-ray, and drugs. We don't have to amputate limbs for bone tumors in most cases. That's a real benefit; how much is it worth? We need to begin to assess both the costs and benefits of innovation.

The system itself is a major problem. We haven't been able to bring full-scale information systems into medicine, for one very crucial reason. We can't afford to. Hospitals and physicians are getting squeezed so badly by low reimbursement – not least by Medicaid and Medicare - that nobody has excess capital. Make no mistake; those whiz-bang computer systems are expensive! In the long run, they'll make us safer, more efficient, more effective, and better. In the short run, they cost a lot. The insurance companies and the Federal government need to step up to the plate on this one, and work with hospitals and doctors to figure out how to pay for the systems which we desperately need.

Lastly, we need to start looking realistically at the medical problems of the poor. They are not just middle-class people who don't have money. Poverty correlates with smoking, and obesity, and violence; with high blood pressure and diabetes; with lack of health education; with adverse lifestyles.

A philanthropist once told me that what we really needed to do is to set up a medical data bank to keep track of everyone on public assistance in Kansas City, and then maybe we could start meeting their lifetime health care needs. Smacks of Big Brother, doesn't it? Yet, he was basically correct. We need a better model of health care for the poor than we have now. We need education, and outreach clinics, and neighborhood health workers, and more education. And that's as true for the rural poor as it is for the urban poor. But every time someone brings this up, the stock response is, "Oh, my God, Medicaid costs too much now!" Of course it does. We're giving episodic care in Emergency Departments. That's the most expensive way we could possibly deliver care. We have a crisis-oriented system for the poor. We think that's all we can afford right now, but it costs us in money, and in human productivity, and in human suffering.

At the end of the day, it isn't clear that all of these problems would be solved if we turned the whole thing over to the government. A lot of people believe that they would. That's self-evident to the folks at Harvard. But they're True Believers. I'm not. If I really believed that anything run by the government is automatically better than anything run by anyone else, then this would look like a great idea. But I don't. And it doesn't. We surely have problems. But a single payer system won't solve them. And yet, they have to be solved.

It is not a sign of communal well-being when men turn to their government to execute all their business for them, but rather a sign of decay...

H. L. Mencken

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REFERENCES

- [1] Franklin Delano Roosevelt, Address to the Annual Dinner for White House Correspondents' Association, March 15, 1941.
- [2] The Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the Physicians' Working Group for Single Payer National Health Insurance. JAMA 2003;290:798-805.
- [3] Fein R. Universal Health Insurance - Let the Debate Resume. JAMA 2003;290:818-820.
- [4] Clinton, R. Now Can We Talk About Health Care? New York Times Magazine, April 18, 2004. Accessed at <http://www.nytimes.com/2004/04/18/magazine>, April 18, 2004.
- [5] Editorial. Chronic Disorder. Investors' Business Daily, August 15, 2003, p A14.
- [6] Blitz R. NS Aims to Shorten Queues at Dentists' Surgeries. Financial Times; August 13, 2003. Accessed at <http://www.ft.com>, August 16, 2003.
- [7] Governor F, Gordon A. Surgery for 70,000 Patients Cancelled 'Only the Day Before.' The Sunday Telegraph, July 20, 2003. (Thanks to Dr. Felix Sabates for this reference.)
- [8] The Physicians' Working Group for Single-Payer National Health Insurance. Proposal of the Physicians' Working Group for Single Payer National Health Insurance. JAMA 2003;290:798-805
- [9] Van Way CW III. The Strength of a Really Bad Idea. Greater KC Med Bull, August, 2003, 5. Reprinted Ibid, December, 2003.

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