Voices of Medicine

By Del Meyer, MD

Speakers at the Association of American Physicians and Surgeons tackle the issues of medical care as a right, the demise of employer-based insurance, and the emergence of defined contribution.

Is Medical Care a Right?

The annual meeting of the Association of American Physicians and Surgeons (AAPS) met recently in Cincinnati. Jane Orient, MD, internist, author and Executive Director of the AAPS, opened the conference with a presentation of the basic constitutional issues of rights and privilege.

The Constitution of the United States protects natural and unalienable rights to life, liberty and property. A right can neither be created nor revoked by government.

In contrast, a privilege is an entitlement granted by government, which has the power to limit, restrict or revoke that privilege at its own discretion or whim. The government may not deprive some people of rights to bestow privileges on others.

If government grants a "right" to medical care — actually a privilege — the government has the power to ration and regulate medical care, force patients to pay for others' care, and to abrogate patients' protected rights to choose their physicians and contract for the care they deem necessary.

If medical care is a "right," then you have no inherent right to buy your own care or your own health insurance, provide or receive truly personal or confidential care, set your own fees based on value provided, practice according to your own best judgment, profit from prudent use of resources or profit from investment in drug research.

The Social Security Act of 1965 (PL89-97) Section 1801 reads, "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine." Today, there are thousands of laws, 132,000 pages of federal regulations and many written and unwritten policies that do just that.

Physicians for a National Health Plan were invited to present their point of view at the AAPS forum, but did not respond to the invitation.

Dean Clancy, a full-time staffer to the House Majority Leader, addressed the group and responded to questions by video from Washington, D.C. He outlined proposals that Congress is considering, including enrolling every child in Medicare up to age 18, then again at age 65.

Mr. Clancy also pointed out that the Robert Wood Johnson Foundation keeps increasing the number of uninsured in this country from 30 to 37 million, to 40+ million, with one estimate as high as 60 million, while the Cato Institute suggests the number is closer to 15

million.

Why Employer-Based Insurance Failed

Gerry Smedinghoff, Director of Actuarial Services for TriWest Healthcare Alliance in Phoenix, spoke concerning public versus private healthcare. The healthcare industry is the only sector of the economy that is failing, and there is nothing employers can do about it.

The categories of healthcare that have decreased in cost over the past 10 years include liposuction, breast implants and laser eye surgery. None are covered by employer-sponsored health plans; patients have complete control and responsibility for their use.

No categories of employer-sponsored healthcare have decreased in cost in the last 10 years, because doctors and patients have ignored the laws of economics in making healthcare decisions. Doctors and patients are no more above the laws of economics than pilots and skydivers are above the laws of gravity.

By defying the laws of economics, costs have increased 124 percent above the Consumer Price Index since 1957; technology is assumed to increase cost; quantity or length of stay is decreasing; time spent increases with waits for patients, physician and payment; choices are decreasing for patients and physicians; and trust is virtually nil from a patient, physician or HMO viewpoint. If laws of economics had been followed, these all would have been reversed.

We have a Jim Crow Health Care System with a privileged class and a disenfranchised class. For private goods (food, clothing, car, house, etc.), buyers chooses what they want, when they want it. No one suffers from another’s choice. With public goods (roads, laws, healthcare), no one chooses; everyone gets the same thing in the same way.

This could be called Rational Ignorance: "I don’t know; and I don’t care." There are minimal consequences if we’re talking about motor oil or soft drinks, but huge consequences when we progress to education, retirement and healthcare.

Responsibility for healthcare gradually shifted from the employer in the 1950s to the federal government in the 1960s, with Medicare and Medicaid and a Marxist labor theory of value.

Responsibility shifted to managed care in the 1970s because of the perception that physicians were irresponsible, and getting rich by keeping patients sick. People actually believed in one-stop shopping that would provide all services to all people in all places at all times at the highest quality at the best price.

Smedinghoff cited a number of historical HMO model disasters that were responsible for healthcare’s shift to PPOs in the 1980s. Healthcare was thought to be suffering high costs because of the lack of economies of scale. However, economies of scale do not work when there is no market choice by patients, no synergy (illegal in healthcare) and no savings accrued from large healthcare mergers. If economies of scale would work, then General Motors should have the cheapest healthcare costs. It doesn’t.

In the 1990s, when managed care flourished, physicians were not only considered incompetent, but even dangerous. Physicians were profiled by actuaries, accountants and utilization reviewers. However, managed care is more accurately defined as medical care managed by people who have no knowledge of medicine or contact with the patient.

This has progressed to capitation, a complete reversal in roles. Actuaries, trained in risk management, tell doctors how to practice medicine, while doctors, trained in medicine, are forced to manage risk.

Managed care causes huge inefficiencies with pre-certification delays, oversight with utilization review, inspection with retrospective case reviews and reworks with second

opinions and claims. Overproduction causes government interference with HIPAA, forcing defensive medicine and the poor design of RBRVS, CPT and DRGs.

Smedinghoff states we need simple solutions for a complex world. He suggests we tear down the wall of segregation — assign the IRC and ERISA to the dustbin of history. Transform healthcare from a public choice to a personal and private choice, and return responsibility to the patient. Just as war is too important to be left to the generals, and just as the education of your children is too important to be left to the government, your health is way too important to be left to your employer."

Restoring Private Insurance

Greg Scandlen, A Senior Fellow at the National Center for Policy Analysis, publishes a weekly newsletter, *Health Policy Week*, He feels health benefits are moving to Defined Contribution Plans, and believes managed care was based on the false premise that fee-for-service medicine was inflationary.

Many factors are forcing the change. The 25-year cost-containment effort is no longer effective due to the diversity and mobility of the changing workforce and growing regulations such as COBRA, HIPAA, PBOR, *et al*. There is increasing patient dissatisfaction, not just in the US but throughout the world. The safety net is frayed with the uninsured and increasing Medicare fiscal problems. Patients are educating themselves and managing their medical information through the Internet. Medical services cannot be managed through a single payer in the era of genome nano-technology.

As the annual rate of growth increases, is the US spending too much or too little on healthcare? The government and others think we spend too much, but the public still feels we spend far too little.

How much change is needed? Eighty percent of most countries feel we need fundamental changes in the healthcare system. The UK, Australia, Canada and the US are similar in this regard. In Canada, the 80 percent happiness at the inception of government medicine has since decreased to 20 percent. The core problem is that these systems rely on third-party payment and will ration care to patients.

Scandlen feels we must unify the consumer and the payer. We must know the costs of coverage. We need more direct pay with pay stubs. We need more choice of plans, providers and benefits. There must be equal tax treatment for non-employed insured. There must be better information, now feasible through the internet, that should also integrate resources, as well as allocate spousal benefits and tax credits with more accountability to both plans and providers.

We must move to individual ownership, allowing employers to contribute to individual premiums with portability and continuity of care. There is less need for regulation. We must reform insurance market regulations, roll back state mandated benefits, rate restrictions and repeal the premium tax. There has to be public policy change, including an expansion of MSAs.

The worst conservatives are those on Capitol Hill who only think of modifying the liberal agenda. They have nothing unique or original to contribute. In short, we must develop a new way of thinking about financing healthcare.

The Rest Of The Story

That was just the first half day of a three-day meeting. Other presentations were equally informative. One was by Jim Redden, an investigative reporter for the *Portland Tribune*, and author of the chilling book, *SNITCH CULTURE — How Citizens are Turned into the Eyes and Ears of the State*. A review of this book will appear in an upcoming issue.

Sally Satel, MD, a psychiatrist and author of the *PC, MD — How Political Correctness is Corrupting Medicine*, also gave a presentation. Her book was reviewed in the

September/October 2001 issue of this journal. You can review the rest of the story in the electronic journal at www.HealthCareCom.net.

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