



A Disingenuous Debate on Health Care Policy



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THE POLITICIANS' APPROACH to the health care policy debate during this presidential primary season has devolved into little more than pandering and demagoguery.

In a previously published article, we cited the now defunct candidate John Edwards using the death of 17-year-old Nataline Sarkisyan to further his political agenda.¹ Sarkisyan died on December 20, 2007, after Cigna initially denied her coverage for a liver transplant, citing insufficient evidence that the procedure would be safe or effective. Jeffrey Kang, Cigna's chief medical officer, observed that, "it is highly unlikely that any health-care insurance system, nationally or internationally, would have covered this procedure."

At the time of her death, Edwards advocated a government-run health plan open to all Americans, rather than the current private financing system. Implicit in Edwards' posturing, a government system would have paid for this and all other experimental procedures.

The public was presented a false promise. No government-based plan anywhere in the world lives up to such a grandiose promise.

In a more recent example, Senator Hillary Rodham Clinton of New York frequently featured in her campaign stump speeches the story of a health care horror.² At multiple rallies, she told the story of Trina Bachtel, a 35-year-old who managed a Pizza Hut. This woman was presented as a young, uninsured minimum-wage worker. Clinton would repeatedly say, "The story haunted me. It hurts me that in our country, as rich and good of a country as we are, this young woman and her baby died because she couldn't come up with \$100 to see the doctor."

Trina Bachtel did die last August, two weeks after her baby boy was stillborn at the O'Bleness Memorial Hospital in Athens, Ohio. However, Ms. Bachtel was under the care of an obstetrics practice affiliated with the hospital. She was asked to pay the clinic \$100 in previously owed billings but was not refused service. Furthermore, she was insured when she sought service from O'Bleness Memorial Hospital.²

Since Ms. Bachtel's baby died at O'Bleness Memorial Hospital, the story implicitly accuses that hospital of turning Ms. Bachtel away. However, the O'Bleness health care system did treat her, both at the hospital and at the affiliated River Rose Obstetrics and Gynecology practice.

O'Bleness Memorial Hospital has now gone on the record. "We reviewed the medical and patient account records of this patient," said Rick Castrop, the health system's chief executive, and any implication that the system was "involved in denying care is definitely not true."

Her campaign acknowledged that Clinton frequently retells stories relayed to her by third parties. However, vetting them was not always possible.

In this case, a spokeswoman for the O'Bleness Memorial Hospital said the Clinton campaign had *never* contacted the hospital to check the accuracy of the story. The Clinton campaign subsequently withdrew this story from future campaign speeches but did not apologize for prior inaccuracies.

Neither of the above would pass muster with the most junior reporter in a credible news organization.

Why is this deliberate use of unverified information so dangerous? It produces an inaccurately informed voting public that becomes biased against the current private based system. Comparing an imperfect present system with a "perfect" future system is counterproductive.

This disinformation influences the full spectrum of the voting public. For example, in a 2004 survey in *Archives of Internal Medicine*, more than half of U.S. doctors indicated that they favor switching to a national health care plan and less than a third oppose the idea.³ Of more than 2,000 doctors surveyed, 59 percent said they support legislation to establish a national health insurance program, while 32 percent were opposed.

These data represent a dynamic change from past findings. For example, in a 2002 survey by the same authors at the Indiana University School of Medicine, 49 percent of physicians supported national health insurance and 40 percent opposed it.

How well does a single payer system perform when compared to our current system? Furthermore, how happy will American physicians be if such a single payer system is adopted?

The answer to these difficult questions depends upon the data used to reach an opinion. Generally positive outcomes data for the Canadian system relates to overall system costs not outcomes.

Furthermore, how would doctors feel about working within a national health care plan if they understood that most of the cost and, therefore, the savings differentiating the Canadian and the American systems relates to differentials in labor costs? Canadian health care workers (including doctors) earn approximately half the amount their counterparts earn within the American system.

The following data, relating to performance and outcomes, are taken from a 1991 National Bureau of Economic Research study.⁴ The percent of middle-aged Canadian women who have never had a mammogram is double the U.S. rate. The percent of Canadian women who have never had a pap smear is triple the U.S. rate. More than 8 in 10 Canadian men have never had a PSA test, compared with less than half of U.S. men. More than 9 in 10 Canadians have never had a colonoscopy, compared with 7 in 10 in the United States.

These differences in screening may explain why U.S. cancer patients do significantly better than their Canadian counterparts. The mortality rate for breast cancer is 25 percent higher in Canada. The mortality rate for prostate cancer is 18 percent higher in Canada. The mortality rate for colorectal cancer among Canadian men and women is about 13 percent higher than in the United States.

Furthermore, among senior citizens, the percentage of Canadians with asthma, hypertension, and diabetes who are not getting care is twice the rate in the United States. The fraction of Canadian seniors with coronary heart disease who are not being treated is nearly three times the U.S. rate.

The advantage that any underperforming single payer system has over the private competitive model is the ability to dictate the fee providers can charge for health care.

Furthermore, such a system can influence utilization by limiting the supply of high cost services. Canada limits the availability of diagnostic and therapeutic modalities along with the availability of hospital beds.

In the future, we may well discover that a single payer approach to financing health care will prove to be superior to our present competitive system. Likewise, we may find that expanding Medicare to all individuals reduces administrative overhead and better serves the needs of the American people.

However, should we elect to move away from the current model for health care financing and adopt a new system, we will discover that reforming the way we *pay* for health care is infinitely easier than actually reforming the health care *delivery* system itself.

The health care policy debate is one of the most important discussions we are now having within the public forum. Health care represents one-seventh of our economy. The infusion of deliberately misleading information by the presidential candidates ill serves the debate. Setting an unattainable level of performance by an alternative financing system against the emphasized shortcomings of our imperfect present system is intentionally misleading. Furthermore, the public's cynicism towards government will only grow when the new system does not meet the unrealistic expectations put forward by politicians today.

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1. "The Case Against Health Care Reform," *Sierra Sacramento Valley Medicine*, March/April 2008.
2. "Ohio Hospital Contests a Story Clinton Tells," *New York Times*, April 5, 2008.
3. "Single-Payer National Health Insurance," *Archives of Internal Medicine*, Vol. 164 No. 3, February 9, 2004.
4. "The Evolving Canadian Landscape," *International Journal Of Canadian Studies*, Fall, 1991.

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