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Stay Healthy: Government Healthcare May Be Coming

If they had been designing a health system from scratch, the change agents assuming power in January would have done things differently. Barack Obama and Ted Kennedy would have given us a Single Payer for medical care, as in Canada and Britain (and Cuba and North Korea) and (according to national healthcare promoters) "the rest of the industrialized world." Senate Finance Committee Chairman Max Baucus (D-Mont.), on the other hand, doesn't feel he needs to go so far back in time, but he'd make similar changes nonetheless. In his *Call to Action: Health Reform 2009*, he speaks of failed efforts to enact "national health insurance" or "socialized medicine," starting around the turn of the last century, in 1900. It's finally time to just get it done, they say.

The motive behind their efforts, they also say, has to do with about 46 million uninsured Americans. But the politicians' plans are not just about insurance, which is only a method of payment for medical services. The real agenda is to use "coverage for all" as a lever to make fundamental changes in the way patients are treated — and in the economy and society as a whole. This is evident to anyone who listens carefully. Obama, Kennedy, and Baucus are talking about *universal health reform*, or what Baucus calls "serious and comprehensive reform of the *health system* in crisis."

This is also evident if one analyzes the "insurance" model they have in mind to follow — Massachusetts' healthcare plan, which boasts of achieving universal coverage, or almost, by forcing most people to buy insurance or face a tax penalty, or, if eligible, to enroll in a government-subsidized plan. "Progressives" like the plan for several reasons. In particular, young and healthy patients would be forced to pay more to subsidize older, sicker patients. (It plays off the Obama "wealth redistribution" idea.) Instead of pricing premiums according to risk, insurers would have to accept all comers, and charge them all the same. This changes the nature of the product from insurance, which is about the accurate pricing of risk, and turns it into a collectivized prepayment system. Welfare, in other words. Premiums become a type of privatized taxation — a neat way of sidestepping protests about tax increases.

What We're Promised

Obama has promised to allow people to keep the insurance plans they have if they like them. Their plans, however, might no longer exist because they might not measure up (likely won't measure up). The plans won't pass muster if they allow a person to benefit from good health and a prudent lifestyle, and not "contribute" enough to the collective pool. But if your plan can no longer be offered, don't worry; a proposed insurance exchange, like the Massachusetts Connector, would match people up with a "high-quality, affordable, comprehensive, nondiscriminatory Health Plan." Insurers may go along with the scheme in exchange for a guaranteed market: 46 million new customers overnight! And individuals would have to buy a product they might otherwise reject as being unnecessary or too expensive. Obama

promised to delay forcing the plan on Americans until insurance becomes "affordable" — by the government's definition, not necessarily the customer's — but he may well accept the demands for mandates.

Obama and friends also promise that they will ensure that providers deliver quality care — better care than we have now. The reformers claim that at the present time the United States spends much more than other countries but still has worse health outcomes. They claim to know this because rankings made by the World Health Organization place U.S. medical care below most other developed countries — far below most socialist countries. In the WHO ranking, France has the best medical care, Italy came in 2nd, the United Kingdom was in the 18th spot, Saudi Arabia 26th, and Canada 30th. The United States came in 37th, just above Cuba (in 39th place). The politicians don't state (or don't know) that the WHO rankings are designed to place a much higher value on "equitable" access and less value on satisfying consumers' desires. In fact, if everyone in a country received poorer medical care than people in the United States, but care was "universal," it could rank higher than the United States. (See "Bad Economics & Medicine" in our January 5, 2009 issue for a more detailed explanation of the WHO rankings.)

And finally, we're also promised savings through nationwide investment in an electronic office management system for doctors' offices. A critical feature of reformed healthcare will be interoperable electronic health records. This "modernization" of the system is supposed to save tens of billions of dollars, at some point, after a hefty initial investment. But its main purpose is to monitor and enforce standards for quality, "medical necessity," reduction of "disparities," and proper billing and coding.

Wrong Diagnosis and Prognosis

The new blueprint will fail for the same reason that the system is already failing: it is really the same old blueprint that violates the basic laws of economics. When the apparent price of something, including medical care, goes down, as because of subsidies, demand goes up. If one is not charged for medical care based on one's level of health and one's number and length of visits to a doctor, one will be more inclined to visit the doctor more often. Collective prepayment drives demand even more, as people who are forced to pay for excessive insurance try to get their money's worth. This causes increased waits for medical appointments and spotlights the biggest problem. As in Canada, there are not enough physicians or facilities to meet the burgeoning demand for "free" services. To get into the "system," you need a primary care physician. In Massachusetts, the first available appointment may be a year away, if you can find a doctor in your area who is accepting new patients.

Exacerbating the shortage of doctors is the fact that when the price of something goes down, there is no incentive to increase the supply (lower payments mean fewer people become doctors). If the price doesn't cover costs and allow some profit, supply dries up completely. Under such a scenario, lines form at gas pumps; grocery shelves empty overnight; and doctors become scarce.

Doctors' Medicare fees have been restricted since the 1980s — and most managed-care arrangements are linked to Medicare. There still are some nice cars in the doctors' parking lot. Some specialist fees are still very high. Many physicians made out very well in earlier years. But contrary to the rhetoric from Rep. Pete Stark (D-Calif.) and other politicians, many physicians are already struggling to make ends meet. Especially in primary care. This is already reducing the number of people entering the medical field, and the planned new restrictions on medical care will make the situation worse. In the past decade, the number of U.S. medical graduates entering family medicine and internal medicine has fallen by half. And it's not just the money. Time pressures and increased demands for administrative

work contribute to burnout: "I felt like I was becoming a guideline-following automaton and a documentation drone," said general internist Christine Sinsky, quoted in a November 27, 2008 article in the *New England Journal of Medicine*.

Incentives work, but letting patient demand set prices is not in the reformers' toolbox. They just want to redistribute the pain. As Baucus admits, his plan would revise Medicare's payment formula so as to redistribute resources from "high-growth, potentially overpaid aspects of health care to underutilized, potentially more valuable services, such as primary care and prevention." This means that "some specialists might take bit of a nick." It's part of a pattern: more healthcare, less sickness care.

And increased demand for "free" services means increased spending — unless rationing is instituted. Some cost data are available. In Massachusetts, the cost of "universal" care was immensely more than anticipated and annual state spending could top $1 billion by the end of this year, but then Massachusetts knew it was not addressing the cost issue. To try to avoid rationing care, one answer has been put forth: the group appointment, like those offered by Harvard Vantage Medical Associates (HVMA). Patients can get in to see a doctor much sooner if they are willing to share their appointment time with about eight other patients. They all sit in the same room for about 90 minutes while a doctor goes from patient to patient examining them. About 80 percent of patients say they are satisfied with the arrangement; some seem to value being in the same room with the doctor for 90 minutes, even if he is not attending to their individual needs during most of that time. The doctors like it too; they get paid for nine individual visits, instead of the four to six they would otherwise be able to wedge into 90 minutes.

A video of a group appointment, posted on the *Boston Globe* website, is a vision of the new system. Dozens of comments about the video and its accompanying article show the deep divide between those who favor the radical "change" and those who are appalled by it. As one person commented to the *Boston Globe*, "I think that as a nation we need to move *away* from rampant individualism toward a system that embraces shared responsibility in a community. You are more likely to follow those pesky lifestyle recommendations if you feel like you'll not only be letting down yourself and your doctor, but also your community."

"It's a third-world standard of care," wrote another disparagingly.

The group appointment is about the *health* of society, the collective. The patients in the *Globe* video all look pretty healthy. Examination of fully clothed people sitting up on folding chairs in a noisy room is not likely to reveal any signs of illness that are not flagrant. The main activity is not the doctor listening to hearts and lungs, but patients listening to the doctor's canned speech about smoking, diet, exercise, and taking all the prescribed drugs. This is not sickness care, which the reformers deplore and that doctors go to medical school to learn how to do. It is not about understanding the individual patient and his illness. It is not about making a complex diagnosis. It is not about personalizing and optimizing therapy in accordance with the patient's needs and priorities. The group visit is for standardized patients with a standardized diagnosis. It's about "education," peer group pressure, and compliance with a cookie-cutter protocol handed down by an expert committee.

It's what reformers mean when they aim to change our priorities to wellness and prevention. The sick are a burden; providing them too much attention could come to be seen as antisocial. "Universal care" might move the United States up in the WHO ranking system, which places a very high value on "equity," and a much lower one on individual patient satisfaction. It would stimulate certain areas of the economy: the provision of information technology to monitor wellness, the expansion of wellness clinics,

and perhaps the birth of a whole new industry like the already existing one in Canada to manage ever-growing waiting lists for *sickness* care. But it wouldn't mean taking better care of people with health ailments.

Enduring Myths

In its entirety, the new plan not only flaunts basic economic principles, it defies observable evidence. Each major premise behind the plan's design is based on fallacious statistics or idealistic desires that show little likelihood of being obtainable.

Prevention: The reformers imply that the sickness-care system will simply wither away when we are all healthy. Baucus enthusiastically quotes Robert Beaglehole, the World Health Organization's director of chronic diseases and health promotion, in claiming that an estimated 80 percent of heart disease, stroke, and type II diabetes, and 40 percent of cancers, could be prevented if Americans stopped smoking, adopted healthy diets, and became more physically active.

However, there has never been a real-life program anywhere that induced a population of previously smoking, sedentary, fat patients to reform and demonstrated such an enormous drop in disease. Leaving aside public-health engineering projects such as sanitation systems, preventive health measures, though valuable, usually do not save more than they cost. The British were long ago promised that once socialized medicine had met all the pent-up demands, and all the prevention programs were in place, costs would go down, and there would be much less sickness. More than 60 years later, people still get sick in the UK and wait years for treatment. The National Health Service never has enough money. And no one learns from the experience.

The uninsured: Then there's the promise that costs will go down if we can just insure everybody and thereby keep people out of expensive emergency rooms. In Massachusetts this hasn't worked because to get in to see the correct doctor to cure their ailments, patients first need to see a primary doctor, and they can't get an appointment. So newly insured patients still go to the emergency room for every medical need, including regular prescriptions.

The constantly repeated assertions about ER abuse, in any event, turned out to be wrong when subjected to scrutiny. An analysis published in the October 22/29, 2008 issue of *JAMA* (The Journal of the American Medical Association), which looked at 127 studies, showed that six commonly held beliefs about the uninsured and emergency room use were either unsupported by evidence, or equally true of both insured and uninsured patients. The uninsured were actually under-represented among patients using the ER for primary care — probably because they were concerned about the cost. And the claim that huge cost savings could be achieved merely by keeping more primary clinics open during off-hours — reducing ER visits — isn't true either. ERs do charge more – but the actual marginal cost per patient is likely to be no higher than that of keeping a primary-care clinic open after hours.

The uninsured have become scapegoats. Costs are so high, the argument goes, because "we all" are paying to take care of the selfish freeloaders who don't buy insurance. We pay through taxes (such as for Medicaid) and higher insurance premiums (because providers shift unpaid costs). That's true to an extent. Large amounts of cost-shifting happen when people abandon private insurance for Medicaid (public insurance). But those people who are truly uninsured (no private or public insurance) often *do* pay taxes (except for a substantial proportion of illegal aliens and those people deemed by the government to be "poor" — who usually shift to public insurance) but arguably not their fair share.

About 40 percent of people in the United States either pay no federal tax at all or they actually get

money from the government as an Earned Income Tax Credit. Some of them use medical care (less care than insured people use), and some of them don't pay their bills. There is some cost shifting from people who don't pay for insurance to people who do, just as honest shoppers pay for shoplifters, but not much. The amount: 2.7 percent in 2004, according to the Kaiser Commission on Medicaid and the Uninsured. Of the uninsured with incomes at least twice the poverty level, 8 percent received some pro bono care during a year, and 50 percent received care for which they were charged. Of the latter, 80 percent paid in full, and another 10 percent were paying in installments, according to William Snyder in a November 21, 2008 article in the *Wall Street Journal*. The real problem with these folks, as reformers might view it, is not that they don't pay for what they use (they usually do), but that *they don't help to pay for what other people use* — except through taxes and the higher prices they are often charged.

Unmentioned by the reformers is the fact that government causes *far more* cost shifting than do the uninsured because of underpayment to doctors and hospitals by the price-controlled government systems, Medicare and Medicaid. Medicare and Medicaid often only pay cents on the dollar toward the actual cost of care given to patients, forcing many doctors to make this money back by charging more to patients who have private insurance — and to the uninsured who pay their own bills. This fact raises the obvious question of what health institutions would do if there were no private sector to shift costs to.

The Obama/Kennedy/Baucus solution to the "uninsured problem" appears to be this: for the uninsured who can't pay big bills, require them to sign up for Medicaid — or for a subsidized "private" prepayment mechanism — so we all pay for them constantly, and not just when they become sick. For the uninsured who can pay, force them to *pre*pay — for care they might or might not use — through insurance premiums.

Information technology: The reformers' favorite panacea is health information technology. Obama promises to "make sure that every doctor's office and hospital in this country is using cutting edge technology and electronic medical records so that we can cut red tape, prevent medical mistakes, and help save billions of dollars each year."

The savings, however, are all hypothetical, long-term savings, and they are mostly destined for the insurance companies and government entities that are paying the bills. Converting a medical office to electronic records is extremely costly and disruptive. The cost in terms of diminished productivity continues for years, and is possibly permanent. Anything that slows patient flow is, of course, an advantage to payers (fewer patients, fewer payments). Arguably, electronic medical records introduce more new errors than they prevent — and errors may be impossible to expunge.

It may seem counterintuitive to say that improved technology will cause more medical errors, but it's true because computer program designs, the programming, or the inputting of data can all cause errors. The December 11 *Sentinel Event Alert* released by the Joint Commission on Healthcare (operating experience and lessons-learned information from the U.S. Joint Committee on Accreditation of Healthcare Organizations) includes statements such as: "Technology-related adverse events in health care can involve, but are not limited to, computerized provider order entry (CPOE), automated dispensing cabinets (ADCs), electronic medical records (EMRs), clinical decision support (CDS), bar coding or RFID (radio frequency identification), virus threats to information security, CT (computed axial tomography) scanning technology, and the loss of patient data." Patient privacy, of course, is inevitably sacrificed. The real effect of electronic records is to enable intrusive monitoring of every aspect of the patient-physician interaction.

We have much more experience with computer disasters than successes in medicine. Rollout of the £12

billion flagship centralized Cerner IT system of the British National Health Service was halted because it was "hugely expensive," "desperately behind schedule," and a "shambles from the start." Suppliers were "deserting in droves." Frontline professionals were "voting with their feet." Before investing billions, why not learn from experience — preferably other people's experience.

Medical errors: Medicine would be both cheaper and better, of course, if doctors always did the right thing for their patients, both in the way of treating them and in giving illness-prevention advice. Toward this end, the reformers plan to save money by making doctors follow strict guidelines for care. But "proven" disease-management systems exist only if we accept authoritative opinion in lieu of actual evidence.

In a system that permits research and innovation, opinion changes about every five years concerning best practices to care for patients. By following government guidelines, we can be sure that patients will be given outdated care regimens. Even a simple government direction, such as making sure a certain test is done, and recording the results, can prove problematic. If we measure certain processes, like obtaining recommended tests, we may show an increase in the number of patients getting those, but even such a seemingly innocuous mandate would change the allocation of resources and affect some medical function that is not being tested. On the items that we don't measure, such as the activities from which effort is shifted to meet the new goals, we won't know the effect, because we won't measure it. Perversely, unimportant things are generally much easier to measure than important things.

What Should Be Done?

Reformers claim that whatever the cost of implementing the new plan, it can't be higher than the cost of not doing anything. Baucus warns that "we" will soon be spending $4 trillion on healthcare if we don't *do something*. The answer to those who say we can't afford to do it? We can't afford *not* to!

Progressives always have a plan and, when they are told their plan won't work, demand that opponents have a plan that's better and more inclusive than the progressive plan. So this is the plan: as Hippocrates would say, "First, do no harm." Not jumping off a cliff is always a good first step, whether that cliff be real or metaphoric, as in government control of medical care. Recognize that health reformers like Obama, Kennedy, and Baucus are not just making empty promises. They can indeed deliver universal "health *coverage*." But it will be at the expense of sickness *care*. We've all heard of the military's excuse that they had to destroy the village in order to save it. The Obama/Kennedy/Baucus ploy is to pretend to save the system in order to wreck it, to put additional money and power into the hands of politicians. (Those politicians who are for the new plan, but who don't see it for the ploy it is, really need to brush up on their research skills or get into another line of work.)

Second, realize that America needs to undo much of what the government has already done – to go back to the free market. A free-market solution is never one, universal solution. It is the sum of millions of individual decisions. Allowed freedom, individual decision makers would unleash creative destruction on much of the current system. To allow a solution that is likely to exceed all expectations, and to reduce costs dramatically, it is only necessary to remove the barriers. Some suggestions, for starters:

• Stop all tax discrimination against individually owned sickness insurance. The present system gives tax breaks to companies that provide insurance to employees, but workers who pay for their own insurance get no such deduction. This causes insurance companies to be unresponsive to providing inexpensive insurance for individuals, and it means insurance is tied to a job instead of being portable

between jobs.

• Allow individuals to purchase sickness insurance across state borders, to avoid costly mandates by states. State governments create lists of services that insurance companies must cover, including non-illness-related things such as in vitro fertilization. The *Washington Times* wrote: "A health policy for a single Pennsylvanian costs roughly $1,500 annually. Cross the Delaware into New Jersey … and a similar health plan costs about $4,000, thanks to state regulations."

• Expand health savings accounts by removing regulatory barriers so that Americans can pay for medical bills with before-tax money.

• End Medicare price controls. Allow patients and physicians to contract for mutually agreeable fees. Medicare can compute its reimbursement by any mechanism it chooses, but that should not determine the fee. This would also have the effect of drastically reducing physician overhead by removing the costs required primarily to justify Medicare's price-controlled, coded fee.

• Repeal the McCarran-Ferguson exemption that permits insurance companies to engage in behavior prohibited to other industries by antitrust law. (Insurance companies can form giant conglomerates that fix prices and make it impossible for competitors to enter the marketplace.)

Much more could be added. But the one-sentence answer is to put patients back in control of their medical dollars and their medical decisions. In a free-market system, prices would be much lower, and patients would have much broader choices. If they had more money in their own pockets – having given less to their insurer – more people would opt for less expensive, less toxic, possibly more effective treatments that insurers have historically refused to cover. Self-insurance for all but the most catastrophic expenses would be very common. There will always be a role for charity and social safety-net programs, but the neediest will be better served by programs targeted to their needs rather than demolishing the ship and giving everyone no choice but to cling to the wreckage.

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