Downgrading American Medical Care

An American plan to help the uninsured, restore Medicare's fiscal soundness, and preserve medical excellence.

By Betsy McCaughey

THE HEALTH PROPOSALS TAKING SHAPE in the nation's capital intend to do more than help the uninsured. The changes will affect everyone. Politicians have promised that if you like your health plan, you can keep it. That may be true, but when you're sick and need care, you'll get a lower standard of care.

President Barack Obama called on health industry leaders to cut the rate of growth in national health care spending by 1.5 percentage points each year. Curbing medical spending will force cuts in hospital budgets, spread nurses even thinner, and reduce the number of diagnostic machines available, causing waits for treatment. Slowing the flow of dollars into health care will also depress the largest growth industry in the U.S. (17 percent of GDP) and cause layoffs. Health care currently employs 14 million people, more than ten times the U.S. workforce at General Motors and Chrysler.

In his weekly radio address June 6, the President claimed "skyrocketing costs" were making it impossible for families to afford health care. Secretary of Health and Human Services Kathleen Sebelius was right on message, warning a women's group about the same "skyrocketing costs." Senators Edward Kennedy and Max Baucus, chairmen of two committees drafting proposals, warned that soaring health spending threatens the stability of American families and the economy.

These doomsday scenarios are untrue. Health care spending is increasing at more moderate rates than in previous decades. Spending increased 10.5 percent in 1970, 13 percent in 1980, and consistently less than 7 percent in each of the last five years, reaching a low of 6.1 percent a year ago (see chart 1).

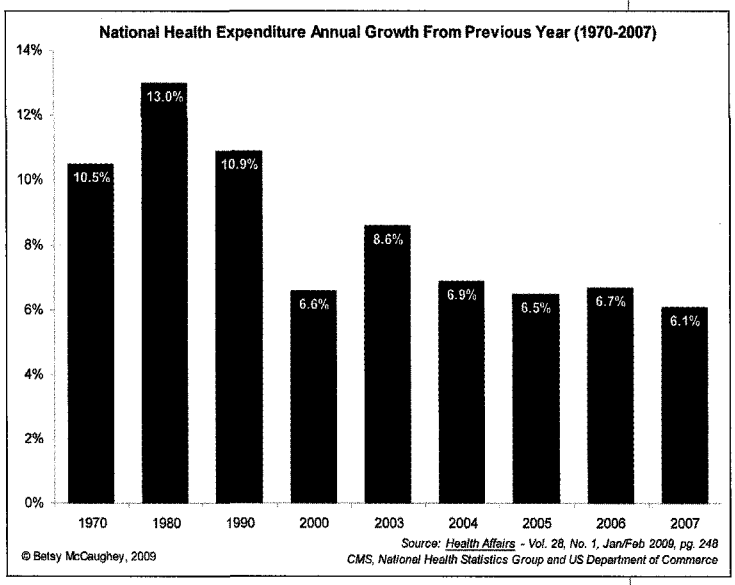


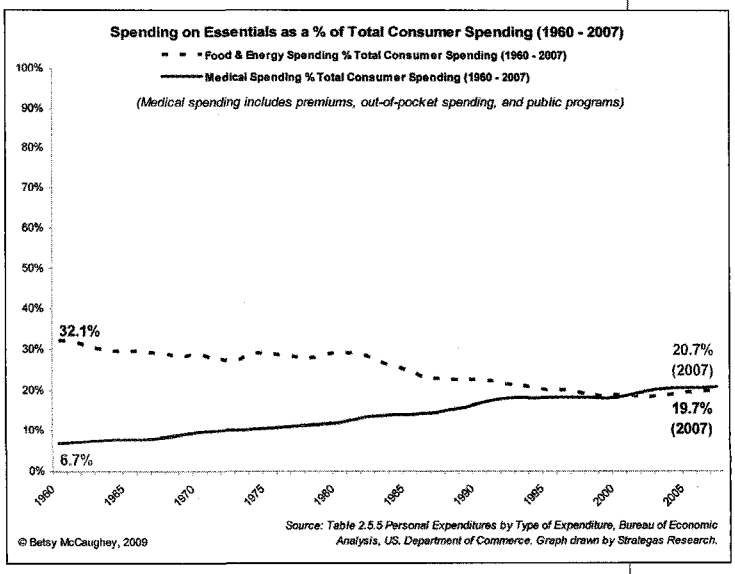
Chart 1

Americans Can Afford Excellent Health Care

EACH YEAR SINCE 1960, food and energy together have taken up a declining share of Americans' expenditures, while housing has taken up a steady share. This has enabled Americans to spend an increasing share of their budgets on another necessity, health care. These four necessities together consume the same share of Americans' spending now (55 percent) as they did in 1960 (53 percent). As further evidence, Americans are increasing the share of their spending that goes to recreation.

Of course, averages don't tell the whole story, and families who can't afford health insurance should be helped. The poorest Americans are already eligible for Medicaid and other government programs. As you will read later in this article, moderate income families can be helped to buy health coverage with vouchers, refundable tax credits, or debit cards. That's a low risk, "fix what's broken" approach.

On June 1, the president's Council of Economic Advisors released a report calling for Americans to cut back on health care. The report pointed to the skimpier health-care consumption in Europe and urged Americans to copy it. But the truth is, Americans can afford better health care than Europeans. Ninety percent of the difference in per capita health-care spending between Europe and the U.S.



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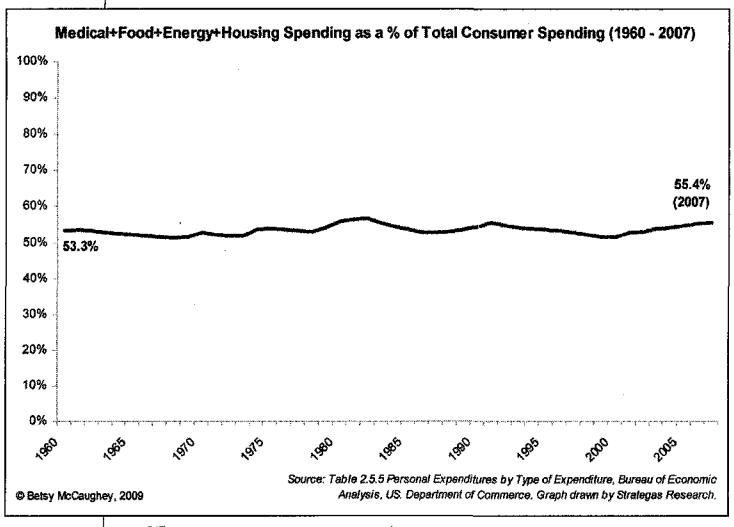

Chart 3

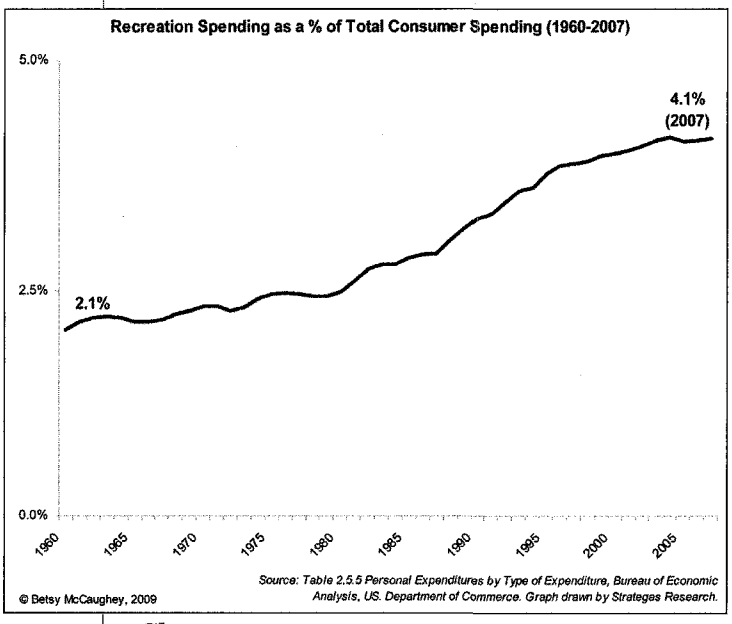

Chart 4

is due to higher incomes in the U.S. Wealth, not waste, accounts for the difference. What Americans cannot afford is a health-care overhaul based on bad information.

President Obama's health advisors are telling us we cannot afford our current standard of care. They have a different agenda.

A Lower Level of Care

DR. DAVID BLUMENTHAL, a Harvard professor and key health advisor to President Obama, agrees that "the more people have, the more of it they tend to spend on health care." But the problem he sees is that as a nation's wealth increases and standards of medical care become higher and more costly, the lowest income groups get priced out. In his extensive academic writings, Blumenthal argued that government controls are needed to push down health care costs (and by inference, standard of care) to a level that everyone, including the poor, can afford, or to what government can afford to provide to everyone equally. The goal is not only universal coverage but also a similar health care experience for everyone, regardless of ability to pay (*New England Journal of Medicine*, March 8, 2001).

Dr. Blumenthal conceded that "government controls on health care spending are associated with longer waits for elective procedures and reduced availability of new and expensive treatments and devices." But he called it "debatable" whether the timely care Americans get is worth the higher cost.

Ask a cancer patient and you'll get a different answer. Delay lowers your chance of surviving cancer. Women in the U.S. are more likely to have regular mammograms than in other developed countries, according to the Commonwealth Fund. Their breast cancer is detected sooner. They are also treated faster and have higher survival rates, according to the Concord 2008 Five Continent Study. The figures reflect all American women, not just those with insurance.

Another key administration figure committed to cost cutting is Dr. Ezekiel Emanuel, a health policy advisor in the Office of Management and Budget and brother of Rahm Emanuel, the president's chief of staff. Dr. Emanuel says that the usual recommendations for cutting costs (often urged by President Obama) are window dressing: "Vague promises of savings from cutting waste, enhancing prevention and wellness, installing electronic medical records, and improving quality are merely 'lipstick' cost control, more for show and public relations than for true change." (*Health Affairs*, February 27, 2008.) Dr. Emanuel is right. A December 2008 Congressional Budget Office report confirms that none of these pain-free strategies will yield much savings.

True change, writes Dr. Emanuel, must include reassessing the promise doctors make when they enter the profession, the Hippocratic Oath. Amazingly, Dr. Emanuel criticizes the Hippocratic Oath as partly to blame for the "overuse" of medical care: "Medical school education and post graduate education emphasize thoroughness," he wrote. Physicians take the "Hippocratic Oath's admonition to 'use my

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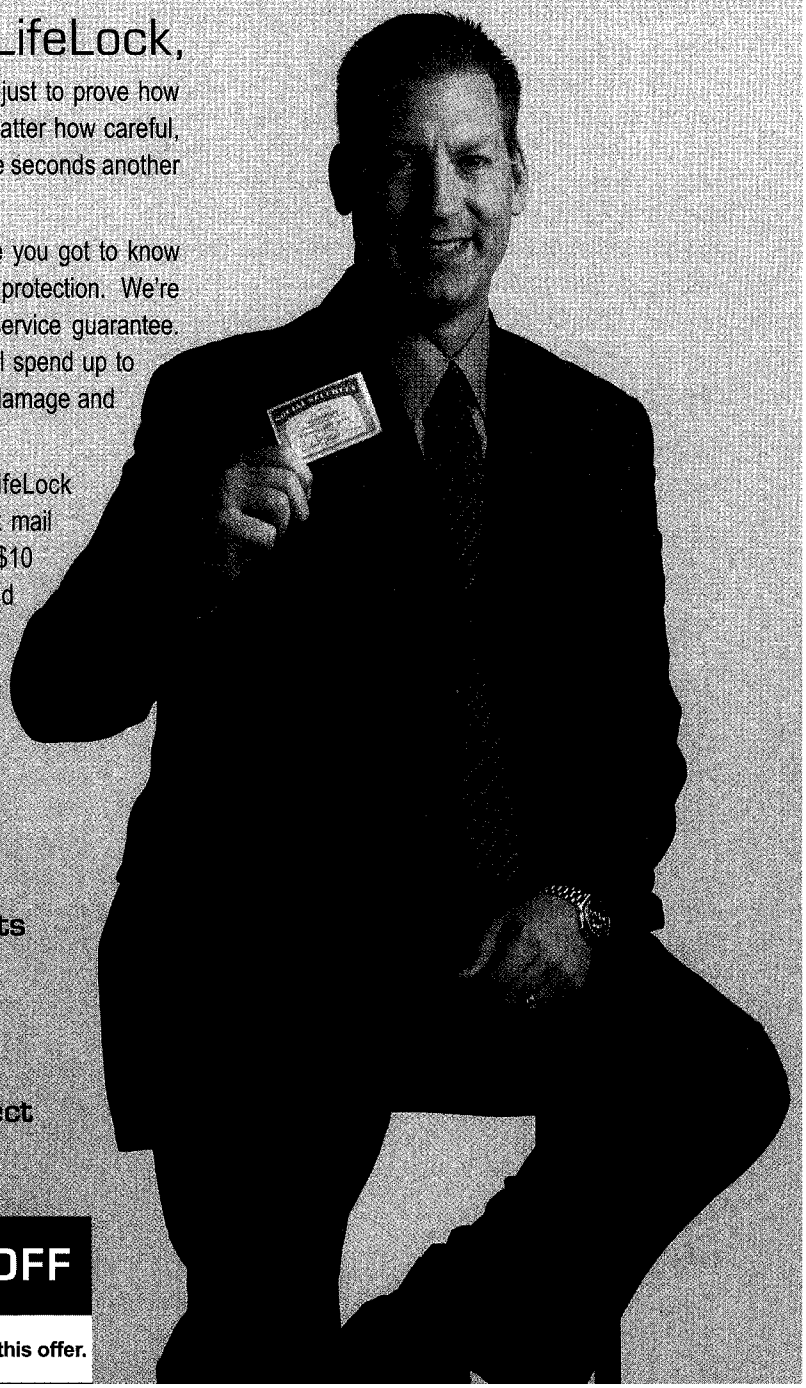

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power to help the sick to the best of my ability and judgment' as an imperative to do everything for the patient regardless of the cost or effects on others." (*Journal of the American Medical Association,* June 18, 2008.) Of course that is what patients hope their doctors will do.

But Dr. Emanuel wants doctors to look beyond the needs of their own patient and consider social justice. They should think about whether the money being spent on their patient could be better spent elsewhere. Many doctors are horrified at this notion, and will tell you that a doctor's job is to achieve social justice one patient at a time.

To control spending as President Obama promises, doctors will have to be instructed to provide less care. Government controls are a blunt instrument. RAND reported that Canada posts lower rates of cardiac procedures than the U.S. almost entirely by restricting their use for patients age 65 and older—the time of life you're likely to need it.

Dr. Emanuel also blames high U.S. spending on standards Americans take for granted. "Hospital rooms in the United States offer more privacy... physicians' offices are typically more conveniently located and have parking nearby and more attractive waiting rooms." (*Journal of the American Medical Association,* June 18, 2008.)

The administration's health advisors would like to see a European-style government-controlled environment of medical scarcity. Do Americans want to copy Europe?

Stimulus Legislation

PART OF THE FRAMEWORK for such controls was slipped into the stimulus legislation signed into law by President Obama on February 17. The legislation sets a goal that every individual's medical records will be entered into an electronic data system. More importantly, your doctor will be guided by electronically delivered protocols on what is "appropriate" and "cost-effective" care. Doctors who are not "meaningful users" of the system begin facing financial penalties in 2014. Patients insured by Medicare and Medicaid will be affected first, because the penalties are imposed by these programs. But private insurers historically have followed Medicare's lead.

How much leeway will doctors have? That's hard to say, because the legislation gives the Secretary of Health and Human Services total discretion to define "meaningful user" and to make the definition "more stringent" over time.

Medical knowledge is evolving so quickly that helping doctors keep up by delivering information on best practices would be beneficial. But telling doctors what to do for the sake of cost control in dangerous. The RAND Corporation, a nonpartisan research organization, found that often physicians did not give patients the optimal treatment for their condition. But over-treating patients was seldom the problem (only 11 percent of the time). Failing to give patients a needed treatment was four times as big a problem (46 percent of the time). That's why prompting doctors to do the right thing will help patients but not curb spending.

Dr. Blumenthal agrees: "Improved medical decision making is as likely to increase expenditures for underused services as it is to reduce expenditures for overused services." (*New England Journal of Medicine,* 2001.) To control spending as President Obama promises, doctors will have to be instructed to provide less care. Government controls are a blunt instrument. RAND reported that Canada posts lower rates of cardiac procedures than the U.S. almost entirely by restricting their use for patients age 65 and older—the time of life you're likely to need it.

In March, President Obama appointed Dr. David Blumenthal to head the system of computer-guided medical care as the National Coordinator of Health Information Technology. Just days later, Dr. Blumenthal settled a debate on whether the system will control doctors' treatment decisions. In an article in the *New England Journal of Medicine* (April 9, 2009), Dr. Blumenthal stressed that the real importance of computers is to deliver "embedded clinical decision support," a euphemism for computers telling doctors what to do. He predicted that if controls are too tight, physicians may resist the government encroaching on their treatment decisions: "many physicians and hospitals may rebel—petitioning Congress to change the law or just resigning themselves to...accepting penalties." Dr. Blumenthal's

latest article corrects CNN's Elizabeth Cohen and FactCheck.org's Lori Robertson, who insisted incorrectly that nothing in the stimulus legislation indicated "the government is going to tell your doctor what to do."

Also slipped into the emergency stimulus legislation was substantial funding for a Federal Council on Comparative Effectiveness Research, a board with a troubling mission. Studying which medication or device works best is obviously a good thing, but comparative effectiveness research is generally code for limiting care based on the patient's age. Economists are familiar with the formula already in use in the U.K., where the cost of a treatment is divided by the number of years (called QALYS or quality-adjusted life years) the patient is likely to benefit. In the U.K., the formula leads to denying treatments for age-related diseases because older patients have a denominator problem—fewer years to benefit than younger patients with other diseases. In 2006, older patients with macular degeneration, which causes blindness, were told that they had to go totally blind in one eye before they could get an expensive new drug to save the other eye. It took nearly two years to get that government edict reversed.

When comparative effectiveness research appeared in the stimulus bill, Rep. Charles Boustany Jr., a Louisiana heart surgeon, warned to no avail that it would lead to "denying seniors and the disabled lifesaving care." Later, Sen. Jon Kyl introduced an unsuccessful amendment that would have barred the federal government from using the research to deny coverage for certain treatments. Now that comparative effectiveness funding is the law, President Obama recently appointed Dr. Emanuel to the Council, and he is likely to play a leading role because of his extensive writings on rationing care based on a patient's age.

Dangerous Misconceptions

THERE IS MORE LEGISLATION on the way. Democratic leaders of three House committees and two Senate committees have pledged to have health-care bills ready for a vote by August. The misconceptions driving these legislative efforts could be dangerous to your health. One is that prevention will eliminate the cost of treating sickness. Prevention saves lives, but 80 percent of preventive measures do not save money. Most of the people who take cholesterol-lowering medications and other precautionary measures would not get sick anyway. Louise Russell, an economist at Rutgers University, concludes that "hundreds of studies have shown that prevention usually adds to medical costs." (*Health Affairs*, March-April 2009.) The economics of prevention are so clear that the only people who claim it saves money are politicians.

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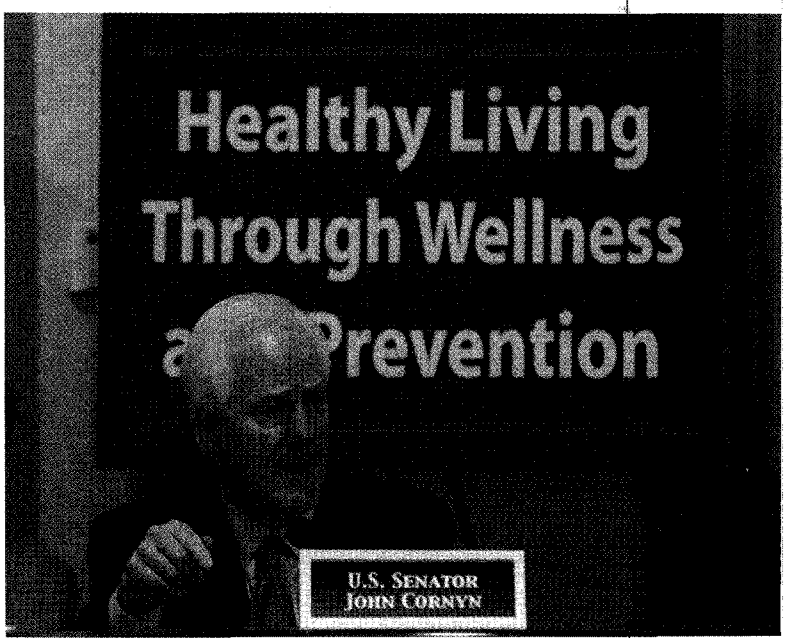
Nancy-Ann DeParle, director of the White House Office of Health Reform, said on March 23 that "we have to get to a system of keeping people well, rather than treating the sickness." That would make sense if all disease were behavior-related, but many cancers and other diseases are linked to genetics or unknown causes. DeParle's pronouncement echoes how Sir Michael Rawlins, a British health official, explains his nation's low cancer survival rates. The British National Health Service, he said, has to be fair to all patients, "not just the patients



with macular degeneration or breast cancer or renal cancer. If we spend a lot of money on a few patients, we have less money to spend on everyone else. We are not trying to be unkind or cruel. We are trying to look after everybody."

This approach is deadly for those with serious illness. In the U.S., about 5 percent of the populace needs 50 percent of treatment dollars. The drumbeat for shifting resources from treatments to prevention should worry any family dealing with M.S., Alzheimer's, Parkinson's, or cerebral palsy, or with a history of cancer.

The administration's strategy of slowing new technology in order to restrain spending will make the wait for medical breakthroughs longer.

By far, the most dangerous misconception in Washington is that the way to rein in health spending is by slowing the development and use of new technology. Imagine any industry or nation thriving on such a philosophy.

Dr. Emanuel criticizes Americans for being "enamoured with technology." Dr. Blumenthal attributes fully two-thirds of the annual increases in health spending to medical innovation.

On that he is correct. A 2008 CBO study documented that at least half of annual health spending increases are due to new treatments and tests, not administrative costs, waste, or even the aging of the population. But the CBO report also reminded us that these innovations "permit the treatment of previously untreatable conditions."

Walk into an electronics store and you will see an array of products that did not exist twenty years ago. The same is true in health care, another industry where growth is driven by innovation. Treatments for heart disease and strokes are as unlike care in the 1960s as the new flat screen televisions are unlike the black and white sets of five decades ago. If you had a heart attack in the 1980s and made it to the hospital alive, you still only had a 60 percent chance of surviving until the end of the year. Now your chance is more than 90 percent. Your chance of surviving a stroke is more than twice as high as it was three decades ago.

Overall health spending could be reduced by 30 to 40 percent by settling for the standard of cure and symptom relief available to patients in 1960, but there is no demand for 1960s medicine at 1960s prices, say CBO researchers. Families dealing with incurable illnesses go to bed every night hoping the next day will bring a cure. The administration's strategy of slowing new technology in order to restrain spending will make the wait for breakthroughs longer.

A Low Risk Alternative

IT'S ONE THING TO CRITICIZE. What's needed is a low-risk way to help people who can't afford insurance. The U.S. Census Bureau shows that of the 47 million people identified as "uninsured," 14 million are already eligible for government programs such as Medicaid and SCHIP (for children) and simply need to sign up. Another 10 million have household incomes of more than $75,000. That leaves 23.7 million people who need help affording insurance, not 47 million.

Food debit cards help 27 million people buy food, similar to the number who need help buying health coverage. In all 50 states, debit card technology has transformed the federal food stamp program, which used to be notorious for fraud and abuse. (Only 2 percent of card users are found to be ineligible, according to the General Accounting Office.) Cards are loaded with a specific dollar amount monthly, depending on family size and income, and allow cardholders to shop anywhere. The same strategy could be adapted to provide purchasing power to families who need help buying high-deductible health coverage. It's what all Americans used to buy (see chart 5), and it's all that's needed for families

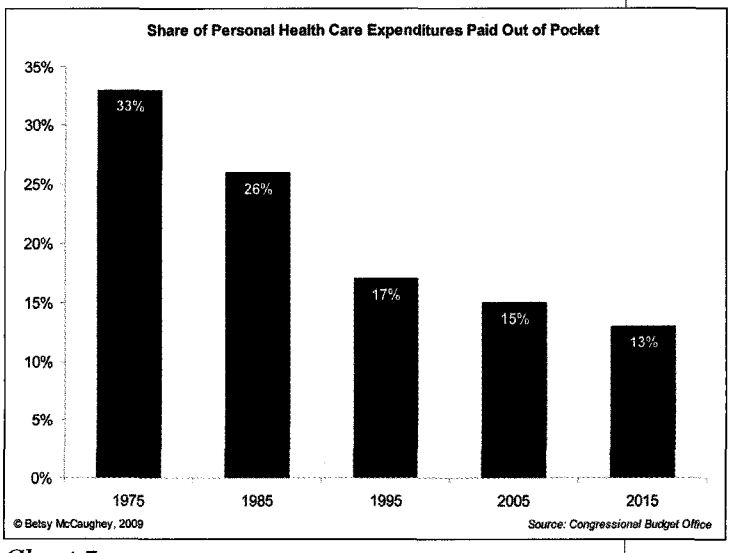


Chart 5

with moderate incomes, who can afford a routine doctor visit.

Debit cards are better than refundable tax credits for three reasons. Many people are uninsured only temporarily (about 22 percent) and not at tax time. Also, some people don't file an income tax return. Finally, a refundable tax credit would remove even more people from an obligation to pay federal income tax at a time when half of Americans don't pay it.

Providing sliding scale assistance, based on household income, to families to purchase this type of coverage would cost $20 to $25 billion a year. The cost estimate could vary for two reasons. First, only a fraction of people who are eligible for government programs actually apply (50 percent of those eligible for food debit cards). Second, U.S. Census data show that many of the uninsured are newcomers to the U.S. (some here illegally). The largest influx of immigrants in any seven years in American history occurred in the present decade. In this same decade, the lion's share of the increase in the number of uninsured took place in the five Border States. In San Francisco, 61 percent of the uninsured are not U.S. citizens, according to public health officials there. The public has not yet decided whether newcomers should be covered.

Whatever the cost of debit cards, it will be less in both dollar terms and risk than a health-care overhaul that forces individuals and businesses to buy coverage and puts European-style limits on health-care consumption.

Fixing Medicare

On May 12, Medicare officials announced that the trust fund that pays for hospital care for seniors would run out of money by 2017. In unison, the administration's key figures rushed to blame "skyrocketing health care costs" for the crisis.

"The only way to slow Medicare spending is to slow overall health system spending through comprehensive and carefully crafted legislation," declared Secretary Sebelius. If rising health costs were to blame, Medicare would have been thrown into crisis in 1980, when annual health care spending increases topped 13 percent, instead of now, when the annual increase is less than half that. Demographics are to blame, and Congress has been warned every six months for decades that Medicare needs to be adjusted.

Telling all Americans they have to cut back on health care because Medicare is fiscally unsound is like ordering all Americans to go on diets and buy fewer groceries because the food stamp program is in trouble. Medicare can be fixed without subjecting the nation to a regimen of health-care scarcity. The safer alternative is to reduce the government's share of the health care bill rather than depressing the nation's largest industry and lowering medical standards for all of us.

The Congressional Budget Office, the nonpartisan research arm of Congress, has suggested alternatives, including asking wealthy seniors to pay more of their costs or inching the eligibility age upward, two months per year, until it reaches age 70 in 2043.

No Time to Spare

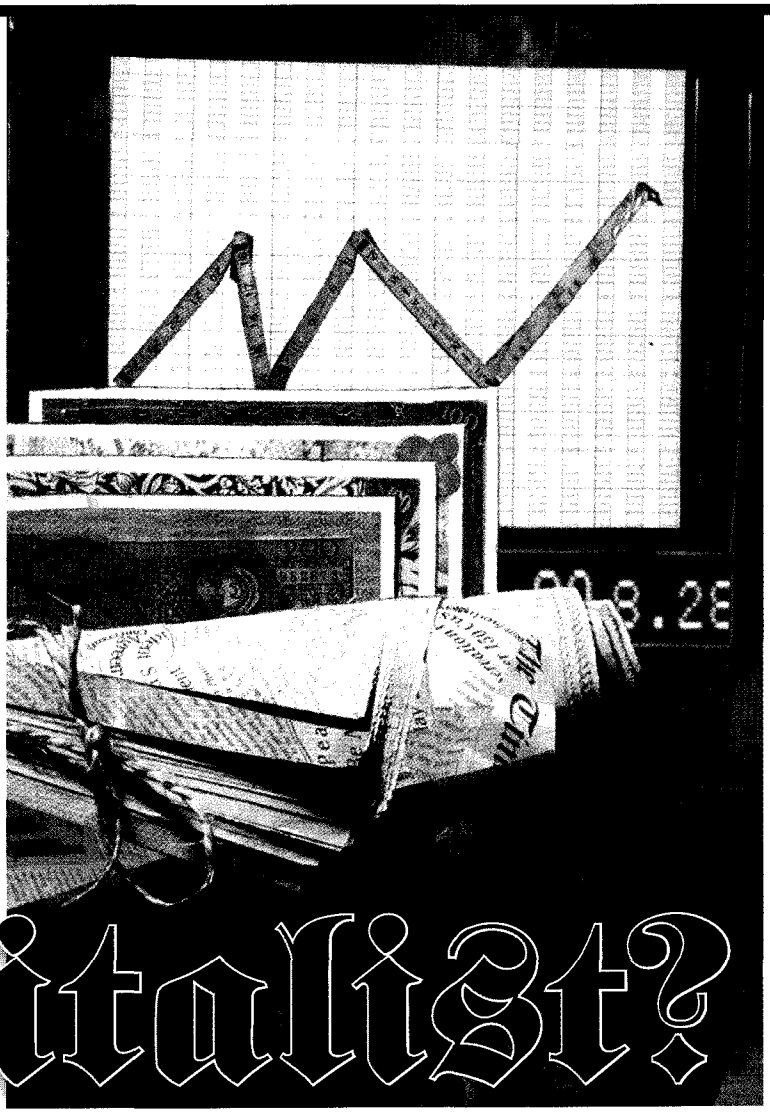
Members of Congress who oppose an overhaul of American health care don't have much time to woo public support for low-risk alternatives. The president's advisors have urged him to hurry his health agenda through. "Speed is essential," Dr. Blumenthal wrote. "Bill Clinton waited nine months to introduce his Health Security Act in 1993, which allowed opposition to mobilize and defeat him." (*New England Journal of Medicine*, November 2008.)

The president's team is also playing hardball. On May 11, the American Medical Association, pharmaceutical industry, insurance lobbyists, and other interest groups jointly announced that they would support the Administration's efforts to rein in health spending. Why would these groups go along? One answer is political arm-twisting, Chicago style. In a November 16, 2008 *Health Care Watch* column, Dr. Emanuel explained how business would be conducted to guarantee support for the President's health agenda: "every favor to a constituency should be linked to support for the health care reform agenda. If the automakers want a bail out, then they and their suppliers have to agree to support and lobby for the administration's health reform effort."

Families dealing with cancer and other serious illnesses need to pay attention to the changes being proposed in Washington, D.C. Proposals to rein in health-care spending will mean longer waits for a nurse, pressures on your doctor to restrict your care, and little hope that the medical breakthrough you need is around the corner.

Betsy McCaughey, *Ph.D., is a patient advocate, founder of the Committee to Reduce Infection Deaths, and a former Lt. Governor of New York State.*

Will the Next Press Be Capitalist?



It will if freedom remains on the American agenda.

By Austin Bay

WILL THE NEXT PRESS BE CAPITALIST?

Whether drained by arrogant habits or strained by admirable commitment, "old" media organizations as currently configured and staffed devour cash—and increasingly fail to replace it.

Leviathans like the New York Times Company and Rupert Murdoch's News Corp. confront an immediate financial crunch, and the economic prospects of their small-market brethren are bleak. Every week struggling daily papers (national, regional, and local) pink-slip employees. Television broadcasters' budgets also shrink as their viewers migrate to YouTube. Even TV cable companies face a new CNN Syndrome—Cash Needed Now.

The New York Times Company and News Corp. have faith in paper—newspapers—and access to very deep pockets. Both behemoths appear to be pursuing a "last man standing" survival strategy, News Corp.'s ploy is financed by its owner's corporate billions, while The Gray Lady—echoing Blanche DuBois in her denial-ridden decline—relies on the kindness of Mexican billionaire Carlos Slim. Since early spring 2009 Slim's massive transfusion of millions in risk capital has kept the *New York Times* printing and pontificating—and palpitating, though just barely. Red ink continues to stain the *Times*'s quarterly corporate report.