Running head: H.R. 3200

H.R. 3200: The Demise of Health Care Quality and the Beginning of the Rationing of Medical Services in the United States

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A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Fall 2009

Acceptance of Senior Honors Thesis
This Senior Honors Thesis is accepted in partial fulfillment of the requirements for graduation from the Honors Program of Liberty University.

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Abstract

On July 14, 2009, the bill H.R. 3200 America's Affordable Health Choices Act of 2009 was introduced on the floor of the House of Representatives. This bill proposes legislation that President Obama and its supporters promise will improve the health care system in the United States. The opponents of the bill, however, believe that H.R. 3200 will negatively impact the quality of America's health care. The bill drastically increases government involvement in the health care process, introduces a public option, which will eventually lead to a single-payer system and proposes regulating the wages of physicians in effort to minimize health care costs. If a government-run health care system is implemented by H.R. 3200, health care quality will be lowered and medical care will inevitably be rationed.

H.R. 3200: The Demise of Health Care Quality and the Beginning of the Rationing of Medical Services in the United States

Introduction

A History of Health Care in the United States

The early steps toward government-run health care. For the past 100 years America has faced the issue of national health care. In 1912, former President Theodore Roosevelt was the first to make it a key issue in his campaign as he ran for the presidency on the Progressive Party ticket. However, Roosevelt did not win the presidential race that year and national health care was pushed aside until 1932 when the Wilbur Commission recommended the expansion of group medical practices and group prepayment systems within the medical world to reduce the financial risk to the individual. The American Medical Association (AMA) and other critics rejected these ideas calling them socialist. Three years later, President Franklin D. Roosevelt signed the Social Security Act of 1935. At this time, a national health insurance program was suggested but not seriously considered as the AMA continued to oppose such a plan "saying it would increase bureaucracy, limit physician freedom and interfere with the doctor-patient relationship" (*A History*, 2009, para. 6). President Harry S. Truman attempted a health care overhaul in both 1945 and 1948 proposing compulsory coverage. The AMA opposed again, warning against "socialized medicine" (*A History*, 2009, para. 8). The plan failed both times because of the strong opposition (*A History*, 2009).

One of the first major steps toward government involvement in health care occurred with the Hill-Burton Act, which Congress passed in 1946. This legislation required hospitals to provide charity care and prohibited racial, religious or ethnic

discrimination. In 1954, Congress passed the Internal Revenue Act, which exempted employee benefits, including health insurance, from income taxes. This exemption was yet another step by the government to involve itself in the provision of health care. While not a major move towards national health care, it is one that has been intensely debated ever since because of the high loss in potential tax revenue (*A History*, 2009).

John F. Kennedy pushed the issue of inclusion of health benefits in Social Security. Kennedy's plan stalled in Congress just like Roosevelt's and Truman's plans had. Then, in 1965, came the birth of Medicare and Medicaid. Social issues were at the forefront of President Lyndon B. Johnsons's domestic agenda when he was elected. As president, he signed legislation creating these two major government-run health care providers. Medicare and Medicaid provided comprehensive health care coverage for senior citizens, the poor, blind and disabled. Today, these plans cover around 105 million people in the United States. Health care costs begin to spiral upward in 1968. By 1971, the need of health care reform of some type was apparent. President Richard M. Nixon supported the idea of requiring employers to provide at least a basic level of insurance to employees while maintaining competition among private insurance companies. At this same time, Senator Edward M. Kennedy proposed the "Health Security Act" which would implement a universal single-payer health reform plan. For Kennedy, it began the effort for health care reform that would continue for the rest of his life (*A History*, 2009).

President Jimmy Carter called for "a comprehensive national health insurance system with universal and mandatory coverage" in 1976 (A History, 2009, para. 21). Again, this proposal fell to the wayside because of a deep national recession. In July of 1988, the first major health care bill in years was approved by Congress and signed into

law by President Ronald Reagan. The Medicare Catastrophic Coverage Act was created to protect older Americans from financial ruin because of illness. The Act was repealed just over a year later. In 1993, President Bill Clinton started his reform effort proposing universal coverage based on the idea of managed competition, which would allow private insurers to compete in a tightly regulated market. President Clinton's Health Security Act failed in Congress in 1994 for many reasons including partisan politics and powerful lobbying by interest groups. In December of 2003, President George W. Bush expanded Medicare to include prescription drugs (*A History*, 2009).

Health care costs had begun to rapidly rise in 2002 and by 2006, health spending had topped $2.2 trillion—16% of the economy. These cost increases and the troubled economy brought health care again to the forefront of Congress and of the 2008 presidential election. Throughout his campaign for the 2008 presidential election, Barack Obama promised to reform America's health care system. On July 14, 2009, H.R. 3200 America's Affordable Health Choices Act of 2009 was introduced on the floor of the House of Representatives. Its proposal reignited debate on the issue of health care reform.

President Barack Obama and his plan to implement health care reform. On Wednesday, September 9, 2009, President Barack Obama went before a joint session of Congress to discuss the proposed health care reform. The serious response of the American public and harsh criticism of the bill by some media outlets towards H.R. 3200 left many Americans anticipating a new solution to the health care problem, eliminating the controversial bill. Instead, the President came before the session in hopes of fostering compromise between the Republican and Democratic parties regarding health care and to

clear up confusion regarding H.R. 3200. Obama spoke about health care reform and declared that it is definitive to the future of the United States (Obama, 2009).

The president cited extreme positions on the left and right and that he recognized that taking a radical approach and revamping the entire health care system would dramatically disrupt the system and the economy:

> I believe it makes more sense to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch. The plan I'm announcing tonight would meet three basic goals. It will provide more security and stability to those who have health insurance. It will provide insurance for those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government. (Obama, 2009, para. 20)

While his stated goals are commendable and changes to the current system are, in fact, much needed, the reform that President Obama has proposed will certainly do far more harm than good. Opponents of the bill believe that H.R. 3200 is dangerous to the quality of America's health care. The bill drastically increases government involvement in the health care process, introduces a public option, which will eventually lead to a single-payer system, and proposes regulating the wages of physicians in effort to minimize health care costs. If a government-run health care system is implemented by H.R. 3200, health care quality will be lowered and medical care will inevitably be rationed.

Understanding H.R. 3200 and health care reform: Does the rhetoric match the reality?

The content of H.R. 3200 has caught the attention of concerned Americans throughout the country. Throughout the bill, issues of extreme government control,

rationing and questionable use of taxpayer dollars arise. There are a number of sections in the bill that pertain particularly to the rationing of health care.

Public insurance plans place 'annual limitations' on health care spending. In his speech before Congress, President Obama explained the aspects of his plan. He promised that it would limit out-of-pocket expenses for patients and would require insurance companies to cover preventative care like routine check-ups and mammograms at no additional cost: "It will provide more security and stability to those who have health insurance. It will provide insurance for those who don't," he said (Obama, 2009, para. 20). He promised that first and foremost, if you currently have health care coverage, nothing in the plan would require you to change your coverage or your doctor: "Nothing in our plan requires you to changed what you have" (para. 21). However, he said the plan would protect patients by making it against the law for insurance companies to deny coverage based on a pre-existing condition. It would be against the law for insurance companies to drop an individual's coverage when he gets sick or to water it down when he needs it the most. Obama said his plan would eliminate the cap insurance companies may place on the amount of coverage one can receive in a year or in a lifetime: "They will no longer be able to place some arbitrary cap on the amount of coverage you can receive…" (para. 22). He doesn't recognize here the far more detrimental cap that will be put in place by the government for all those who will be on the public plan (Obama, 2009).

Section 122 of H.R. 3200 states—"The cost sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B)" (H.R. 3200, 2009, p. 29)—which would

establish an annual limitation on receivable care, which would in turn require that health care be rationed. The government has to place a limit on the amount of care they can afford to cover. The “annual limitation” as it is called, specifically states that expenditure on services that fall in the essential benefits package for a family or individual cannot exceed the level specified in the bill. This amount is $5,000 for an individual and $10,000 for a family (H.R. 3200, 2009). It makes sense that the government would be forced to place a spending cap on each individual; when the number of people covered by the government will undoubtedly rise by 36 million with the implementation of a public option, basic economics leaves no question that the cost to the government would also rise (Montgomery, L. 2009). According to an article written in February of 2009, shortly after Obama took office, *The Washington Post* reports that Obama proposed a $634 billion fund for his health care plan. Some experts have predicted that the amount will actually be closer to $1 trillion (Connolly, 2009). Even with a trillion dollar budget, it is a budget that only allows so much money to be spent which will force the need for regulation. Walter E. Williams of the Cato Institute recognizes:

> When price isn't allowed to make demand equal supply, other measures must be taken. One way to distribute the demand is by queuing -- making people wait. Another is to have a medical czar who decides who is eligible, under what conditions, for a particular procedure -- for example, no hip replacement or renal dialysis for people over 70 or no heart transplants for smokers. (Williams, 2004, para. 9)

If the government were not in the position of providing health care, this would not have to happen.

Ezekiel Emanuel provides an example of the reality of a 'private-public advisory committee.' Section 123 provides for a government committee that will decide what treatments and benefits individuals will receive: "There is established a private-public advisory committee which shall be a panel of medical and other experts to…recommend covered benefits and essential, enhanced, and premium plans" (H.R. 3200, 2009, p. 30). This section of the bill calls for a "private-public advisory committee" which will make decisions regarding covered benefits and plans (H.R. 3200, 2009). According to a report done by the Heritage Foundation, Obama is quoted saying about Americans:

> They're going to have to give up paying for things that don't make them healthier. … If there's a blue pill and a red pill, and the blue pill is half the price of the red pill and works just as well, why not pay half for the thing that's going to make you well? (Obamacare, 2009, para. 5)

While his point is valid, this statement is an indication that the government is going to have input on the decision of whether or not you get to have the red pill or the blue pill.

One of the people who has an influential role in this area is Ezekiel Emanuel, health adviser to President Barack Obama. Emanuel wrote an article entitled, "The Perfect Storm of Overutilization." Emanuel's article affirms what Obama has said, that as of 2005, the United States spends more on health care per person than any other developed country, yet generally health outcomes are less impressive. Emanuel blamed high health care costs on a variety of factors, the first one being overhead and administration costs which he said wastes more than $50 billion. Secondly, he said that physicians make more money and prescription drugs are more expensive in the US than in other countries resulting in higher overall cost of care. Third, he said that Americans

prize nice amenities. The need to have new everything all of the time increases costs even more. Ultimately, however, Emanuel blames high health care costs on the overutilization of health care which comes in two forms: high volume of use and/or need or more expensive specialists, procedures, tests and prescriptions than are appropriate. Generally, Emanuel blames high costs on the latter of these two overutilizations (Emanuel, 2009).

Emanuel says we have more surgeries, use more new drugs, go to more specialists and other such things than other countries. He calls this waste (Emanuel, 2009). These other countries, however, operate on government-run health care systems, often single-payer and universal, which probably limits their access to an abundance of quality care which Americans currently have access to and take advantage of. Also, Americans tend to live less healthy lifestyles including fast food and busy schedules with little time for exercise and therefore have a higher need than other countries for health care services.

Emanuel pinpointed several factors that he said drive overuse. One problem he pointed out is the culture among doctors. Emanuel said that physicians are trained to be meticulous. They are rewarded in school and in their careers when, rather than being efficient and only treating the problem that the patient is in the doctor's office or hospital for, they are thorough, discover other problems and treat the patient for those as well. He said that this encouragement of doctors to be thorough rather than efficient results in overuse and waste (Emanuel, 2009). Another factor Emanuel recognized is that patients like fancy, high-tech and new health care. He said that while technological innovation is important and health care is constantly developing, the desire for the best will often cause American patients to request tests, drugs and other treatments that are unnecessary (Emanuel, 2009). These two points that Emanuel makes clearly represent his mindset that

health care should be limited in the United States in order to eliminate “waste” and cut costs. What Emanuel refers to as “waste”, however, is what many would refer to as quality care, innovation and ultimately, saved lives.

A statement that is indicative of Emanuel’s position on health care is: “Costs cannot be controlled unless overutilization is substantially reduced. … The best hope for reining in costs is to devise financial incentives for physicians and patients that result in greater health care value,” (Emanuel, 2009, p. 2791). Simply put, he believes that Americans use health care too much and that government must control health care. In an attempt to determine how overutilization can best be prevented, Emanuel recognizes the difficulty and probably impossibility of stopping the technological growth in American medical practices. Americans like new technology too much and he does recognize that growth in that area does have some benefit and it is undesirable to stop it completely. He realizes that changing physician training and culture has been attempted very often, yet it is usually ignored. “However,” Emanuel (2009) says, “the progression in end-of-life care mentality from ‘do everything’ to more palliative care shows that change in physician norms and practices is possible” (p. 2791). This statement by Emanuel reveals that his belief is the costs should be minimized by reducing care. This reduction—or rationing—has begun to take place with the elderly in end-of-life care and he hopes that it will spread throughout the system to the treatment of all patients. The factor of “waste” in health care is continually recognized by those pushing a universal health care plan. According to Emanuel, a big factor in all of this waste is the meticulousness of doctors--the way they look for problems a patient might have while they are being treated for

something else. He actually criticizes a doctor who makes sure his patient is completely healthy before he sends him away.

How government bureaucracy in health care will lead to rationing. Section 142 gives a government-appointed health care commissioner the authority to decide the health benefits that individuals will receive:

> The Commissioner is responsible for carrying out the following functions under this division: … The establishment of qualified health benefits plan standards under this title, including the enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury. (H.R. 3200, 2009, p. 42)

The section specifies that the health care commissioner is responsible for choosing benefits for recipients. The recipients will not be able to choose their health care plan for themselves, rather this commissioner will decide what each person is qualified for. So many of the provisions in this bill give this decision-making authority not to the citizens of the United States, but to government bureaucrats.

In his book, *Flatlined,* Guy L. Clifton, neurosurgeon and clinical investigator, (2009) says, "If the behaviors of patients are added to the behaviors of providers, total waste in medicine cannot be less than 50 percent" (Clifton, 2009, p. 62). He went on to explain that the statistics show that there is a greater percentage of follow-up treatment and surgeries in high-spending regions than in low-spending regions. Clifton linked this to the greater concentration of specialists and hospitals in high-spending regions. He said that variations in the illnesses in the different regions only accounted for 27 percent of the

differences in expenditure, while the greater supply of hospital beds and specialists accounted for 42 percent.

To a purely objective reader it could appear that the rationale to determine "waste" based on high-spending versus low-spending regions is a somewhat backward process. It is true that there are more doctors, hospitals and specialists in high-spending areas and as a result there is a higher cost of health care in these areas because patients have the option of obtaining additional follow-up health care. What Clifton deems as "waste" is actually just an increased accessibility and therefore usage of more advanced and specific treatment that is not provided in low-spending areas due to the lack of demand (Clifton, 2009).

Clifton (2009) suggests that low-spending areas should be the "benchmark". He maintains, "If doctors in high-spending areas practiced like doctors in low-spending regions, Medicare cost could be reduced by 28.9 percent with improved quality" (p. 59). Clifton believes that patient-satisfaction and functional statuses are the same in low-spending areas as in high-spending areas and that mortality is improved in the low-spending regions (Clifton, 2009).

Clifton (2009) goes on to say that in communities where there are many doctors, especially in a particular specialty, they will arrange a higher number of patient visits and additionally be liberal in administering tests on their patients. He said "and the more a doctor looks for, the more a doctor finds" (p. 60). He said that these increased patient visits and tests which result in the discovery of further problems are a great factor in the "waste" he describes and that increased visits and tests can be directly linked to the number of cardiologists in a region (Clifton, 2009).

In his book, Clifton (2009) details the ways that he believed health care should be reformed. In regards to the "waste" factor, he said, "Payment to hospitals and specialists should be for an episode of care—from admission to the hospital or surgery center until discharge home—rather than for each moment and service along the way" (p. 220).

The problem Clifton fails to recognize with this idea is that it takes away from an individual's right to seek further care if he desires it. No doctor, government program or insurance company is currently forcing patients to accept treatment that they do not need. The medical procedures that are unnecessarily performed should not be a problem to the health care system or country as a whole unless they are being funded by the government. In this case, they play a part in increasing the federal deficit and spend taxpayers' money in unwise ways. The way to avoid this problem is to keep from involving the federal government in the funding of health care and medical services. If the government is involved, the regulation that will be required to "monitor quality" as Clifton suggests will also increase costs while the option for the average citizen, especially those who currently have health care, to access whatever treatment they and their doctors deem necessary, will be limited by government agencies that have neither the time, education or resources to understand the individual needs of each patient.

Writing about the potential rationing of health care, Devon Herrick argues that government funded health care researchers will be tempted to take the small step from comparing effectiveness of treatments and drugs to comparing cost-effectiveness. He says that instead of finding what works better, they will gradually begin deciding what is cheaper. This could eventually lead to policies similar to ones used by the National Institute for Clinical Excellence in Britain. NICE was originated to "to ensure that every

treatment, operation, or medicine used is the proven best. It will root out under-performing doctors and useless treatments, spreading best practices everywhere" (Of NICE and Men, 2009, para. 3). Instead, as it has been faced with the overwhelming task of cost-control in a nation of 61 million citizens, it has essentially become a rationing board (Of NICE and Men, 2009): "NICE sets a value on a year of life, and those therapies that exceed that cost per life-year are not funded" (Clemmitt, 2009 p. 20). This value is determined by a formula that Emanuel discusses in his article "Principles for allocation of scarce medical interventions". The formula is called quality-adjusted life-years (QALY). It essentially measures the quality of life of a person who has an illness or impairment in comparison to a healthy person, therefore determined the value of their life compared to a healthy person. This formula simply calculates what is determined to be the quality of life based on a person's physical condition and fails to factor in the possibility that a person with a disability or disease may adapt to their circumstances and actually value their life-years in the same way that a completely healthy person might (Emanuel, Wertheimer 2009).

Only recently, NICE has denied women with breast cancer a powerful life-extending drug called lapatinib saying it is too expensive. This is just one example of the rationing that government must implement when they are given the responsibility of providing national health care (Hope, 2009). "The Government announced plans last year which they said would make sure that patients were able to get access to these drugs. This is yet another example that their system isn't working and that patients are suffering as a consequence," said Shadow Health Secretary Andrew Lansley (Hope, 2009 para. 25).

Ezekiel Emanuel (2009) coauthored with Govind Persad and Alan Wertheimer to write an article called “Principles for allocation of scarce medical interventions.” In this article, the group discusses how medical care should be rationed in an event of scarcity. In the opening paragraph is the following statement: “We recommend an alternative system--the complete lives system--which prioritises younger people who have not yet lived a complete life, and also incorporates prognosis, save the most lives, lottery, and instrumental value principles” (p. 423). While this statement reflects what the authors believe should be done in the case of scarcity, Emanuel has made known his position regarding health care reform, minimizing “waste” including physician thoroughness and based on his stance on these matters, it stands to reason that scarcity and rationing may become very real possibilities. In this case, this article states that care will be rationed and provided first and foremost to younger people. Emanuel himself realizes that this may present an objection to his plan. In his article, he states, “The complete lives system discriminates against older people. Age-based allocation is ageism.” He defends his plan by arguing that, “Unlike allocation by sex or race, allocation by age is not invidious discrimination; every person lives through different life stages rather than being a single age” (Emanuel, et. al., 2009, p. 429). The complete lives systems does not only discriminate against the old, but also the very young. Emanuel explains that infants have not received the investments that adolescents and young adults have and as such, care would be preferentially given to someone who is 22 over a newborn baby or a toddler (Emanuel, et. al., 2009). Emanuel’s plans creates a triage system in which his goal is to maximize the number of complete lives lived. The problem with this plan is that it gives the government the opportunity to decide who is worth providing care for.

If a single-payer health care system is implemented in the United States, sources referenced throughout this paper have concluded that there will be scarcity in the medical field. Government will be unable to meet the demands of the health care needs of the general population at which point they will begin to have to implement different forms of rationing. Emanuel and his colleagues believe that younger people are in the position of being "worse-off" when facing medical difficulty because they have had fewer years of life: "Prioritising the youngest gives priority to the worst-off—those who would otherwise die having had the fewest life years—and is thus fundamentally different from favouritism towards adults or people who are well-off" (Emanuel, et. al., 2009, p. 425). This philosophy that the young deserve more life years can easily translate into the belief that the old are losing their value and as a result even less care will be provided to the elderly.

There are other potential forms of rationing that are likely to occur that can be witnessed in Canada, the UK and other countries with national health care plans: "If U.S. policy makers can take one lesson from national health-care systems around the world, it is not to follow the road to government-run national health care but to increase consumer incentives and control," says Michael Tanner, director of Health and Welfare studies at the Cato Institute (Clemmitt, 2009, p. 29).

How the 'public option' will drive out private insurers. The health care reform that is currently being considered by Congress includes somewhat of a compromise between the private insurance and single-payer options: the public option. With this plan, the government will create a public insurance option that will be thrown into the market along with all the other private insurance companies, the goal being to create an added

measure of competition to reduce health care costs. Conservatives are hesitant to embrace this idea because, while it may sound good on the surface, the problems lie in where this "public option" could eventually lead. First of all, it relies on the integrity of the government agency that will maintain it to make sure it stays within a fair price range that private insurance companies have a chance to compete with. Secondly, the fear is that, in time, this public option will become the only option (Clemmitt, 2009).

Part of Obama's plan is to create an insurance marketplace where individuals and small businesses will be able to shop for health insurance at competitive prices. He said that this would provide an arena that is appealing to insurance companies because they can compete for new customers. He compared it to the way that large companies and government employees purchase health insurance (Obama, 2009). However, Section 222 of H.R. 3200 denies any opportunity for legal review on any health care prices set by the government: "There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 224" (H.R. 3200, 2009, p. 124-125). In this case it will be incredibly difficult, if not impossible, for private insurance companies to contest low public option rates and compete against them. Eventually, this will cause private insurance companies to go out of business. This provision basically gives the government full control to charge whatever they want. According to the Heritage Foundation, this creates a situation in which "the umpire is also the first baseman" (Obamacare, 2009, para. 4). It is continually argued that the public option will increase competition. In his September 2009 speech to the joint session of Congress on health care reform, President Obama addressed the issue of the public option. The president stated that he wants insurance companies to stay in business. He

argued that they offer an important service and are a large employer of American citizens and he has no desire to eliminate them. Instead, he simply wants to hold them accountable. The way he proposes to do this is to create a not-for-profit public option available in the insurance exchange. It would be cheap and it would keep insurance companies from price gouging and create fair competition in the market. Obama says that insurance companies will not face the impossibility of trying to compete with the government because the public option will not be subsidized by taxpayer dollars. He compares the proposed public option to public universities suggesting that it will do as they do by providing a quality alternative that creates competition but does nothing to harm private universities (Obama, 2009). The Heritage Foundation does not believe that the public option will simply create competition among insurance companies. Instead, they believe that this public option will eventually eliminate private insurance companies: "If the federal government creates a health care plan that it controls and also sets the rules for the private plans, there is little doubt that Washington would put its private sector 'competitors' out of business sooner or later" (Obamacare, 2009, para. 4).

Prior even to the introduction of H.R. 3200, a June 2009 *New York Times* article by Robert Pear said that the American Medical Association let Congress know that they stand in opposition of any government-run insurance plan. The AMA told the Senate Finance Committee:

> The AMA does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to

> restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans. (Pear, 2009, para. 6)

The AMA believes that the result of a public health care option will be the eventual termination of private insurance companies. They do not believe that these private companies have the capacity to compete with a government-run public option that can undoubtedly offer health care at lower costs. This will eventually leave health care insurance entirely in the hands of government officials and the AMA "absolutely oppose[s] government control of health care decisions or mandatory physician participation in any insurance plan." In their opposition, the AMA clearly recognizes the perils of removing choice in treatment from the hands of physicians and patients (Pear, 2009).

How H.R. 3200 will increase the doctor shortage problem, especially in areas of specialization. A big concern currently facing our nation is a shortage of doctors: "The president promises that his health-care reform proposal will address the problem of a primary care physician shortage---and he's right. He will make it worse," Allysia Finley said in a *Wall Street Journal* article (Finley, 2009). The United States currently already faces a shortage of between 5,000 and 13,000 doctors. "Add millions of previously uninsured people and the shortfall will balloon to as many as 50,000 doctors," predicts an article by Reuters News (Stern, 2009, para. 4). Section 1121 says that all physicians, regardless of their specialty, will receive the same pay: "Service categories established under this paragraph shall apply without regard to the specialty of the physician furnishing the service (H.R. 3200, 2009, p. 241). This is a potentially dangerous threat to the quality of health care in the United States. If a doctor sees that there is no financial

benefit to specializing in a particular field why would he spend the extra time and money necessary to become a heart surgeon, OB/GYN or an eye doctor? If there is not reason to specialize then fewer and fewer doctors will do so which will limit the quality of care a patient can receive because there will be no experts on the specific treatment he needs. This standard pay rate for all physicians will particularly affect the quality of health care because it will reduce, if not altogether eliminate, the desire of doctors to focus on a particular area and spend extra time studying that field when there will be no additional monetary reward over that of being a general physician (Adams, 2009). Dr. Jeffrey Moses, interventional cardiologist, named to "America's Top Doctors" said:

> If you have heart failure or heart attack or coronaries in general in the hospital you need to be treated by a cardiologist. Study after study shows that . . . when you have an illness and you want to have an accurate diagnosis and the most up-to-date and accurate treatment, you want a specialist. (McCaughey, 2009)

Tom Miller, a fellow at the conservative American Enterprise Institute says that a public plan will reduce costs, but unless much better ways are developed to monitor care, the lower costs would simply lead to lower quality. The Senate Republican Committee said, “Under a new government-run plan, Americans will find it more and more difficult to make appointments with physicians because lower payments make it increasingly unaffordable for providers to see them” (Clemmitt, 2009, para. 59). An article by Peter J. Cunningham of *Health Affairs*, states that “many physicians are already reluctant to accept Medicaid patients because of low reimbursement…” (Cunningham, 2006, para. 2). He further states that relatively low Medicaid payment rates and high administrative burdens are major reasons for not accepting Medicaid patients, according to physicians.

Among physicians accepting no new Medicaid patients in 2004-05, about five out of six (84%) cited inadequate reimbursement as a moderate or very important reason for not accepting new patients. Billing requirements and paper work were cited by 70 percent of physicians as reasons for not accepting new patients (Cunningham 2006).

If such is the case now, when there are 43.5 million enrolled in Medicaid, as of June 2008 (Medicaid Enrollment, 2009) out of an approximate 304 million people in the United States at that time (USA, 2009)—just over 14% of the population—how will doctors respond to a nationalized health care program with a public option that will eventually put all Americans on a government-run health care program?

According to Michael F. Cannon, director of health-policy studies at the Libertarian Cato Institute, and Michael D. Tanner, health care researcher, in their book *Healthy Competition*, they recognize that research suggests that government provision of health care would actually lead to higher administrative costs than currently exist rather than offset them. Based on a study done by Patricia Danzon, Celia Moh Professor at The Wharton School, University of Pennsylvania, the amount spent on administration in Canada is an estimated 45% of claims compared to the private health insurance companies in the United States in which less than eight percent of claims are spent on administration (Cannon and Tanner, 2007).

In the National Physician Survey in Canada, 56.3% percent of Canadian doctors responded that system funding was a major impediment to their delivery of health care to their patients. In second place, 47.5% said that a major impediment is the availability of personnel. 45.9% said paperwork and 44.9% said bureaucracy (National, 2007). This

survey also revealed that doctors across Canada are "concerned about inadequate access to health care services for their patients" (Access, 2008, para. 1).

Every health care system deals with the issue of shortages and in countries where government runs health care, rather than the market providing more jobs for specialists creating more room in hospitals and expanding to adjust to patient needs, the government forces those who need care to wait. In Canada, Great Britain and New Zealand, patients waiting for treatment experience incredible delays where in the United States, wait periods are typically much shorter. What Clifton and Emanuel call "waste" in the form of so many specialists and hospitals is definitely preferable to waiting 15 to 25 weeks for heart surgery or over a year for a hip replacement (Cannon and Tanner, 2007).

How rationing will be implemented with H.R. 3200. It is certain that with H.R. 3200 will come the rationing of health care and Section 1145 of the bill specifically subjects cancer patients to rationing:

> Insofar as the Secretary determines under subparagraph (A) that costs incurred by [cancer] hospitals…exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011. (H.R. 3200, 2009, p. 272)

The section says that if a cancer hospital has higher expenditures than a regular hospital then actions will be taken to lower the spending of the cancer hospital. Chemotherapy alone can cost around $4,400 a month which would almost use the entire yearly allowance for an individual in just one month (Cancer Superdrugs, 2004). The section does not provide for any reasons why the spending at the cancer hospital may need to be

higher. The result of this limitation will be that many cancer patients will not be able to receive the proper treatments because of this form of rationing. Cancer patients could end up dying when they could have been saved because of hospital cost cuts by this bill.

If the government implements H.R. 3200, then the United States health care market is sure to see a reduction in quality of care and an increase in rationing of medical services based off of these references within the bill. While the language in the bill that will result in rationing is at times vague, the fact that "amendments offered in House and Senate committees to block government rationing of care were routinely defeated" (Obamacare, 2009, para. 7) seems to reveal that politicians know it is both necessary and inevitable with a public health care plan. President Obama admitted that cost could be the deciding factor in whether not a patient will be allowed treatment when he was asked about an elderly woman who needed a pacemaker. He responded, "Maybe you're better off not having the surgery, but taking the painkiller" (Obamacare, 2009, para. 7).

The Costs of Health Care Reform

President Obama's proposed budget. In regards to paying for the proposed health care reform, President Obama promised that his plan will not add to the federal deficit and he promised never to sign a plan that would. He said that reducing the waste and inefficiency that currently exists will pay for most of this plan. More will be paid for by charging insurance companies a fee for their most expensive plans, which will also have the effect of encouraging insurance companies to provide greater value for the money. Reforming malpractice laws, focusing on patient safety and allowing doctors to practice medicine will further bring down the costs of health care. Obama said that his plan will cost $900 billion over the next 10 years. He said that this is less than the amount spent on

the wars in Iraq and Afghanistan and it is less than the tax cuts passed by Congress at the beginning of the previous administration for wealthy Americans. Most of the plan will be paid for by money already being spent on health care and he emphasized repeatedly that his proposed plan will not add to the federal deficit (Obama, 2009).

President Obama (2009) emphasized the importance of passing health care reform when he said:

> Everyone in this room knows what will happen if we do nothing. Our deficit will grow. More families will go bankrupt. More businesses will close. More Americans will lose their coverage when they are sick and need it the most. And more will die as a result. We know these things to be true. (para. 54)

President Obama went before Congress and before America on September 9 with an attitude of patriotism, bipartisanship and openness, but underneath all of this was the unwavering resolve that seems to permeate the Democratic party that the only real way to solve the health care crisis is through some level of public insurance and government-run health care (Obama, 2009).

How government fiscal insufficiency will result in rationing. Ultimately the government does not have the ability to decrease waste or even demand in health care. In contrast, they say that no matter how much power it may have, government simply cannot change the laws that govern economics. If people perceive health care to be free, the demand will go up (Cannon and Tanner, 2007). Emanuel argues that the way that insurance companies operate through paying the cost of procedures and other things eliminates competition in the market because consumers do not experience the direct spending of the money. Therefore they are not motivated to seek less expensive products

or eliminate unnecessary procedures (Emanuel, 2009). This final point falls in irony to the message Obama has declared that every citizen of the United States should be provided with health care and that out-of-pocket expenditures at the time of health care services should be curtailed if not even altogether eliminated and offers further evidence that demands for medical services will go up when "free" health care is available to everyone.

David G. Green and Benedict Irvine, two scholars from Civitas, the Institute for the Study of Civil Society, in the United Kingdom, have authored several books and articles about health care. In their book *Health Care in France and Germany* they discussed the widespread rationing in the UK and how Germany and France have sought to avoid a similar problem. They concluded that "governments should not try to be the single payer [for health insurance] because rationing will be the result" (Green and Irvine, 2001 p. 88). In a study done about the Canadian health care system, Irvine along with Shannon Ferguson and Ben Cackett discuss rationing. They recognize the consequences of the high demand of consumers for free health care saying, "Like other nations experiencing limitless demand, an ageing population and the costly advance of medical technology, Canada has faced pressure to control health expenditure. It has done so through explicit rationing" (Irvine, Ferguson and Cackett, 2005, p. 2). They point out that while the Canadian system may appear attractive on an ideological level, "the reality is that the Canadian tax-funded single-payer model restricts expenditure to such an extent that health care supply far from matches demand" (Irvine et. al., 2005, p. 6). Due to of the high demand and limited funds, Canadians do not have the quality in medical products and services that the United States has:

> Countries with national health care systems also lag far behind the United States in the availability of modern medical technology. Even though Canada is fifth among advanced nations in the share of its economy it devotes to health care, it ranks in the bottom third of nations when it comes to access to medical technology. (Cannon and Tanner, 2007, p. 37)

The RAND Health Insurance Experiment demonstrated how waste is actually perpetuated and increased when consumers are not responsible for direct costs. In this study, patients who had the most drug coverage were two times more likely to use more expensive drugs even though research revealed that most of them did not need the higher priced prescription. However, because they only paid a co-payment, they did not realize the full expense of the drug and did not decide to use the drug based on their need of its specific function of relieving pain without irritating the stomach, thus contributing to the waste. In essence, this experiment proved "that people with excessive coverage utilize care that does nothing to improve health" (Cannon and Tanner, 2007, p. 59).

Regina Herzlinger, DBA, was elected one of the "100 Most Powerful People in Health Care" by *Modern Healthcare* magazine. She has done extensive research on health care and in her book *Who Killed Health Care*? she discusses single-payer versus universal health care. Herzlinger agrees that all Americans should have access to health care, but the details of how this is accomplished is where she tends to disagree with many who promote a universal health care system. She maintains, "Government control smothers competition under a blanket of uniformity but it is competition that will improve the quality of health care services and will create the best opportunities for cost control" (Herzlinger, 2007, p. 142). She argues that competition in the market is the most

effective way to control costs and raise quality. Herzlinger (2009) believes that if a single-payer system were to be implemented, innovations that increase productivity would be suppressed and "significant cost control can come about only by rationing health care services, an action that invariably leads to waiting lists for treatment and untold inconvenience, suffering and even death" (p. 142). The Civitas study on Canadian health care affirms this statement. It states that the Canadian provinces have proven their ability to manage cost control through the limitation of growth. It also explains that "the downside of this cost controlling efficiency is evident by the problem of waiting lists and dilapidated technology and equipment" (Irvine, et. al., 2005, p. 2). The Canadian think tank, the Fraser Institute found that overall, the median waiting times for medical treatment in Canada between the appointment with a specialist and treatment are higher than clinically reasonable waiting times (Email and Walker, 2007; Roff, 2009). The Fraser Institute cites an assessment done in 2000 by the Canadian Medical Association which argued that "shortages have led to an 'unconscionable' delay in the diagnosis and treatment of diseases such as cancer, heart disease, and debilitating bone and join ailments" (Irvine, et. al., 2005, p. 3).

Herzlinger describes how in Canada, the single-payer system actually widened the socioeconomic gap between lower, middle and upper classes. Every Canadian system has health care coverage provided by the government, however, waiting times that are detrimental to their health and often their lives cause Canadians who can afford to pay for their own treatment to seek it from private clinics in Canada or escape to the United States. This leaves the lower and middle classes waiting for whatever treatment they can receive from their government coverage for however long the wait takes while the rich

are able to purchase immediate and quality treatment. In addition to these socioeconomic problems, studies have shown that over the years health care quality in Canada has deteriorated. In 2006, for example, patients had to wait four months, on average, to see a specialist. That is 90% longer than the average waiting times in 1993 (Herzlinger, 2007).

CQ Researcher article "Health Care Reform" discusses the advantages and disadvantages of a single payer system. The author, Maria Clemmitt, states that conservatives are opposed to this type of system largely on the grounds that they believe government funding of the health care system will cripple innovation and increase costs. The article quotes Cannon:

> Let individuals control their health-care dollars, and free them to choose from a wide variety of health plans and providers. Experts suggest that one-third of U.S. health-care spending, or about 6 percent of gross domestic product, is pure waste, and that's mainly because government already controls half of our nation's health-care dollars and lets employers control an additional quarter. Nobody spends other people's money as carefully as they spend their own. (2009, para. 30)

If there is a single-payer in health care, there is a tremendous drive to regulate costs. President Obama recognizes that the current government-run health care programs, Medicare and Medicaid, will soon require more spending than every other government program combined. Our country cannot afford this, Obama said. "Put simply, our health care problem is our deficit problem," (Obama, 2009, para. 12). In a system where health care is free to citizens, the demand is sure to rise, placing an ever increasing demand on the federal budget. Conservatives argue that this financial burden on the government will

inevitably result in the rationing of health care simply to keep costs down (Clemmitt, 2009).

Civitas and the Fraser Institute both affirmed that the government has no way to limit costs aside from direct rationing. And they must limit costs because they simply do not have unlimited resources: “Like other nations experiencing limitless demand, an ageing population and the costly advance of medical technology, Canada has faced pressure to control health expenditure. It has done so through explicit rationing” (Irvine, et. al., 2005, p. 2).

Clemmitt cites Donald P. Condit from the Acton Institute think tank who also recognizes that when someone else, in the proposed case the federal government, is shouldering the bill of health care, consumption increases. As a result of “free” health care, patients would visit doctors more often than they currently do and costs of health care would increase. It is this increase in cost that will lead to restricted health care accessibility (Clemmitt, 2009). *The Wall Street Journal* published an editorial in June 2009 with figures showing that when people view health care as free, they will want more of it.

A far better alternative is to increase individual responsibility for medical decisions. In 1965, the average American paid more than half of his health care out of pocket. Spending has since increased sevenfold, but the amount that consumers pay directly hasn't even doubled. When people aren't exposed to the true cost of their care -- though it is paid in foregone wages and higher taxes for public programs -- they consume more care. The research of MIT economist Amy Finkelstein suggests that roughly half of the real increase in U.S. health spending between 1950 and 1990 is due to Medicare and

the spread of third-party, first-dollar insurance. (Obama's Health Care, 2009, para. 15) This is a problem that a national health care plan will not solve.

Conclusion

The reality of H.R. 3200 and H.R. 3962 and President Obama's plans for reform.

President Obama has repeatedly cited the Mayo Clinic in Minnesota as a standard of excellence by providing high quality patient care at low costs. He has repeatedly praised their efforts and promised that the health care reform he is proposing will achieve the same result—excellent care at low cost. However, despite President Obama's constant praise, Mayo does not reciprocate. A few days after the introduction of H.R. 3200, Mayo released a response to the bill on their blog. While acknowledging some of the positive aspects of the bill, such as universal insurance, they stated, "The proposed legislation misses the opportunity to help create higher-quality, more affordable health care for patients. In fact, it will do the opposite" (Ham, 2009, para. 6). They also maintain that the proposals being discussed in Congress do not have the necessary ingredients to "drive necessary improvements in American health care" (JaneJ, 2009, para. 2) and that "the real losers will be the citizens of the United States" (JaneJ, 2009, para. 2).

It has been suggested that the public option that has been put forward is in reality a roundabout way of implementing an entirely public health care system: "A new public insurance plan to compete with private health plans. …is a Trojan horse for government control and the progressive destruction of Americans' private…coverage," said Robert E. Moffitt of the Heritage Foundation (Clemmitt, 2009, p. 9).

Throughout the past few months, H.R. 3200 has been revised and expanded into the new bill, H.R. 3962. This new bill is even longer than the original at 1,990 pages long and according to Republican Congressman from South Carolina, it has the same problems as H.R. 3200 (Starr, 2009): "When H.R. 3962, the Affordable Health Care for

America Act, was introduced, I was disappointed to find that many of the problems in the original bill had not been addressed or changed in any way," Barrett said (Starr, 2009, para. 19). Essentially it lays out the requirements surrounding a "qualified plan" that has not yet been determined by the government. The bill was passed by the House of Representatives on Saturday, November 7, 2009. Its fate will be determined by the Senate, which unveiled the Senate Majority version of health care reform on November 18, 2009, at 2,074 pages long with no significant changes.

If this bill is passed, the Congressional Budget Office estimated what the plans will likely cost:

> An individual earning $44,000 before taxes who purchases his own insurance will have to pay a $5,300 premium and an estimated $2,000 in out-of-pocket expenses, for a total of $7,300 a year, which is 17% of his pre-tax income. A family earning $102,100 a year before taxes will have to pay a $15,000 premium plus an estimated $5,300 out-of-pocket, for a $20,300 total, or 20% of its pre-tax income. Individuals and families earning less than these amounts will be eligible for subsidies paid directly to their insurer. (McCaughey, 2009—Pelosi Health Care, para. 4)

According to White House website, "President Obama is committed to working with Congress to pass comprehensive health reform this year in order to control rising health care costs, guarantee choice of doctor, and assure high-quality, affordable health care for all Americans" (Health Care, 2009, para. 11). These promises are all well and good, but it is the methodology by which the president has proposed implementing these things that had many Americans fearfully viewing H.R. 3200 and now fearfully viewing

H.R. 3962. President Obama is envisioning a utopian society where every citizen is taken care of and cost is not an issue. The President and other supporters of this health care reform bill seem unable to realize the way in which other countries that have adopted a universal, single-payer or government-run health care system may spend less on health care and "waste" may be reduced, but in turn, patients are forced to wait extravagant amounts of time for surgeries and other treatments and it is difficult for patients to secure specialized care. These health care systems create and foster an environment where even the former Prime Minister of Canada, Paul Martin, chose to go to the United States for surgery rather than have it in Canada.

As noted in *New American* magazine, in a 2003 appearance at an AFL-CIO conference, Obama said, "I happen to be a big proponent of a single-payer, universal health care plan. …That's what I'd like to see, but as all of you know, we may not get there immediately" (DuBord, 2009, p. 16). If President Obama's dream becomes a reality, if the government is able to implement a single-payer, universal health care plan, then the examples created in Canada and the United Kingdom and the investigations done by numerous think tanks, doctors and researchers reveal that Americans will begin to realize the reality of rationing and a lowered quality of health care in the United States. As President Obama has said himself, "Without competition, the price of insurance goes up and quality goes down" (Obama, 2009 para. 35).

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