

Health Care Reform Update

July 26, 2009

“During times of universal deceit, telling the truth becomes a revolutionary act”

George Orwell

As health care reform is being discussed daily in both the Senate and the House of Representatives, we would like to help our patients understand some of the issues and how they could affect you. There is a great deal of rhetoric from Washington. The stated goals are noble, but the nuts and bolts of how President Obama *et.al.* plan to achieve these goals are concerning, and often counterproductive. The name, “H.R. 3200, America’s Affordable Health Choices Act of 2009” is truly disingenuous.

The first principle of medicine should also be the first principle of government. In latin, it reads “*primum non nocere*” or “first, do no harm”. As flawed as some view our current health care delivery system, it is far better to do nothing, than to do something harmful. As a local electronic billboard reads, “If you think that health-care is expensive now, just wait until it is free.”

Most of the proposals put forth, would create a government run system that would not allow doctors to provide state of the art technology, require doctors to ration care and interfere with the doctor–patient relationship. If passed, it will dramatically impact your ability to access quality medical care.

In Massachusetts, there are individual mandates and insurance premiums are the highest in the nation. Doctors there are so swamped that some have resorted to “group exams”. In Hawaii, a joint public/private program aimed at covering the poorest children was cancelled after seven months, as 85% of the enrollees were children who had previously been insured by their parents but were now insured by the state, at taxpayer’s expense. Canada also started with a “public option” for insurance. Canadians flock to this country for care in a timely manner when they can’t get it in Canada.

One of the stated goals of President Obama’s Universal Health plans, is to improve both qual-

ity and efficiency. This is indeed admirable. However, the mechanism is scary. By collecting data, they would define the “best and most efficient practices”. How do they get their data? The government would require doctors to provide all of your personal health care information to the government. That means men, if you “ask your doctor about Cialis”, the government will know. Women, if your periods are irregular, the government will know. This is not just an Orwellian nightmare, it is real and is in the proposed legislation.

The American Medical Association has sold both patients and doctors down the river. Patient choice, patient privacy, and patient control in their own care, apparently are less important to them than a few extra dollars. A few dollars, that by the way, can be revoked at the whim of Congress.

The physicians of the San Antonio Orthopaedic Specialists would have you look at our mission statement. It states that we “...are dedicated to providing excellence in subspecialty orthopaedic care and to treating each patient as if they were family.” There are already more than 11,000 pages of government regulations concerning physician’s practices. Our concern is that if President Obama’s proposed measures pass, and we are forced to comply with many thousands of pages of new regulations, it will be impossible to provide state of the art care and also impossible to treat patients as if they were family.

We encourage you, the patient, to contact our President, our Senators and your Representative. Now, more than ever, your voice is needed. Call, Fax, or email, but please let your elected officials know that you value choice in health care, value your privacy, and value your doctor–patient relationship. These are all threatened by H.R. 3200.

Washington's most popular Myths about Health Care

Excerpted from the American Association
of Physicians and Surgeons

www.aapsonline.org

Myth 1: An electronic medical record could save your life in an emergency.

False: In an emergency, information technology does not stop bleeding, start IV's, defibrillate the heart, or put in a breathing tube. In an emergency, those are the things that save your life, and if you need them, doctors and nurses are the ones to administer them.

Myth 2: A public plan could save enough on administrative costs to provide coverage to all.

False: Data from the Congressional Budget Office shows that insurance companies spend at least 50% less on administration than government does on its health programs. Further, Medicare is externally administered by private companies: its non-care costs are 5.7%. If it were administered like other government programs, administrative costs would increase by \$1 trillion over the next 10 years.

Myth 3: Americans are going bankrupt, and American companies are noncompetitive, because we don't have "universal health care."

False: Only about 5% of bankruptcies can be traced to medical debt as the cause. The av-

erage net worth for bankrupt households is \$44,600, while medical debt accounted for less than \$18,000. Large companies are strapped by Union demands for gold plated health care policies. Small businesses are strapped by inequalities in the tax code, forcing them to pay more for the same coverage.

Myth 4: Infant mortality is lower in other countries because they have "universal" tax-funded medical care, and the U.S. does not.

False: A number of countries report lower mortality than the U.S., but it has nothing to do with the source of payment for medical care. In Japan, a country which has good statistics, the national system does not cover normal childbirth-or prenatal, postnatal or postpartum care. In the U.S. premature, low birth weight babies, who have a much higher risk of earlier death, have a better chance of survival than anywhere else, because of the excellent medical care they receive.

Myth 5: Cost control and quality will emerge from comparative effectiveness research.

False: Most medical research, like that done by the National Institute of Health, is aimed at finding better ways to treat a problem. Comparative Effectiveness Research, is only concerned about the value of an

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Deadly Doctor

N.Y. Post 7/24/09



By Betsy McCaughey,
NY Post 7/24/09

The health bills coming out of Congress would put the decisions about your care in the hands of presidential appointees. They'd decide what plans cover, how much leeway your doctor will have and what seniors get under Medicare.

Yet at least two of President Obama's top health advisers should never be trusted with that power.

Start with Dr. Ezekiel Emanuel, the brother of White House Chief of Staff Rahm Emanuel. He has already been appointed to two key positions: health-policy adviser at the Office of Management and Budget and a member of Federal Council on Comparative Effectiveness Research.

Emanuel bluntly admits that the cuts will not be pain-free. "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," he

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Myths

existing treatment. The plan fails in its goal as it looks only at large groups, not at individual patients. It is, in as many words, the rationale for discrimination against an individual for the greater good. Particularly disturbing are some of the people appointed to this board. Please see “Deadly Doctors” in this issue.

Myth 6: Life expectancy is longer in other countries because they have universal tax-funded medical coverage, and the U.S. Does not.

False: The longest-lived people are probably the Japanese. They have good genes, are seldom overweight, and eat lots of fish. They have had a government funded medical system since 1927. They also have a robust private medical sector. Japanese, like all people, except Canadians and North Koreans, are not restricted to a single payor. How do we know that they wouldn't live even longer without their government medicine?

Myth 7: Universal coverage, enforced through an individual mandate, as in Massachusetts, will achieve universal access and reduce costs.

False: While well intentioned, this bipartisan plan has backfired. The result is that health care premiums are approximately double that in other states. The number of uninsured decreased due to subsidies, not mandates. State spending is up 42% in less

than two years. Utilization of medical services is as are wait times for basic services.

See also:
<http://online.wsj.com/article/SB123811121310853037.html>

Myth 8: Spending more on prevention and “wellness” will enable us to spend less on medical care while improving health.

False: The idea of having a “wellness” rather than a “disease” orientation is politically appealing. No-cost and low-cost choices—diet, exercise, avoiding risky behavior—are available to all Americans, without any involvement by health plans or government.

A review this year of 599 papers published on the topic of preventative interventions showed that 80% actually cost more. Prevention and early detection saves lives. Except for prenatal care, and childhood immunizations, attempts at “wellness” work, but cost more.

Myth 9: A “public option” is needed to spur competition, keep private plans honest, and bring down costs.

False: The problem here is by what set of rules will the government play? If they play by the same rules as private insurance companies, their premiums will be the same. If they either use tax dollars to cover administrative overhead, or use their monopsony power to squeeze providers, their rates will force out private competition.

If the government really wanted competition, they'd have repealed the McCarran-Ferguson exemption that shields the insurance industry from anti trust laws.

Myth 10: If you like your health plan and your doctor, you can keep them.

False: To some extent, this statement may be true—for right now. There is no constitutional guarantee for the right to choose a doctor or form of payment. The public option is a slippery slope towards a Canadian style single payor. Many Canadian physicians fled the country to practice here when universal coverage began. While the President is not planning to force you to change, there is no promise that your plan or your physician will still be available.

As regulation has increased over the last several years, physicians have been taking early retirement. The best and the brightest are no longer committing to medicine. The projected doctor glut of the 1980s is already a shortage, which will only get worse the deeper that the government gets into the practice of medicine.

The bill eviscerates ERISA, a complex law that simplifies insurance contracting for multi-state corporations, or 132 million people. State by state contracting is cost prohibitive. Companies will drop coverage, paying 8% penalty. Workers are out of luck. (WSJ 7/20/09)

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Myths

Myth 11: There are 46 million or more Americans without “health care”.

False: First, there is a big difference between “health care” and “health insurance”. There are probably very few, if any, that are denied life saving medical care on the basis of ability to pay. There are very tight laws (EMTLA) that require a hospital to treat any person who shows up on the doorstep requiring care.

Those with low income tend to say that their health is poor. The percentage of those reporting poor health is about the same whether on Medicaid or uninsured.

This figure is widely quoted. It does, however, include somewhere between 10 and 25 million illegal aliens. These illegals do get health care, at our emergency rooms, and at taxpayer expense already.

The fastest growing sector of uninsured are families making over \$75,000 per year, those that could afford it, if it were worthwhile.

Myths are updated most days. Please visit www.aapsonline.org and look for “Mythbusters” about 2/3 down the page in the center

Deadly

wrote last year (Health Affairs Feb. 27, 2008).

Savings, he writes, will require changing how doctors think about their patients: Doctors take the Hippocratic Oath too seriously, "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).

Yes, that's what patients want their doctors to do. But Emanuel wants doctors to look beyond the needs of their patients and consider social justice, such as whether the

money could be better spent on somebody else.

Many doctors are horrified by this notion; they'll tell you that a doctor's job is to achieve social justice one patient at a time.

Emanuel, however, believes that "communitarianism" should guide decisions on who gets care. He says medical care should be reserved for the non-disabled, not given to those "who are irreversibly prevented from being or becoming participating citizens . . . An obvious example is not guaranteeing health services to patients with dementia"

(Hastings Center Report, Nov.-Dec. '96).

Translation: Don't give much care to a grandmother with Parkinson's or a child with cerebral palsy.

He explicitly defends discrimination against older patients: "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. Even if 25-year-olds receive priority over 65-year-olds, everyone who is 65 years now was previously 25 years" (Lancet, Jan. 31).

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