James L. Holly, M.D.

Healthcare Policy Issues Part II
Reality, Responsibility and Rights
By James L. Holly, MD
Your Life Your Health
The Examiner
August 13, 2009

If the two options in the future of healthcare are “rationed” care or “rational” care, and it is our position that they are (see The Examiner Your Life Your Health, August 6, 2009 at www.jameslhollymd.com), then the context of these option can be understood in terms of the reality of healthcare, the right to receive and/or to lead healthcare, and the responsibilities which accompany those rights and realities.

Reality

Since the advent of Medicare in 1965, it has been obvious that healthcare financing and management will never return to the *laizze faire* style practiced in the past. *Laizze faire* describes a policy of allowing events to take their own course. The French term literally means to "let do". It is a doctrine that holds that the State generally should not intervene in the marketplace. The reality, taught to us by the experience of the last forty-four years is that someone is going to control and manage healthcare. The only real question is, “Who?” The reality is that the payment for healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the question of “Who is going to pay for the services?”

Second, because of the expense of technology and of the increasing access to healthcare by a larger population, it is possible for healthcare alone to bankrupt the United States. Unchecked, the cost of healthcare delivery can prevent the balancing of the Federal budget, consequently, the financing of healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the questions of, “How much is a service worth and how much is society willing to pay for it?”

Third, because there are limited resources available with which to continue to provide the excellent healthcare, which the citizens of this country presently receive, someone has to allocate those resources. Who? The financing of healthcare will never return to a system where the medical decision making process takes place in isolation and independent from the question of, “What is society’s responsibility to its most vulnerable citizens as far as access to affordable healthcare is concerned?” And the corollary questions, “How much healthcare should be accessible to everyone?”

Fourth, the government has assumed, by law, the responsibility of providing healthcare to a certain segment of our population, and the government is not going to surrender that responsibility. The facts of this reality are explained by the actual, average per capita cost of care which is calculated based on CMS’ (Centers for Medicare and Medicaid Services) payments for healthcare in the United States. It is calculated on a county-by-county basis for every county in America. This does not include administrative costs.

To control escalating healthcare costs and to insure quality of care to beneficiaries, CMS attempted to keep its responsibility for delivery of healthcare within the historical average per capita cost. They did this by contracting with insurance companies to transfer their risk to someone else for a “set fee.” In fact, CMS determined to realize an “upfront” savings by paying insurance companies only 95% of the per capita cost, creating an immediate 5% savings in their healthcare cost, while also “locking in” their cost by transferring the risk to insurance companies.

The reality is that the Healthcare Trust Fund, which is administered by CMS, is approaching bankruptcy. However, if 50% of Medicare beneficiaries would adopt a managed-care form of healthcare delivery, the Trust Fund would remain solvent for the next 100 years.

The reality is also based on the concept of “risk.”

Insurance companies allowed the government or private industry to transfer the responsibility for paying for healthcare to the insurance company. As a result, the government or industry can know that the cost for the healthcare of that population will not cost any more than the contracted amount which is based on the historical per capita cost. The government and industry has therefore managed its risk by transferring that “risk” to a private corporation. Once an insurance company contracts with CMS or industry, that company assumes the “risk” for the healthcare of its membership for a year. If the healthcare costs more than the contracted amount, the insurance company loses money; if the healthcare costs less than the contracted amount, the insurance company makes money. But, in no case will the government or industry provide more money for the contracted period. For budgeting and planning that is an asset to the government and to industry.

In his book, *Against The Gods: The Remarkable Story of Risk*, Peter L. Bernstein chronicles man’s experience with making current decisions on the basis of what may or may not happen in the future, the very basis of assuming risk for future healthcare. He states:

> “The ability to define what may happen in the future and to choose among alternatives lies at the heart of contemporary societies. Risk management guides us over a vast range of decision-making, from allocating wealth to safeguarding public health, from waging war to planning a family, from paying insurance premiums to wearing a seat belt, from planting corn to marketing cornflakes.”

In healthcare risk management, the government and industry has turned over to private enterprise, a responsibility which the government has not been able to manage successfully, i.e., providing quality, cost-effective healthcare in an escalating cost environment. A private company accepts this risk with the idea it can do a better job than the government. A private company believes it is possible to make a profit, while fulfilling the responsibilities the government assumed by the creation of Medicare and Medicaid. This is the reality of current healthcare financing. Once assumed, the risk becomes that of the private company. The company cannot go back to the government for more money.

For many reasons, some valid and some not, the American public has not widely accepted this transfer of risk, although most of those who have experienced this form of healthcare management find that it works well for them. There have been some horror stories which have been used to create fear of this form of "risk management," not unlike the fear which has been used by the current administration in creating a "healthcare crisis" and also not unlike the fear which has been used by the minority party to oppose the administration's plans.

These are the realities which healthcare providers, patients and managers of public policy must face in attempting to deal with reforming healthcare. We will argue that healthcare does not need reforming as much as it needs transforming. This distinction will be discussed later.

The second relevant issue is responsibility

Each player in healthcare delivery today is in an unspoken partnership, which has actual and implied responsibilities.

- Payers principally the government and insurance companies
- Providers (physicians and other deliverers of health services)
- Patients (insured)

Each "player" has peculiar responsibilities. The payers, of course, have responsibility for operating within the "realities" of risk which they have assumed whether they are the government or an insurance company. Both are responsibility for assuring that access to healthcare and that the quality of that healthcare are maintained.

Providers are responsible for providing evidenced-based care with an emphasis on preventive care and the maintenance of health. In "risk-managed" care, healthcare is more directed toward preventative healthcare than to treating a problem, which has already developed. Physician must also be aware of the differences in cost for care. The reality is that care obtained at one place, which is equal to the quality of care obtained at another, can be three times as expensive. To conserve the healthcare resources for the benefit of everyone, the physician's responsibility is now, not only to assure quality, but also to be attentive to cost-effectiveness.

The patient has responsibilities. In order to get the expanded benefits and cost decrease of healthcare which is provided by the government, or by an insurance company which has accepted the government's risk, the patient is responsible for utilizing physicians who accept their responsibilities to practice evidence-based care and to be attentive to the cost of that care. The patient also has a responsibility to avoid habits, such as smoking, excessive alcohol consumption, inactivity and other behaviors which cause increased health problems, when and where possible, and to cooperate in obtaining preventive care, which can decrease the cost of maintaining health before serious and costly problems develop.

The Third Relevant Issue is Rights

One of the most contentious questions in public policy debates is whether or not a citizen, or even a non-citizen resident, legal or illegal, of the United States has the right to healthcare?

Another question which is not being addressed is, if a person has the right to healthcare, can that person by their personal conduct, choices or habits abrogate those rights? The Declaration of Independence explicitly and the Constitution implicitly addresses “inalienable” rights. While I would argue that every citizen of the United States has the right to healthcare, I would argue that that is not an “inalienable” right and that the individual can “alienate” themselves from their right to that care, or at least to certain parts of that care, by their behavior choices.

This is a serious ethical question and one which must have an answer. It cannot be answered independently in individual cases but must be answered as a matter of public policy. I would argue that the right to unlimited access to healthcare can legitimately be associated with limitations based on the choices of the individual. This argument would include the principle that a person’s behavioral choices, which increase the cost of their care, could increase their individual and personal responsibility for the cost of that care. As a general concept this position is, I think, valid but it is too simplistic to be the whole answer.

The patient has, I would argue, the right to access to needed healthcare. However, the rights of the patient must be balanced with the rights of the public who are assuming the major burden of the cost of that care and those rights must also be balanced with the rights of healthcare providers. Likewise, the rights of providers and payers must be balanced against and with the rights of the patient. The patient should have the “right” to choose any primary care provider and the patient should have the right to go to any specialist. But, just as I would argue that the patient can lose their right to unlimited healthcare, I would argue that a healthcare provider can lose the right to provide care, which is going to be paid for by someone other than the individual receiving that care, if the provider is unwilling or unable to make sound, evidence-based-care choices, which also take into account the cost of the patient’s care.

A corollary to this concept is that any patient can choose to receive any legal and ethical care from any provider if the patient is paying for that service out of their own pocket. Whatever the future of healthcare policy holds, it must not exclude the possibility that an individual can contract personally and independently with a healthcare provider for any service they desire, so long as that care is legal and ethical. This may seem like an unnecessary concern, but history has shown that it is not.

Healthcare providers also have rights. Most physicians have resorted to demanding their right to lead health care management. The new realities have often resulted in that demand being rejected. If providers wish to exert influence over the delivery of healthcare, they will have to accept their responsibilities and collaborate with payers and patients. This is a perfect segueway into the third installment of this discussion which will address the need for transforming of healthcare rather than the reforming of the healthcare system.