Commentary on"American Pie" by Steffie Woolhandler, M.D.

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The above article by Steffie Woolhandler, M. D., calls for a single payer national health system run by the federal government. Similar proposals have been floated over the years, and this year again a bill has been introduced in Sacramento to mandate a single payer system here in California. I feel compelled to comment on these "progressive" ideas which Dr. Woolhandler argues are held by vast numbers of other practicing physicians.

It is of interest to note that Dr. Woolhandler, hailing from a poor parish in Louisiana, is an Associate Professor of Medicine at Harvard, co-director of the Harvard Medical School General Internal Medicine Fellowship program, and the "co- founder of Physicians for a National Health Program (PNHP), an organization that educates physicians, other health workers, and the general public on the need for a comprehensive, high-quality, publicly-funded health care program, equitably accessible to all residents of the United States." She asserts that health care is the right of all people living in this country, regardless of economic or immigration status. She rightly points out how inefficient our current system of health care is in converting dollars put into our system to direct patient care. The administrative overhead and the profits generated for various suppliers, hospitals, investors, and others are far higher in the United States than in Canada, for example. She envisions a "Canada deluxe" system whereby elimination of our inefficiencies (and profits extracted at the expense of less care) can free resources—which already are being expended—to help finance the 40 million or more uninsured. This newly available money supposedly would ensure care for all, and without imposing any further financial burden on those who cannot afford it (the elderly and the poor, as well as many in the middle class). This is a noble and principled stand in which she claims to have taken the high ground, and she admonishes us all not to try to fly the same old overloaded plane over and over, knowing it will crash before it takes off.

My current perspective derives from a place far different from that of Dr. Woolhandler. Yes, as a young man, I embraced the liberal left's agenda. I began medical school full of idealism, planning on becoming a primary care physician, hoping to use medicine to spread "social justice." I trained as an

internist at Tufts New England Medical Center in Boston. In fact, I did serve in the National Health Service Corps as a primary care internist in Somerville, Massachusetts (one mile as the crow flies from the Massachusetts General Hospital, and a few minutes drive from Cambridge Hospital where Dr. Woolhandler now practices). In those years, I did accept and proselytize for the notion that medical care in America ought to be a right and not a privilege, and I was angry with a medical establishment which seemed to me to be intent on protecting physician rights and prerogatives instead of promoting personal sacrifice for the good of all patients. But primary care did not suit my personality so I began training in anesthesiology at the University of California at Irvine Medical Center in Orange in 1981.

I have practiced anesthesiology in community hospitals in Orange County since then and have witnessed and participated in a raging torrent of changes which have stood Medicine on its head. The idealism of my youth survives, but I have grown into a mature physician at the "top of my game." My perspective, and likewise my politics, have evolved because of what I have had to endure on so many levels to permit me to continue to practice medicine.

I believe that our health care system is a complete mess, and in large part because of the federal government and its policies and regulations, which appear to have been constructed by a well-meaning and influential Eastern intellectual elite who fail to anticipate the unintended consequences of its far-reaching tinkering with incentives, tax breaks, and regulations. On reflection, one might even argue that federal mandates and incentives even created the "business of medicine," deriving from the flawed notion that efficiencies incentivized at the federal level could slow the growth of medical spending and save federal dollars. Well, growth did slow, doctors took a bashing, businesses boomed, and the federal government saved some money, but those savings have been played out, and now we are talking about attacking the same problem a few years later because the fundamentals have never been addressed.

The federal government has essentially mandated Medicare participation by forbidding participating physicians to bill patients for the balance of their charges. Since 1992, the federal government established an oppressively low maximum amount for the billings for anesthesiologists' services (based upon flawed Hsaio walkovers which were really only three CPT codes), an amount

marginally more than the maximum for Medi-Cal billings. Resource-Based Relative Value Scale (RBRVS) has become the de facto standard for billing for many insurance companies which pay contracting physicians some multiple (like 120 percent) of Medicare. Primary care physicians have done better since RBRVS than many other specialties, and they have embraced RBRVS, just as some primary care physicians may be espousing a single payer national health system in part because they feel confident that remuneration under such a system logically would be an extension of their current reimbursement. Furthermore, the Relative Value Update Committee is hopelessly incapable of changing the relative worths of different specialties because this has become a zero sum game: what one gets, another loses. Medicare has a ludicrous update formula against which we have lobbied Congress for years, but to no avail. Payments to academic anesthesiologists supervising residents have one standard for surgeons and, illogically, a more burdensome standard for anesthesiologists. Our specialty thus has a long and largely painful history of dealing with the feds, and it cannot envision participating in a single payer system under their direction or control.

We just cannot afford to risk turning over our entire profession to complete control by the federal government or some quasi-federal authority. Instead, I believe we should evaluate the plan professed by the AMA: Palmisano, DJ et al. "Expanding insurance coverage through tax credits, consumer choice, and market enhancements: the American Medical Association proposal for health insurance reform." *JAMA*. 2004 May 12;291(18):2237-42. We should try to salvage and modify and help our system evolve by appropriate incentives and market principles.

The House of Medicine is divided, just as is the general populace, concerning many important societal issues. It is just not logical, nor should it be legal, to try to nationalize the medical profession in the face of an independent legal profession and even an independent grocery system. Surely the government must provide (and that means fund) a basic level of medical care for all of its citizens, just as it provides basic legal services and food stamps for the indigent. It is time to recognize that we have to accept more than one system of care because we simply cannot afford to provide a Cadillac for all at less than Ford reimbursements. People who can afford to pay for special services ought to be entitled to do so rather than being barred from doing so. The model more appropriate to our health care system may be the English

modification wherein there is both a national health system and a private system which exist in parallel fashion.

No, I don't yet have a response to Woolhandler that provides a constructive approach to the current problems of unbridled costs, the un- and underinsured, catastrophic illness and inefficient and ineffective deployment of the monies that we do spend on healthcare, but neither am I convinced that a single payer system is the answer. However, for starters I would propose taking some of the most egregious profit motivation out of the system by returning to a time when hospitals and insurers could either be non-profits or privately held for-profits. The burgeoning of publically-held and traded for-profits with over-arching fiduciary responsibilities to investors indifferent to any fundamental motivation other than the bottom line seems to me to have done a lot to divert money from funding actual patient care.

Dr. Woolhandler's "dog" is no better a hunter than mine! Idealism is a wonderful thing philosophically, but even idealists may see fit to temper their ideas in the face of reality, to evolve, and to move closer to the center politically.