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Rational Health Care Reform: Reflections of a Practitioner

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When I first came to Johns Hopkins as an intern, more than three decades ago, I remember being impressed by the caliber of patients on the wards. There were CEOs of major companies, presidents of large organizations, princes and queens from different countries, and they were, in many cases, dying of horrible diseases. What they all had in common was that they would have gladly given every penny and every title they had for a clean bill of health. At that point, I truly understood how incredibly important health care is. For this reason, I am certainly happy that the topic has risen to prominence recently, and I am delighted that the new health care bill addresses such things as exclusion from insurance because of pre-existing illnesses and lifetime caps on insurance benefits. This is all well and good, but unfortunately, we really have not addressed one of the major issues, which is cost. The United States already spends approximately twice as much per capita for health care as the next closest industrialized nation in the world.\textsuperscript{1} This indicates that there is no lack of intention or effort to provide health care, but there is a great deal of inefficiency. Before doing things that further increase the cost, we should look at ways of increasing efficiency and decreasing costs.

I would start by asking the question: what do you need for good health care? I submit that you need to have a good doctor and a patient with a medical problem. At some point, a middleman came along to facilitate the relationship between the doctor and the patient, and now the middleman has become the primary entity, with the doctor and the patient at its beck and call. When there is a primary relationship between a doctor and a patient, costs are automatically examined more closely than in a situation where there is some nebulous third party to whom all

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bills are submitted and who gets to determine what services should be available for certain patients. Because of this, we should design policies that are aimed at getting the middleman out of the equation.

One of the first things that could be done is to recognize that the cost of getting an operation—an appendectomy, for instance—is different in New York City than it is in Miami than it is in Oklahoma City than it is in Dallas. By having so many variations and ways of billing and collecting, we justify the mountains of paperwork involved with medical claims and the armies of people to push that paper around. All of those people have to be paid out of each health care dollar. We can remove most of them by recognizing that virtually every diagnosis has something known as an ICD-9 code, and every procedure, from drawing blood to a craniotomy for a tumor, has something known as a CPT code. These provide standardization in medicine so that all billing and collection can be done uniformly and in a computerized manner.

Many insurance companies would argue that if the system were simplified in such a manner, a physician could indicate that he had done two appendectomies when in fact he had only done one, so that he could be paid twice. However, there are weaknesses to the insurance companies’ protests. First of all, very few physicians that I know would ever consider such an unscrupulous act, and secondly, I think there are better ways to deal with the very few people who are that dishonest. This is why we have a criminal justice system. I would advocate that the penalties for committing medical fraud be very severe, such as lifetime loss of medical license and no less than ten years in prison. Under such circumstances, not only would all physicians be extraordinarily meticulous about correct billing submissions, but they would also check every bill “seven ways to Sunday” to make sure it is correct. One might not think that harsh penalties work, but all one has to do is look at the rate of drunk driving in Sweden versus the United States. In Sweden, the penalty for drunk driving is extreme, and it virtually does not occur, whereas in the United States the penalties are quite variable and sometimes negligible. The savings we would encounter by having physicians simply submit the ICD-9 code(s) and the CPT code(s) and be reimbursed

2. For a comprehensive explanation of the punishments and frequency of various drunk-driving laws on other nations, see National Highway Traffic Safety Administration, On DWI Laws in Other Countries, available at http://www.nhtsa.gov/people/injury/research/pub/dwiothercountries/dwiothercountries.html. Because of strict laws, the people of Sweden “do not drive after drinking.” Id.
Another thing we should consider is how to take care of the 47 million uninsured patients. On a historical note, it should be remembered that prior to the time that insurance companies were able to dictate the cost of health care and pay whatever they wanted to pay, most hospitals and physicians took care of a significant number of indigent patients and felt it was their duty to do so. Therefore the 47 million people in this country without insurance actually do not exist. Why do I say that? Because, if they have a medical emergency, they can go to the emergency room where they have to be treated. The problem with that system is that it costs five times more to be treated in the emergency room than it does in a neighborhood clinic. What that means is that at some point we have to recognize that we are taking care of them anyway. All of us are paying for it, and therefore we need to come up with some type of incentive that would encourage each individual to go to the neighborhood clinic rather than to the emergency room. I submit that we do not have to reinvent the wheel; we can look at other social welfare provisions in our government, such as the Food Stamp Program. People on food stamps learn very quickly not to go out and buy porterhouse steaks within the first five days of the month and starve the rest of the month before they get their next monthly allotment. They learn to be rational in the way they space their food purchases, and they are able to survive adequately. If we had an electronic health account that was replenished on a monthly basis, it might have a similar effect. Under this scenario, if Mr. Smith has a diabetic foot ulcer, he would be much less likely to go to the emergency room and blow half of his monthly budget than he would be to go to the clinic. He would get the same treatment in both places, but in the emergency room they would patch him up and send him on his way, whereas in the clinic they would patch him and up and say, “Now Mr. Smith, let’s get your diabetes under control.” We begin to talk about preventive health care and a whole other level of savings. As our population ages, we would be extremely well served to look at wellness as opposed to sickness.

One of the reasons that health insurance is so expensive is that we in the medical profession have become so good at saving people’s lives or improving their quality of life through sophisticated treatments. We are now able to take an extremely premature baby, give him certain drugs, put him in an incubator, and do various procedures to save him whereas previously he would have been lost. At the end of that salvation, we hand the insur-
ance company a bill for $1,000,000. Likewise, we are now able to take an eighty-five-year-old woman with hypertension, diabetes, and thyroid disease who develops a tumor of the brain or the lung, and we can remove the tumor and restore her to her baseline. We then hand the insurance company a bill for $600,000. After seeing this enough times, the insurance companies feel that they can justify enormous rate hikes and hide behind the issue of catastrophic health care, which is very difficult to dispute.

I should hasten to point out that not all health care insurance companies are greedy and looking only for money, and, in fact, there are some that are truly concerned about patients. Those companies probably would agree with my next suggestion: to remove from the insurance companies the responsibility for catastrophic health care. They would only be responsible for routine health care, defined by a certain dollar amount, and the government would be responsible for catastrophic health care. That would mean that we would be able to predict how much money the insurance companies need to take in, and we would have a pretty good idea of how much they have to put out, based on actuarial tables. They would be regulated, along with the cost of insurance, yet they would still be allowed to make a profit, just as utilities are able to make a profit. Indeed, if we did not regulate utilities, we would all probably be having trouble paying for electricity and water.

Now one might ask, how in the world is the government going to deal with catastrophic health care? Well, we do not have to create a new government entity; we already have one in existence called Medicare. It would simply be open to everyone, rather than just people who are sixty-five and over, and it would kick in at a certain dollar amount per illness. Obviously, it would be necessary to tighten up the processes that allow Medicare payments to be accessed, since there is currently an enormous amount of fraud in the system. However, if we make catastrophic health care a government responsibility, we will finally have to consider such problems as end-of-life care. Currently, we stick our heads in the sand and ignore the problem, but we still end up spending 40–50% of all Medicare dollars during the final months of a person’s life.3 We poke them and prod them and put them in intensive care units, basically torturing them until they die. There are few other industrialized countries that engage in such futile efforts, and that is one of the reasons that

other countries' medical costs do not approach ours. I have no
doubt that we could reach a rational way to deal with end-of-life
issues in a very compassionate and reasonable way.

In order to accomplish this, we would also have to deal with
tort reform. In many cases, physicians perform procedures that
they know are probably not going to be beneficial in the long
run—they are simply afraid not to perform them when someone
can come along and say that they could have saved a patient's
life. There are few other industrialized nations that experience
the malpractice problems that we do, and I do not believe that
this is because our doctors are worse than doctors elsewhere; in
fact, I believe that our doctors are better than those in most parts
of the world. The problem is not that we commit more malprac-
tice, but rather that there is a special interest group that does not
want to see tort reform. Anyone who follows the votes in Con-
gress knows that every time tort reform has been introduced, it
has passed in the House, but it has been filibustered to death in
the Senate by senators who have a strong alliance with the Trial
Lawyers Association. To my amazement, about a year ago my
wife and I were at a public forum in Virginia attending a debate
between Republicans and Democrats about such things as health
care. One of the Democrats present was Dr. Howard Dean, who
is refreshingly honest about many different issues. He was asked
why there was no tort reform legislation in the new health care
bill, and he said, “The people who wrote [the health care reform
bill] did not want to take on the trial lawyers in addition to every-
one else they were taking on. And that is the plain and simple
truth.” This comment was akin to saying that the Democrats did
not want to take on their own supporters, because the reform
spent much time taking on other interest groups. I was shocked
at his honesty in a public setting, although I already knew that
this, in fact, was the reason there was no tort reform in the
legislation.

Those who say that tort reform is not that big of an issue and
that it really is small potatoes in terms of the costs of health care
really do not have a good grasp on the subject. They perhaps do
not realize that the cost of defensive medicine is virtually incalcu-
lable. They perhaps do not realize that many physicians become
frustrated, depressed, and quit due to malpractice suits. I know a

4. InstForLegalReform, Howard Dean on Tort Reform, Trial Lawyers and
Health Care, YouTube (Aug. 27, 2009), http://www.youtube.com/watch?v=Idp
VY2cOINnM. See also Health Care Run by Trial Lawyers: Jim Moran and Howard Dean
newsnets.org/html/HealthInsurance/2009/0828/Health-Care-Run-By-Trial-
number of neurosurgeons who have left practice after lawsuits because they were working themselves half to death, rewarded only by being told that they are terrible human beings who are inflicting injury upon others. In many cases, patients do not want to sue their doctor or the hospital, but they have no other way of recouping money to deal with unfortunate outcomes or accidents. Most other nations have found ways to take care of injured patients, but the aforementioned special interest group wants no part of that here because it would impact their income.

These are just a few ideas that could have an enormous impact and help bring the cost of insurance coverage down to a point where people and families could afford to own their own insurance and not have to get it through their employer. This would help remove many of the middlemen and also would create a situation where we could tell people that if you get an annual physical exam, you receive a 2–3% discount on your insurance premium. This would be extremely worthwhile, and we would catch many diseases at a much earlier stage and would be able to intervene when the costs would not be nearly as great as in late stage diseases.

The bottom line is this: do we want to restore in this country a system in which people take personal responsibility for their own health, have their own insurance in their own hands, and have a personal relationship with their health care providers, or do we want to have more government control of health care and other parts of our lives? These are two different models, and there are people who would advocate for each of them. I think we have to make a decision as to which way we want to go.