SEPPIAN

Winter Issue

The newsletter of the *Society for The Education of Physicians and Patients*

DARING TO TELL THE TRUTH ABOUT HEALTH CARE

Volume 7, Issue 4 **Seppian** *January, 2002*

SEPP Meeting— ***Tort Reform— The Malpractice Maelstrom***

State Representative Mike Turzai

Monday, February 18, 2002, Tambellini's Restaurant -7PM on Route 51 South All are welcome

Successful Summit—2001
Draws Those Concerned About Freedom in Healthcare

On November 17, 2001 The Society For The Education of Physicians and Patients sponsored its fourth major summit on healthcare. Expert presenters from across the country representing the medical profession, the nursing profession, employers and employees, and insurance providers discussed the hard issues of quality and access and how it has been compromised by the third parties such as Medicare and managed care. Government intimidation of physicians via fraud and abuse initiatives that result in excessive sentences for not complying with 132,000 pages of Medicare code was discussed by Andrew Schlafly. Medical ethics and the trends leading to rationing, and a medical culture of death were presented by Jerome Arnett, M.D. Dr. William McArthur of Canada, exposed Canadian healthcare for what it really is and presented stirring information on other such failing systems. We learned that failure of single payer systems in Canada and Britain is based on the necessary rationing that the inefficiency of expensive bureaucracies and political process creates.

Jane Orient, M.D., President of the Association of American Physicians & Surgeons spoke on physician inde-

(Summit - Continued on page 4)

Health Care Quality: Would It Survive a Single-Payer System?

Robert J. Cihak, MD and Merrill Matthews, Jr., PhD

In recent years some have been promoting a government-managed, single-payer health care system at state and national levels. What would a state-run system mean to the quality of the U.S. medical services? But first, what does "quality" in medical care really mean? Is it an issue of access? Or is it related to "outcomes?" Does it mean the best care available? Or do convenience and cost play a role?

In a normal market, people make quality tradeoffs, sometimes substitut-

(Single Payer- Continued on page 2)

SEPPIAN Contents

President's Corner—Professional Death

Meeting Schedule for 2002

The 50 Employee Obstacle to MSAs P. 1

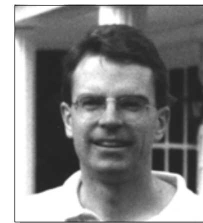
Healthcare Quality and Single Payer? P.1

Healthcare Summit Supporters P. 5

Emergency Power - State Based Healthcare Dictatorship –P.6

The 50-Employee Obstacle to MSAs.

When Congress enacted its limited MSA program as part of the Kassebaum-Kennedy Bill, it excluded employers having more than 50 employees. The requirement is set forth in Section 220(c)(4) of Title 26 of the United States Code.



Andrew Schlafly
Legal Counsel of AAPS

There is no rational basis for this arbitrary limitation. Why is it there?

It hinders the success of MSAs in the market. Groups having less than 50 employees are the least profitable sector of the health insurance market, easy to lose money serving.

Efficient management of risk of loss depends directly on the size of the group. The risk of catastrophic health expenses in a group of 1,000 is easily covered by the premiums of the healthy members of that group. Not so for every group of 25.

An insurer must sign up 50 separate groups of 25, with enormous administrative costs, to attain the same level of risk pooling provided by en-

(The Obstacle—Continued on page 3)

(Single Payer—Continued from page 1)
ing less quality for lower costs or greater convenience. **However, when people are insulated from the cost of health care because the government is paying the bill, the role of value declines.** Patients want quality at any price — because someone else is paying that price. Ironically, when someone else is paying the bill, the insistence upon quality declines because patients — indeed, any type of consumer — are willing to tolerate bad outcomes and poorer service when they are free.

Some quality factors are objective, while others are subjective; some can be measured, some cannot. We identify some factors below and explain why they should be part of any evaluation of health care quality under a single-payer system.

Access

One of the most touted benefits of a single-payer system is that it would be more efficient than the current system. People would have a family physician who they can see regularly, rather than postponing needed care until they are forced to go to the more expensive emergency room.

However, getting to see a family physician under a single-payer system may not be as easy as proponents suggest. **A recent flu epidemic in Toronto expanded the waiting times to see a family physician to five to six weeks — so far in the future that most patients either would have recovered from their illness and no longer need to see a doctor or would have become critically ill** and gone to an emergency room.

Affordability

Proponents of a single-payer system contend that when the government controls the cost of health care, the profit motive is removed, which means the same money can be spread over more people, which saves even more money as well as lives.

When most people enter the single-payer system, they believe someone else — personified as "the government" — is picking up the bill. As a result, people feel insulated from the cost of care and therefore tend to over consume — driving health care spending much higher than it would be if patients insisted on value for money. The irony here is that the process that makes health care affordable for the vast majority of people —a third party paying the bill — is the primary factor behind making the health care system unaffordable. In their effort to contain the cost escalation, single-payer systems control health care utilization from the top down with spending limits and price controls.

Scarce Funding and Rationing

As a result, there is never enough money to fund any program as much as proponents and patients would like. Moreover, the decision on which programs get funded and by how much is often determined more by which group has the most political power rather than a program's true needs and merits.

In a single-payer system, the government makes the larger decisions about funding levels, leaving bottom feeders such as the doctors, hospitals and other health care providers to make the tougher individual decisions about whose care to ration. The targets of rationing are usually the marginal cases, the very young, the very old and the very sick. The patient is often simply told, "There's nothing more we can do for you," a true statement within the confines of the limited budget.

In England, some kidney patients died while dialysis machines remained idle because hospitals said they did not have the resources to keep the machines running full time.

In Canada, 121 patients waiting for heart bypass surgery were removed from the waiting list because their condition had worsened to the point that they could no longer survive the surgery.

New Technologies

In a single-payer system health care budgets always end up tight after the politicians discover that they can't raise taxes to meet the demand for services. Middle level feeders, such as the administrators and bureaucrats, often limit adoption of new medical technology because it's too costly. They usually provide only enough funds to purchase a limited amount of the newest technology - if any at all. **Decisions on what to buy and when to buy it are often arbitrary and guided more by expedient politics than good medicine.**

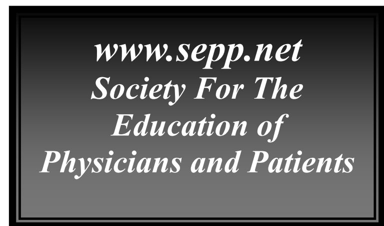
Stories abound of Canadians going to extreme measures in order to gain access to medical technology. For example, several years ago an enterprising hospital in Guelph, Ontario, decided to allow animals needing CT scans to enter the hospital in the middle of the night — charging pet owners (Canadian) $300 apiece. There is nothing necessarily wrong with that except that thousands of people in Ontario were waiting up to three months for an appointment on the same machine.

For physicians, single-payer means single employer. Yet some proponents for a single-payer monopoly gripe about working for corporate HMOs. **Yet any single-payer system will surely resemble a huge HMO, without any competing services. This would look like a U.S. Postal Service without competition from UPS, FedEx, e-mail or fax machines.**

Finally, in light of the recent attacks on the American homeland, we believe that the federal government has been grievously distracted from its primary duties, such as national defense, as spelled out in the U.S. Constitution. The resources of the federal government would be best redirected to such primary duties and away from meddling with the alluring mirages, such as the single-payer medical care vision.

The best way to expand citizens' control over their own care is to adopt free-market options that allow more choices and options. If policymakers move toward a single-payer system that tries to impose universal coverage, they will find that citizens will be left with neither care nor quality.

Dr. Cihak is the Past—President of the Association of American Physicians and Surgeons. He is a retired radiologist in Aberdeen, Washington, and a nationally distributed columnist. Merrill Matthews is a health policy analyst with The Healthcare Intelligence Network This column was adapted from their Washington Policy Center study. The complete study (# 01-13) is available at http://www.wips.org/HealthCare/PBMatthewsCihak HealthCareQualiiy.html.



(The Obstacle—Continued from page 1)
rolling one employer with 1,000 employees. In addition, there are added costs of increased bankruptcy and probably an older age population among small businesses.

When a large company goes bankrupt, it typically has assets that fund essential expenses like health insurance premiums. Not so for a small company. Moreover, large companies are known for expelling older employees, with costly health expenses, through "early retirement," unlike small businesses.

HMOs know that the money is in serving the larger corporations, and target their marketing there. HMOs undoubtedly lobby against any removal of the 50-employee prohibition on MSAs, as do other threatened special interests.

Is there a political or legal argument against this arbitrary 50-employee rule? Perhaps. The rule prevents small company employees from pooling their health risk with others.

The 50-employee rule splinters and fragments the market into tiny segments, frustrating adequate risk pooling by many. The result is lack of health insurance for many employees.

One could argue that insurance companies should provide small company employees with the same risk pooling that is available to large company employees. It is arguably discriminatory to allow such different treatment for the two classes.

In large companies, the employees pool their risks for the purposes of health insurance, and HMOs exploit that opportunity. MSA providers are prevented from pooling their risks in the same manner, and small company employees suffer from that discrimination.

The unjustified 50-employee bar on MSAs must end.

Andrew Schlafly is legal counsel for The Association of American Physicians and Surgeons.

Dennis Gabos, M.D.
President of SEPP

Professional Death

The Inverse Universe of Healthcare

The Society For The Education of Physicians and Patients enters its tenth year of endeavor to preserve that which has made American Healthcare strong. Sound academic and clinical training for physicians, nurses and allied professionals; an environment that encourages hard working, qualified individuals to enter these professions and rewards them for excellence and dedication. These traits and our mechanism of funding of healthcare has brought to Americans the most advanced healthcare on earth. For most of the last 50 years we had funded healthcare with true insurance, less government, and minimal third party interference. We had honored hard working nurses with increased pay, benefits, positions of esteem in the nursing hierarchy. Years of dedicated service were considered a benefit by hospital administrators. Likewise the long hours of reimbursed and non—reimbursed service in the practice of medicine held its own reward for physicians. Their status was one of esteem and trust. When there was no funding for needed service they gave of themselves. Sounds good. It used to be true.

We now live in the inverse universe of healthcare. Now that which was considered of value is viewed as without value. That which was welcome is feared. That which was laudable now criticized. We face a healthcare crisis with a shortage of nurses and physicians. We face a crisis of values as freedom principles are supplanted by corporate and government schemes accurately described as socialist in nature. Healthcare is stolen from hospitals and doctors by third parties that grip them.

Medicare for that last five years has steadily dropped its reimbursements on key services while the cost of living goes up. This holds for hospitals and physicians. Other insurers tend to follow this trend. Irresponsible hospital boards and administrators have aligned with the third parties and accepted “stealing of healthcare” and rationing of dollars. This ultimately translates to rationing of services while the bureaucracies continue to grow. Hospital administrators have abused the nursing profession by dictating that nurses take care of more patients, sicker patients, older patients, faster so as to accommodate the demands of ruthless third parties and government. In addition nurse extenders (pretenders) called “patient care associates”, aides, etc. dilute the ranks because it reduces costs. Nurses response to this professional rape is to leave the profession. Now that which was valued is not. Quality is something pretended and assessed by shallow “satisfaction polls”. Longevity in the nursing profession is undesirable because the senior nurse costs more. It also helps to have younger uninitiated, less experienced nurses, not only for cost purposes but to remove memories of

(Corner—Continued on page 7)

(Summit—Continued from page 1)

pendence. Dr. Orient emphasized that the impact on quality of care and decay of the profession of medicine is in proportion to the intrusion of the third party payers and government.

Medical Savings Accounts were the highlight of the morning sessions and many creative methods of employing this powerful patient empower insurance vehicle were presented. Stewart Slonin, Michael Bridgham, Allen Wishner, Merrill Matthews , Ph.D., Michael Bond Ph.D., presented the Medical Savings Accounts concept and the actual experience and success that many companies have had with MSAs.

Phyllis Schlafly, nationally known political analyst, commentator and founder of Eagle Forum spoke on Medical Privacy. Mrs. Schlafly has made an inestimable impact in her active role influencing policy making in America for over 30 years.

Diane Lataille, R.N. a practicing nurse spoke of the serious issues of nursing and the nursing shortage. (Please see President's Corner)

Congresswoman Melissa Hart gave a legislative update and participants encourage her to continue to support MSAs and amend the legislation.

Videos are being processed and will be available.

Dr. Larry Dunegan
First Recipient of the John Adams Award

Congratulations to Dr. Larry Dunegan as first recipient of the John Adams Award. The award was commissioned by SEPP to honor and celebrate the member who exemplifies the character and dedication of one of Americas' greatest founding heroes. When one looks at the life of John Adams it is readily observed that he was the engine for freedom. He was a tireless worker who against odds raised the banner of freedom in a quiet determined fashion. He solicited monies and aid for the war effort from countries that might be unlikely supporters. He traveled treacherous seas and crossed rough and challenging terrain risking life and limb to enlist help for freedom. He is an unsung hero that history now recognizes as key in our quest for freedom.

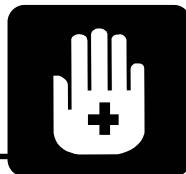
Dr. Dunegan likewise, has demonstrated a commitment to the cause of freedom in healthcare. His plaque read as follows:

The Society For The Education of Physicians and Patients honors and acknowledges on this day November 17, 2001, the work of

Lawrence Dunegan, M.D.

for his tireless efforts to defend and uphold the principles of Freedom that make America strong and his dedication to the pursuit of Restoring, Protecting, and Preserving Freedom in American Healthcare.

Support Those Who *Support SEPP*



Trademark Ostomy & Surgical Supply

1-800-404-7799
Fax 1-412-489-0478

J&J, Kendall, Bard, Rubbermaid, Convatec, Hollister, 3M
Call Today for a Catalog

A special thank you to our supporters of the Healthcare Summit-2001

The following sponsored display booths and tables for the Summit making it possible not only to create additional financial support but provide support for interested individual's tuition and registration.

Guidant Pacemakers— Greg Celani
Pacesetter Pacemakers— John Siebert
Merck Pharmaceuticals—E. Wilson
Merck Pharmaceuticals—Carol Herman Tice
Mellon Bank— Jack Wild
R. Nelson and Associates—R. Nelson
AAPS Pennsylvania Chapter (Association of American Physicians and Surgeons)— J. Pendleton, M.D.
Association of American Physicians and Surgeons– Jane Orient, M.D. and Andrew Schlafly Esq. (special expenditures)
First MSA—William West , M.D.
Ambassador Nursing (Jim Burke & Chuck Miller– SEPP members)
Amel's Restaurant—Ralph Reiland

Table Hosts

Mon Valley Urology Inc.—(Joel Rach, M.D. & Peter Tucker, M.D.)
Community Care Plus— Matthew Coppola, M.D.
Emergency Assn. Of South Western PA.
Allegheny Institute for Public Policy—Jake Haulk
Kidney Disease & Hypertension Assoc.—Dr. Lutes

Dr. Fernand Parent & Associates
John C. Eisley, D.O.
James A. Solan, M.D.
Ralph Vitt, CHFC
William E. Reisinger, M.D.
South Hills Pulmonary Assoc. Inc. (Dr. David Celko)
Gene W. Manzetti, MD
Joseph M. Young, M.D.
Robert Urban, M.D.
Dennis Gabos, M.D.
John Robinson, M.D.
Dennis Szymaitis, D.M.D
Dennis J. Mateya, M.D.
Joseph T. Michael, M.D.
David E. Brougher, M.D.
Lawrence A. Dunegan, M.D.
WPA Optometric Society (Hans Lessman)
Penna. Optometric Association (Hans Lessman)
John Gollatz, M.D.

SEPP would like to acknowledge the volunteers who were so helpful in organizing, registering, and coordinating the Summit:

Yvonne Urban
Kathy Fuller
Lisa Gabos
Kathy Wissner

We are also grateful to Ford Fuller and other members of SEPP who participated in planning, publicizing, and financing of the Summit.

St. Jude Cardiac Rhythm Management Division
Pacesetter Pacemakers
Ventritex Defibrillators
John Siebart
24 Hour Availability
412-456-7332

EMERGENCY POWER

AAPS News—
Volume 58, No. 1 January 2002

In days when smallpox was a clear and present danger, Thomas Jefferson wrote: "to secure these Rights [as to Life, Liberty, and the Pursuit of Happiness], Governments are instituted among Men, deriving their just Powers from the Consent of the Governed."

In 2001, long after smallpox was pronounced extinct, "our nation has awakened to the realization that the government's foremost responsibility is to protect the health, safety, and well being of its citizens." Or so declares the preamble to the Model State Emergency Health Powers Act (MEHPA), which HHS Secretary Tommy Thompson is urging States to adopt.

Jane Orient, M.D.
Executive Director of The Association of American Physicians and Surgeons

Under this Act, the Governor would derive dictatorial power from declaring a public health emergency, with the consent of no one. No unalienable rights would be recognized. Liberty and property rights could be suspended; after 60 days, the State legislature could terminate the state of emergency, but only by a two-thirds majority of both chambers.

A public health emergency is whatever the Governor defines it to be. The only pretext needed is "a disease caused by a living organism." The draft states, "An infectious disease may, or may not, be transmissible from person to person, animal to person, or insect to person".

Public health officials, among others, would have broad, unfettered access to personal health records. Pharmacists and physicians would be required to report any "unusual" health patterns, and personal information about patients exhibiting an "unusual" pattern. Individuals suspected of harboring an "infectious disease" could be forced to undergo medical examinations-and physicians could be forced to provide them, or be liable for a misdemeanor. Patient refusal of a vaccine or medical treatment as directed by the Governor would also be a misdemeanor.

Any inconvenient laws or regulations could simply be suspended, and new laws-and penalties-effected by fiat.

The Governor could commandeer any private facilities or resources considered necessary, including, but not limited to, communication devices, carriers, real estate, fuels, food, clothing, and medical facilities. He could impose price controls and rationing, and otherwise control the allocation, sale, use, or transportation of any item as deemed "reasonable and necessary for emergency response"-specifically including firearms.

The State is supposed to provide "just compensation" to owners for seized property-unless there is "reasonable cause" to believe that it "may endanger the public health," in which case it may simply be destroyed, with no recourse.

With the whole structure of checks and balances abolished, there is nothing to stop a Governor from condemning the property of a political opponent and subjecting him to "quarantine" [imprisonment] in a pesthouse on an ex parte order. His only right would be to a hearing within 72 hours- or nearly a week if the isolation began on Friday afternoon before a three-day weekend. State officials would have no meaningful accountability for taking such actions.

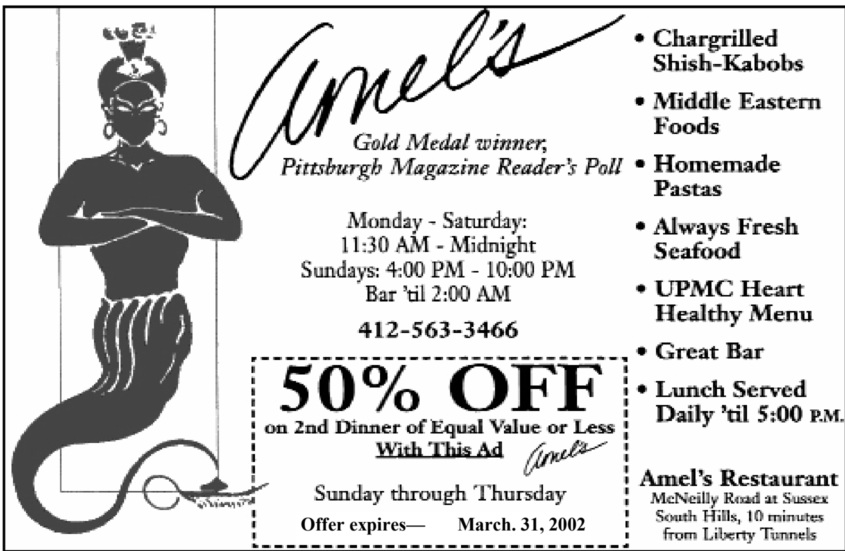
Adjectives such as "reasonable," "significant," and "substantial" are in the Act-for the State to define. There is no requirement for scientifically valid assessments, risk: benefit analysis, or judicial or even administrative review. And risks less than 1 in 1 million are already the pretext for intrusive, costly regulations such as mandatory vaccinations.

These powers should "scare the immune system out of any American"; though desperate times call for desperate measures, "ceding this much power to

(Emergency - Continued on page 7)

Ask For
Ambassador Nursing
Health Care Agency
Providing Nurses and Nursing Assistants
for all of your Patient's Home Health needs

RNs, LPNs, Home Health Aides, & All Therapies
***FREE* - No - Obligation**
Patient Assessments
Specialist In Insurance Cases
Medicare Certified
24 Hours — 7 Days a Week
Ambassador Nursing
For a Free Brochure
Call 1-800-211-6002



(Emergency - Continued from page 6)

states is too desperate by far" (Investor's Business Daily, 12/3/01). "This law treats American citizens as if they were the enemy," stated George Annas, chairman of the Health Law Department at the Boston Univ. School of Public Health (San Francisco Chronicle, 11/25/01).

Since the Act relies exclusively on force and central planning, it is not surprising that the author, Lawrence O. Gostin, was a member of the informal single-payer group, as well as the bioethics group, of the Clinton Task Force on Health Care Reform. The ideas are not new; September 11 is the occasion for what AAPS Past President Robert J. Cihak called "political war profiteering" (WorldNetDaily, 11/29/01).

Dr. Cihak notes that in the State of Washington, public financing of a sports stadium is an "emergency." Many powerful groups, such as the National Governors Association and the National Association of Attorneys General are promoting this legislation (see www.forhealthfreedom.org for a list). The AMA apparently concurs by silence, although it has opposed mass smallpox vaccination because of the adverse effects, including a 1 in 1 million risk of death and 1 in 1,000 risk of potentially serious reactions.

AAPS has posted a detailed analysis of the Act, a one-page alert suitable for distribution to patients in your office, and a letter sent to about 500 State, county, and specialty medical societies, at ***www.aapsonline.org***. The analysis includes a number of suggestions that States should consider for improving emergency preparedness.

Helpful laws would protect physicians and others from civil liability when helping disaster victims, and suspend regulations that impede public health measures (e.g. mosquito control) but have no scientifically proven benefit.

To survive bioterrorism or other hazards, the State needs trained personnel, state-of-the art laboratories and equipment, stockpiled essential drugs and supplies, and protected utilities and communications systems. Emergency electrical power would save lives-potential empowerment of would-be dictators or stormtroopers is a grave risk.

The destruction of citizens' freedoms and rights also imperils their very lives, as 20th century history shows.

(Corner—Continued from page 3)

conditions under which quality was paramount—i.e dumbing down. There was a 20% decline in enrollment in nursing school from 1995 –2000. The average age of a nurse in the country is 42 and in Pennsylvania is 47. We have a shortage of 125, 000 nurses presently. Statistics show that younger nurses likewise don't intend to stay. Some local hospital administrators are importing foreign nurses as cheap labor to fill these positions and protect their own bureaucracies. (See www.sepp.net—*The Plight of Nursing* for more) Physicians are now being driven from healthcare as their professional autonomy and incomes are usurped by government and third parties. The application pool to medical school is decreasing- 18% from 1995– 2000. A recent article in Health Affairs estimates a shortage of 200, 000 physicians in less than 2 decades. This is consistent with previous data. (Fig.1) The response—dumb it down with physician extenders. The role of nurse practitioner will change from a complementary one to a physician replacement—with many years less training and clinical training.

Now quality is the lesser consideration. The fear of hospital administrators is not a declining but, increasing census as they can't staff. The veteran nurse is a threat, not a blessing. The goal of healthcare is a short length of stay and lower cost per case, not care of the patient. The nurse's stations are now occupied by expensive non—clinicians policing physicians. The media has portrayed physicians as greedy, uncaring and sometimes predatory, highlighting a fraction of the profession and dismissing the altruism of the vast majority.

Down is up and up is down in our inverse healthcare universe.

Dennis Sobo MD

A survey indicates 38% of doctors age 50 or older plan to retire within one to three years. Another 16% said they plan to significantly reduce their practice or refuse new patients, according to Merritt, Hawkins & Associates, an Irving

AMNews staff. July 24, 2000

Plan for the next 1-3 years?
Retire -- 38%
See no patients, change career --10%
Reduce workload -- 16%
Work as temporary -- 12%
No change -- 18%
Other -- 6%
Biggest frustration?
Managed care hassles -- 56%
Medicare/Medicaid hassles 15%
Long hours -- 4%
Liability worries -- 6%
Patient attitudes -- 8%
Business pressures -- 6%
Other -- 5%

Fig.1

GUIDANT

Saving and Improving Lives Through Innovation

Pacemakers and Implantable Cardioverter Defibrillators

Greg Celani—Representative

1-800-CARDIAC

www.guidant.com

SEPP—Schedule for Meetings –2002
All meetings at Tambellini's Restaurant
Route 51 South
Time—6PM for Board of Trustees
7PM General Meeting—Open to all
Dinner Meeting

Monday, February 18, 2002
Monday, May 20, 2002
Monday, August 19, 2002
Monday, November 18, 2002

S.E.P.P.-Society for the Education of Physicians & Patients
A Health Care Professional and Patient
Advocacy Organization
Protecting and preserving patients and health care professional's
Rights, Freedoms, and Responsibilities
SEPP— 724- 929-5711 or 412-364-1994
SEPP—P.O. Box 101117 , Pittsburgh PA 15237-8117
***For Health Care Update* call- 1-800-546-7070**
Web Site —— *www.sepp.net*

SOCIETY FOR THE EDUCATION OF PHYSICIANS AND PATIENTS

The mission of The Society For The Education of Physicians and Patients is to promote the education of patients and health care professionals in order to facilitate unencumbered participation in a healthcare system that respects and nurtures patients' and physicians' freedoms, rights, and responsibilities. The Society focuses on the responsibility of the physician as patient advocate and promotes quality medical care by supporting policies that encourage freedom, choice, enhancement of the patient-physician relationship, and fiscal responsibility.