

Toward Socialized Medicine (Part II): Fighting the Leviathan

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The Misnomer of "Insurance"

There are laws against the mislabeling of products to hide their real ingredients or to claim the presence of a component that is lacking. But which is the worse disservice to Americans? The mislabeling of products manufactured for sale, or the misrepresentation of ideas or political actions? Millions have been led to believe that programs such as Social Security and Medicare are insurance simply because they are called "social insurance."

Even though the Medicare Part A card is labeled "Health Insurance," the United States Supreme Court held long ago that Medicare is not insurance, but rather a tax on one segment of the population to pay the bills for another segment. In other words, it is a tax on workers to pay the medical bills of retirees. Similarly, Social Security is a tax on today's wages to pay a pension to those retired at age 65, or even at age 62. No insurance contract exists for either of these programs, and no Social Security or Medicare funds are banked for investment and growth.

In the early 1940s until the government's intrusion into medicine by Medicare in 1965, private medical insurance was expanding rapidly. In 1965, 7.7 million of the 16 million Americans then over the age of 65 were covered by private medical insurance. That insurance, like home owner's insurance, car insurance, and life insurance, enabled policy holders to share the risks of catastrophic or unexpected needs.

Insurance was not only readily available but also reasonable in cost because it was utilized only by those faced with costly services in cases of serious illness or accident. In order to be insured, the risks had to be unpredictable. Before government interfered, costly medical and surgical needs were rarely experienced by more than 5 to 6 percent of the public in any one year.

Contrast the situation today, when insurance is expected to cover all minor aches and pains and to cover federal or state mandates for coverage that is neither needed nor desired.

Accelerating Cost Increases

Today, the half-life of medical knowledge is estimated to be less than five years. There is a steadily emerging stream of new and better diagnostic and therapeutic tools, along with an expanding pharmaceutical industry. The new medications may be more expensive, but they possibly obviate the need for still more expensive and invasive treatments, hospitalization, or surgery.

As costs increase, we hear or read almost daily that some 39 to 40 million people are without insurance for medical care. While no clamor exists for investigating which costs are excessive, or which costs are unnecessary, there are insistent demands for government to assure universal coverage of these excessive costs.

Often described as one-seventh of the nation's economy, medical services constitute the only segment denied the freedom of the marketplace, as a result of government regulations, mandates, and price controls. Rules and regulations for Medicare alone have

now reached 130,000 pages, and a recent government report stated that for Medicare alone, more than \$2 billion dollars every month is lost because of mismanagement, waste, and fraud.

While President Clinton in his inaugural address stated that "the era of big government is over," since that date more than 400,000 pages have been added to the Federal Register.

Why should never-elected bureaucrats, protected by tenure and assured of lifetime economic protection because of taxpayer-paid pensions, be empowered to write rules and regulations, print them in the Federal Register, and then implement them with the force of law? Congressional failure of oversight has allowed these unaccountable bureaucrats to impose ever-increasing, unintelligible paperwork on citizens, with its attendant costs.

One of our Founding Fathers, James Madison, wrote: "It will be of little avail to the people that laws are made by men of their choice, if the laws be so voluminous that they cannot be read and so incoherent that they cannot be understood... that no man who knows what the law is today can guess what it will be tomorrow!"

Contributing to the cost increases are the overhead of agencies like Blue Cross/Blue Shield that are assigned by the government to handle economic transactions. Managed care, a euphemism for the entrepreneurial interference between patients and physicians for profit-making ventures, takes another chunk out of the medical dollar, including lavish compensation of chief executive officers. In August, 2002, it was reported that Anthem paid its CEO \$13,000,000 in 2001.

Government regulation and managed-care overhead, both extraneous to medical care, are major contributors to costs, yet they make no direct contribution to the actual care of the sick and the injured.

The Growth of Litigation

A third contributor to cost is the predatory section of the trial bar. Plaintiff's lawyers even advertise on television to incite litigation for stress, worry, and concern over what might happen, disregarding the absence of any known impairment.

The last 20 years have seen a steady growth of class-action suits, making multimillionaires and sometimes billionaires of lawyers, especially those milking the cash cows of asbestos and tobacco. Newly attained wealth has been used to gain political power at both state and federal levels. For example, in the year 2000, the Democratic Party committees received \$11.6 million in contributions from wealthy trial lawyers and their lobbyists, even exceeding the \$11.3 million that the Democrats received directly from labor unions.

Physicians, no matter how talented or experienced, are limited by price controls that deny even the very wealthy the ability to reward their doctors more generously than the government allows. Meanwhile, young attorneys start at \$100 to \$150 per hour. Some older attorneys receive \$500 to \$800 per hour, and some attorneys have even received in excess of \$30,000 per hour.

California Medicine reported in August, 2002, that in recent years 25 percent of California physicians had been sued, with only

10 percent of the cases getting to court with a legitimate cause. The other 90 percent includes those that settled rather than incurring the expense of defending a non-meritorious suit.

What Can Physicians Do?

Our best weapon is truth. We must make our case to our patients. Unless our freedom and economic rights are restored, we will continue to be overwhelmed by more government intrusion. Patients need to hear that the most direct, the most economical, and the best medical care is a result of direct contract between patients and their physicians, with no middleman.

Americans need to be reminded that the Constitution grants only limited and defined powers to the federal government. The government does not have a legitimate authority to deny physicians the right to receive a market price for their services: a right enjoyed by mechanics, plumbers, carpenters, architects, engineers, athletes, film stars, government employees, and lawyers.

Shortly after his inauguration, President Ronald Reagan, speaking before a crowd of 5,000 at the Jefferson Memorial, presented his Economic Bill of Rights, based on fundamental constitutional principles: 1. Freedom to work; 2. Freedom to enjoy the fruits of that work; 3. Freedom to own and control property (that includes intellectual property); 4. Freedom to participate in a free market.

Physicians today are denied every one of these freedoms. It is time to say "Enough!" Only strong, sustained political activism will regain these rights. To win the battle, we must fight it, and as Winston Churchill told the graduating class of his old prep school, "Never, never, never give up!"

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Fighting to Preserve Private Medicine: the Role of AAPS

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The Formation of AAPS

The first meeting of the Association of American Physicians and Surgeons was held on December 1, 1943, at the Elks Club in East Chicago, Indiana. It appears that the formation of AAPS was initially the idea of Ronnel Waterson, a layman who saw the need for such an organization while serving as executive secretary of the East Chicago, Indiana, Academy of Medicine.

AAPS Directors emphasized the point that AAPS was not a rival of the AMA, but was intended to function more as its conscience. Initially, membership in the AMA was a prerequisite for joining AAPS. And for a time, AAPS had its headquarters on Michigan Avenue in Chicago.

The founders had, in fact, tried to work through the AMA to "preserve the American System of the practice of private medicine." The Lake County Medical Society prepared a resolution asking the AMA to adopt an aggressive attitude in medical economics, public relations, and legislation. The resolution was adopted by the Indiana State Medical Association, and a delegate was instructed to present it at the next AMA House of Delegates meeting. Because no action was taken on this resolution by the AMA House of Delegates, a group of Lake County Physicians decided that a new organization was needed.

By the time of the fourth meeting of AAPS on February 6, 1944, 120 doctors from 35 states had joined in response to a mailing of 108,700 copies of "The News." By that time, \$4,200 had been deposited in the bank. The mailing cost \$711 for copies and \$1,090 for postage.

There was some discussion regarding solicitation of financial support from ancillary organizations such as hospitals, pharmacies,

and drug manufacturers. There was strong insistence that such financial support have no strings attached although AAPS leaders called that "an impossible dream."

By early 1945, Mr. Waterson and several of the directors had addressed 19 different medical societies from Massachusetts to San Diego. A number of medical organizations endorsed AAPS, including the Colorado State Medical Society and six county medical societies in that state; the Alachua County Medical Society in Gainesville, Florida; the Christian County Medical Society in Taylorville, Illinois; three county medical societies in Indiana; two county medical societies in Michigan, including the Wayne County Medical Society in Detroit; the Clark County Medical Society in Las Vegas, Nevada; the Sullivan County Medical Society in Monticello, New York; three societies in Ohio; the Cambria County Medical Society in Johnstown, Pennsylvania; and the Colleton County Medical Society in Wentche, South Carolina.

AAPS Advocates Non-Participation

The first mention of the National Physicians Committee, which advocated government medicine, occurred at the 1945 meeting. In response to this proposal, AAPS decided to promote the idea of non-participation in any federal insurance plan. Though AAPS discussed the promotion of private insurance, this suggestion was not implemented because the AMA had made similar plans (which were later dropped).

The press response was hostile to AAPS:

"At least one organization of physicians seeks support on the basis of a pledge from doctors to refuse to serve under any system of politically controlled distribution of medical care." On the other hand, "the National Physicians Committee takes the unqualified position that doctors *must serve within the framework of any system that is officially adopted as a national policy*. It holds that the menacing threat of state medicine can be avoided and the independ-