

From the President:

Access: Too Little, or Too Much?

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The word “access”—used in conjunction with “to medical care” or “to health care”—might be imagined to denote the ability of a sick person, or someone with a medical condition, to find a physician willing and able to address the problem.

This phraseology has become commonplace in medical journals and in the lay press, but I do not recall hearing, until recently, the anguished plaint that patients lack “access” to medical care, or that their “access” to it faces threats. Nor do I recall seeing or hearing of anybody in my neighborhood suffering a lack of care. As a former intern and resident in a series of urban hospitals, I cannot recall any evidence that people with even minor ailments were turned away.

Quite the contrary. I recall my astonishment when people with the most trivial ailments showed up in the clinics and the emergency room: minor, long-term skin blemishes; ordinary colds; an enlarged uvula, compared to what was shown in the *Anatomy Coloring Book*; sore wrists from handcuffs; a paper cut.

Just as surprisingly, these things were seemingly accepted as matter-of-fact, mixed in, as they were, with gunshot wounds, pulmonary emboli, malignant hypertension, tension pneumothorax, seizures, peritonsillar abscesses, Boerhaave’s syndrome, tubal pregnancy, and so on. It is true that, in the few minutes taken to speak with the man whose uvula seemed to him to be too large, one might be able to console him over the death of his wife from throat cancer, and to reassure him that his uvula was within the limits of normal.

Things have reached the point at which people appear wanting toenails treated for yellowing, due to fungus, that has been present for 63 years, ever since it was contracted in the South Pacific during World War Two. They have seen a television advertisement for some pills touted for ugly toenails. They want a second opinion, from a specialist, that the brown spots on their arms that have been present for years with no symptoms, which their regular physician has told them are of no medical concern, really are not a problem, and why can’t they be removed anyway—they’re unsightly. We hear that it costs only \$10 to see a physician, so, “I come in whenever I have a concern.” Going to see a physician seems to be as routine as a trip to the grocery store. The medical chart of even a healthy person can weigh a few pounds.

It must be tougher to get neurosurgery for nonexistent or minor problems, but then, nobody seems to have a cosmetic or functional

problem that they think unnecessary neurosurgery can solve. However, sexual function, so important in our brave new society, is being “treated” vigorously. (Excuse me, I should say “dysfunction.”) Fat is being sucked out and repositioned by liposuction, and hordes of children are being treated for attention deficit hyperactivity disorder, totally unrecognized by the medical profession until the last half of the 20th century. Whether it is confined somehow to the United States of America, or whether we need a global program to save children around the world from this dread affliction, I do not know.

What has happened to cause this hand-wringing over “access,” and how is it related to the above phenomenon?

Part of the problem is that medical services are nearly free to the recipient, while others pay for them with their taxes. Accelerated availability in turn accelerates usage. Taxation hides the nexus between money earned by one person, but spent by another. There is an indirection afforded by the third party represented by the enormous government bureaucracy. The Medicare and Medicaid programs both gave certain sizable classes of people—those over age 65, and those whose known incomes fall below a certain level—unfettered access to as much medical care as they wish to receive.

Suddenly, anyone with a Medicare or Medicaid card could gain access to medical attention of any kind, at any time, at no, little, or vastly discounted personal cost. In effect, people older than age 65, and people considered to fall below some income level, were given unfettered access to the Treasury of the United States. Each of them, as a unit, could determine how much the taxpayers would be forced to spend on them. Each of them was given access to the pockets of the working taxpayers of America, who have been fleeced by compulsory, confiscatory federal taxation. There is a reason why the Framers of our Constitution had a provision in its original form for no direct taxation. They realized that it would dispose to tyranny, and so it has.

Taxpayers cannot confront the people who are spending their confiscated money, whether for playing golf or for the eradication of ugly spots or the treatment of impotence. They cannot confront Medicaid recipients who have illegitimate children or who buy \$80 sneakers or expensive video game units—to say nothing of alcohol and tobacco. Anger is building up. Taxpayers are squeezed. On the other hand, millions of people have acquired the notion that medical services are theirs by right, and free for the taking. Some of them probably have no idea that government has no money of its own—that all the money the government has was taken from people by threat of force.

Another recent development contributing to the perceived problem of “access” is television and magazine advertising by pharmaceutical companies, accompanied by the admonition to “ask your doctor.” One does so by making an appointment, of course. The problem of “access” is said to be especially acute in dermatology, with people waiting up to six months to be seen by a dermatologist.

Recently, I saw an advertisement stating, “Millions of women struggle with excessive facial hair.” Sound serious? Not really. Tweeze it, bleach it, wax it—a few tough people just let it grow. We should ask them for insights on how they manage before we flood doctors’ offices with cries for help. A bar graph shows how many millions remove UFH (unwanted facial hair) at various intervals, telling us that UFH affects women of every race and every age from puberty to old age.

Then, a question: “Have you heard about the only prescription cream proven to reduce the growth of unwanted facial hair?” Then, the little come-on: “Over 300,000 women have!” But that’s only 1.5 percent of the minimum number of women estimated to want it (20 million remove UFH weekly). The abbreviation “UFH” tries subtly to confer an aura of respectability on this “problem” by putting it in the same category as SOB and CAD, for shortness of breath and coronary artery disease respectively, and by not actually spelling it out, suggests that it is so common and so well-recognized that everyone will know what UFH is and what it means in suffering to millions of women. Or maybe it is simply that the purveyors of the product realize that there is a comical aspect to their claim, and want to hide behind this acronym.

Nothing inhibits a patient, for example a young woman on Medicaid, from making an appointment, and gaining access to a physician for this very complaint. I have seen it. Once the patient has this access, the physician can inform the patient that Medicaid does not pay for cosmetic procedures. But our liability system makes it hard for the physician to stop there. Should he take a look to make sure she doesn’t harbor an unsuspected melanoma? How should this be “coded”? “Worried well”? “Obsessive-compulsive”? “Body dysmorphic disorder”? Or just “unwanted facial hair”?

This advertising reaches far more than the 41 million afflicted with unwanted facial hair, with the message that trivial problems can be and should be corrected—by consulting a physician and seeking pharmaceutical treatment.

A third development concerns the physician, who often leaves medical school at age 26 or so, then does a residency for a minimum of three years, on low pay, and deeply in debt. When such a person is faced with taking care of human beings with real medical problems, for less than he might pay his veterinarian for a visit, and facing the liability problems unique to the United States of America, where the tort lawyer is king, he is likely to reject the measly “reimbursement” he may receive from a government program. The program also extorts much uncompensated labor from him in the form of following telephone book-sized manuals of regulations, filing forms, re-filing them, and keeping up with OSHA, CLIA, HIPAA, and other regulatory burdens. He may decide that there is better money and lower stress in doing things that people want, but will have to pay for with their own funds. This deletes him from the ranks of physicians who are doing the heavy lifting in treating real illness.

Imagine that the McDonald’s restaurant chain has just been told that it must offer its food at much lower prices—almost “free”—because there are so many people who need food. Until now, one could enter one of those restaurants and get food in minutes. But because the food is now nearly free to the person who eats it—paid for by taxation—more people decide to eat at McDonald’s and spend the money they would have spent for food on an all-terrain vehicle, a trip to Disney World, a Gameboy, a gold chain, and a cell phone upgrade.

Now when you go to McDonald’s you will find quite a crowd. The crowd will be even bigger if someone advertises a special croissant available only at McDonald’s to help people lose weight, for example, and exhorts them in advertising to go to their favorite McDonald’s restaurant to get the croissants—but doesn’t tell them that the croissants are expensive, and that they will have to pay the full price themselves.

How about the servers? They used to fill orders with assembly-line speed and coordination. Now they can never clear the line; they go home exhausted. They have to explain to a lot of dissatisfied people that the croissants are not available for the same low price as everything else; they are not a part of the program to keep elderly people, regardless of their income level, from having to pay the going rate for food, nor are they a part of the program to let low-income people have all they want to eat. Some employees seek an easier job, and those left behind must carry a heavier burden.

Whereas one could previously walk into a McDonald’s restaurant at any time and have food served in minutes, our imaginary McDonald’s would soon develop an “access” problem, caused precisely by granting people unfettered “access” to tax-subsidized food. Everyone, needy or not, would go to McDonald’s for food because others are paying for it. Then McDonald’s, by advertising the special croissants, draws even more people in, but can’t profit because costs increase while customers refuse to pay for the croissants that they expected to be free. More exhausted workers leave McDonald’s, making “access” even worse.

It is not an exact analogy, because the servers do not have to decide who is actually hungry, or who merely likes others to pay for their food.

At one time, a physician could presume that someone showing up in the emergency room or clinic had a problem that needed a physician’s attention, not something so minor that people could take care of it on their own, or something that probably had a nonmedical solution. This is no longer true.

Adding up taxpayer funding, pharmaceutical advertising that encourages people to see a physician for trifles; a tort system that drives physicians out of certain areas and certain types of work, like brain surgery and delivering babies; and below-cost payment to “providers,” the sum is a huge influx of people to facilities they would not have attended previously and a decreased supply of physicians to serve them: an access problem, first in perception, then in reality.

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