Government Price-Fixing in Medicine: the Demanding Entitled Patient

James A. Savage, M.D.

"The State is the great fiction through which everyone seeks to live at the expense of everyone else….The State cannot satisfy one party without adding to the labor of the others."

–Frédéric Bastiat, 1848

Governments fix prices when the political support of one group is deemed to be more important than the support of another. Politicians of both major political parties have confiscated the sweat of the collective brows of physicians to purchase the votes of our patients—assuring, in most cases, their pathetic perpetual incumbencies.

We have been devalued and standardized so that we are viewed as simply identical cogs in the machine—cogs easily replaced by others as interchangeable parts. To politicians' way of thinking, the medical care provided by one physician is neither better nor worse than that provided by another. The best glaucoma surgeon in the country is prohibited by law from charging one red cent more than someone fresh out of his residency who has done only five trabeculectomies.

Price fixing always, always, always leads to shortages. In this case, unfortunately, the patients will not be able to figure it out because it is not a shortage of medical care, but a shortage of excellent medical care. It will simply get to the point that the compensation barely exceeds what it costs to provide the best care. The best college seniors will go for law degrees or MBAs—anything but medicine.

One would hope that patients would have the good sense to appreciate this and recognize what a value physicians' fees are nowadays compared to those of accountants, plumbers, hairdressers, and—most of all—attorneys. Long experience with human nature has taught me otherwise. I am constantly reminded that irony is the supreme overriding force in the universe when entitled patients, while arrogantly ensconced in my examining room chair, demand, with perfectly straight faces, that I do even more for them than they and their hit-men in Congress have already throttled out of physicians. Several years ago a patient canceled his appointment, incensed that I had charged for an office visit 4 months following his glaucoma operation. My letter to him follows. (His name, of course, has been changed.)

February 25, 2000

Dear Mr. Rodham:

I was disappointed to hear you had canceled your May 18 appointment. I understand you have taken issue with my charging for your January 17 visit. After I explain the basis for my fees, you can decide whether you still think your charges were out of line.

I accept Medicare "assignment"; therefore the maximum I am allowed to collect for any service to a Medicare patient (like you) is the "reasonable" fee set by the Federal Government. For your trabeculectomy operation, Medicare allowed $708.13. As is their custom, they paid 80 percent ($566.50). The remaining $141.63 was paid by your co-insurance, AARP. Medicare further stipulates that surgical fees are "global," covering your operation and all related postoperative care for 3 months. Because your operation was on September 8, no charges were allowed until December 9. Remember, your surgery was for glaucoma, a chronic, potentially blinding disease, requiring examinations and treatment for the remainder of your life.

Your operation was a complex, multi-step, microsurgical procedure requiring no small amount of experience and skill. As you search for a less expensive ophthalmologist, be certain you find one who knows where and how deeply to cut, and how tightly to pull knots in sutures finer than some human hairs. If you are interested in the many details of the steps in the operation you can consult the textbook chapters and related references I have authored on the subject. They appear on pages eight and nine of the enclosed copy of my curriculum vitae.

On January 17, your eye pressure was 9 (compared to 16, prior to surgery). However, you no longer needed Timoptic or Xalatan eye drops for pressure control. I called three local pharmacies. Their average retail for one year's worth of these medications is $499.12 per eye, 70 percent of what I was paid for surgery and 3 months of aftercare.

Expenses in ophthalmology offices usually vary from 50 to 60 percent, and are sometimes even higher. The government taxes the remainder. As a consequence, my "take home" pay from the $708.13 was approximately $200. Do you honestly feel that I was overpaid at $200 or that you were overcharged? Of course, you weren't charged at all! Medicare and AARP paid the surgery bill.

Had I billed for a visit on December 17 instead of January 17, your 1999 deductible would have been in effect. I doubt you would have noticed the charge or said a word about it. This is the problem when the consumers of medical care demand the highest quality but have no idea of, or concern for, what it costs. Incidentally, Medicare reduced my $75 charge for the January 17 office visit to their "reasonable" charge of $44. After overhead and taxes, my "take home" for that examination was between $12 and $13.

This morning's *Wall Street Journal* reported that the going rate for free-lance clowns—you heard me, clowns—is $50 per hour! Perhaps my most sensible career move after high school would have been to buy a red rubber nose, a pair of size 72 yellow wing-tips, and a squirting flower, instead of 13½ more years of school.

Your vision measured 20/25 at your last visit. This is impressive, considering your age-related macular degeneration and severe glaucomatous visual field loss extending to the center of your visual field. I sincerely wish I could make your macula 16 years old again and that you didn't have so much glaucoma damage. All I can do is control your eye pressure, and I challenge anyone to say that I failed.

It cannot be found in Webster's dictionary, but the real definition of "overpaid" is "anyone who makes more money than I do"! After years of dealing with patients, it would not surprise me to be accused of price gouging if I did surgeries in the comfort of patients'

living rooms and only charged what it costs for an oil change. Perhaps my perspective is influenced by what I have to pay lawyers, plumbers, mechanics, accountants, and my office staff. Unfortunately, the government ratchets down what I am allowed to collect for my services, but neglects to ratchet down my expenses as well!

Fees have been cut so low it costs nearly as much to provide good care as the law allows us to collect for it! I wonder where I will find an expert when I am your age and I get sick. I *will* know where to find the smart college students who *would have been* the medical experts. Instead of medical school and a career with *all* the responsibility for unrealistic outcomes demanded by patients, they will pursue a field in which they can still make a good living and get as far away from the government as possible.

Many of us in practice would love to get out of medicine. Unfortunately we spent nearly our whole lives (70 percent, in my case) in school learning to do our work, such as a microsurgical sight-saving operation that the government says is worth less than a plumber would confidently charge to install a commode.

Mr. Rodham, the most important thing of all is that you receive the care you need for your eyes. This can only come from an ophthalmologist in whom you have full confidence. If I had as little regard for the value of my physician's talents as you apparently have for mine, I would have canceled the appointment too!

If I can help you in any way with your eyes, please do not hesitate to contact me.

Sincerely,
James A. Savage, M.D.

Physicians emerge from training in their fourth decade, usually with substantial debt. Now that fees are capped at such a low level, usually with healthy doses of bureaucratic and other abuse, fewer and fewer capable and innovative candidates are willing to choose medicine as a career. Some would argue that once the system is rid of greedy doctors, we could finally have an army of Marcus Welbys, indifferent to compensation. This will not happen. Human nature does not cease to exist simply because politicians, knuckles white from wringing physicians' necks, wish it were so.

No infinite supply of humanitarians with 2400 SAT scores exists, eager for a career guaranteed to grind them into dust. The same intellectual strength that would make them the most capable physicians will enable them to see what a trap medical practice has become and make them unwilling to choose medicine as a career. Applicants to medical schools will still be mostly straight-A students. However, the well-documented transformation of college grades from a Gaussian curve into a stalagmite-shaped aberration (stark confirmation of rampant grade inflation) is a topic far too large for this discussion.

Avoid getting sick. Those who will care for us in our dotage will not be of the same stuff as their progenitors, who built the best system of medical care, now dying, that ever existed. It breaks my heart to know that the day is coming when American medicine will no longer be the envy of the entire world. Where will the sick from the far reaches of the globe go to get the very best care when it no longer exists here?

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Is Physician Income Too High, or Too Low?

Craig J. Cantoni

Is the income of physicians sufficient to attract qualified people to the profession and retain them through their most productive years?

There is some evidence that the answer is no. As reported by AAPS and other organizations, increasing numbers of physicians are closing their practices for early retirement or to pursue other careers. And doctor shortages have become so common in rural areas that the federal government has given special visa considerations to foreign nationals to work in small towns.

One of the primary causes is a reduction in Medicare fees, which also are used by private insurers to set their reimbursement schedules. Physicians are facing a 10 percent cut in Medicare fees next year and a projected cut of 40 percent over the next nine years. During the same period, the cost of running a practice is projected to increase by about 20 percent. To make matters worse, independent physicians are facing increased competition from corporate-owned clinics staffed by nurse practitioners and located in big-box stores.

On the other hand, physicians continue to rank near the top of all professions in income, especially physicians in certain specialties. According to the Department of Labor's Bureau of Labor Statistics, the highest paying occupations in the U.S. in 2006 were physician specialists, chief executives, dentists, airline pilots, air traffic controllers, and engineering managers. But BLS data are incomplete, because they rely primarily on payroll records and exclude earnings in the form of business income from physician-owned practices.

So what is the answer? Is physician income too high, or too low?

The question is impossible to answer, although I have 30 years of experience in the compensation profession, having set the compensation of tens of thousands of people in hundreds of occupations, ranging from chief executives to janitors. If someone with my experience is unable to answer the question, then the government will also be unable to answer the question if movie director Michael Moore gets his way and the medical industry is nationalized.

The question cannot be answered because there is not an unfettered market today for either physician labor or medical care. The government has distorted the markets for both through various misguided, shortsighted, and ham-handed actions. For example, the government limits the number of medical schools and foreign