From the President:

Government Medicine Is Hazardous to Your Health

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The Association of American Physicians and Surgeons was founded in 1943 specifically to fight against the government takeover of the practice of medicine. Since that time, the organization has had triumphs and losses, but has tirelessly supported free markets and patient-centered ethical medicine.

Today we continue the battle, and to paraphrase Winston Churchill, we have fought them on the beaches, and now the enemy is in our own backyard. Why do we persevere? Because government medicine fails, and it fails spectacularly. Government healthcare wonks around the world and in America promise better quality, lower cost, and better access, but government medicine produces just the opposite. The same government that brought us the $600 toilet seat is now bringing us the $3 aspirin, and the $250 bone screw. Let us review the talking points and the facts.

Myths and Facts about the Quality of American Medicine

The World Health Organization (WHO) loves to devalue American medicine, ranking it 37th in the world, somewhere behind Sudan. But in spite of this report card, the powerful and wealthy, when sick, flock to America for care. Boris Yeltsin underwent heart surgery in a special hospital, by American-trained surgeons, and imported Dr. Michael Debakey from Texas to supervise. His free universal Soviet healthcare system was satisfactory for the gray masses, but not for him. Two Canadian premiers and at least one member of parliament have crossed the border clandestinely to get their medical care in the U.S. If universal government medicine is so great, why didn't they stay home?

When the former sultan of Brunei needed care, did he go to Sweden or France or any other socialized, "equitable," more highly WHO-ranked country? No, he came here. People who know, and can afford to, vote on quality with their feet. And for good reason. They know that "fairness of distribution," one of the major determinants of the WHO ranking, doesn't really count when you are sick.

What really counts is outcomes. In 2007, the British journal of cancer *Lancet Oncology* looked at survival from cancer around the world by country.[1] On every chart, for every cancer examined, the best outcome, the best survival, was in America. And the differences were not trivial. For example, if one considers cancers that affect men, and lumps all cancers into a pool of outcomes, the chance of surviving five years after diagnosis in America was 66%, but in Europe it was 47%, and in Britain, nicknamed the "sick man of Europe," 45%. Canada fared a little better at 53%, which may reflect the ability of some Canadians to jump the border to America for treatment. For breast cancer, five-year survival was 90.5% in America, and 78.5% in Britain. Similarly, survival after heart attack or stroke is better in the U.S. than in Britain or Canada, with their universal healthcare care. So, in answer to "Who you gonna call?" when you get sick, the answer is "us."

Why is there a 20% better cancer survival in America? A major reason for this discrepancy is the lack of access to specialty care in government-run systems. In addition to the million-plus patients waiting for surgery under the National Health Service (NHS) in Britain, many more wait for evaluation for cancer or heart disease. The average time from diagnosis of breast cancer to seeing a cancer specialist in Canada is 45 days. In fact, only 50% of women biopsied for abnormal screening mammography get their diagnosis within 7 weeks.[2] In America, we worry if we can't get a patient in to see the oncologist over a long weekend. In America for every million people 1,000 are receiving dialysis; in Europe it is 537 per million, and in England 328 per million. Those who are untreated suffer and die. As reported in a study by the National Kidney Research Fund and Sheffield University, "If the doctors responsible for those patients cannot find a unit to take them, then the only option is for the doctors to keep them comfortable in hospital until they die."[3] And while American cardiologists debate the best noninvasive ways to stratify cardiac risk in asymptomatic patients, Canadian medical journals publish articles concerning the best way to keep people from dropping over dead while waiting in line for care.[4]

Another recurrent chant of the pro-government medicine forces is, "We spend more than any other country, yet have shorter lives and a higher newborn death rate!" The first truth is, longevity is very much determined by genetics and lifestyle and has less to do with medical care. Secondly, America, being a very large and industrialized country, kills many more people on the highway and in farm accidents than does tiny Luxembourg. And, unfortunately, we have an epidemic of obesity, which is a major cause of disease and mortality. But it turns out that this talking point may use untrue "facts."

In a recent comparison of life expectancy in Britain and the U.S. by the RAND Corporation,[5] the British have longer life expectancy at birth, possibly skewed by the newborn tally differences noted below, but for every year of age after that, America begins to narrow the gap, and by age 60 catches up. By age 75 there is a clearly better life expectancy in America than in Britain: an additional 0.6 years for men, and 0.7 years for women—in spite of our obesity, trauma, and racial disparity, and higher incidences of cancer and diabetes. This suggests that over one's lifetime, medical care in America may be playing an even more significant role than the sound-bites suggest.

As James P. Smith stated, "It appears that at least in terms of survival at older ages [of people] with chronic disease, the medical system in the United States may be better than the system in England."[5] Coauthor James Banks concluded: "The United States'

health problem is not fundamentally a healthcare or insurance problem, at least at older ages. It is a problem of excess illness—and the solution to that problem may lie outside the healthcare delivery system. The solution may be to alter lifestyles or other behaviours."[5]

As for infant mortality in America, an infant who takes a single breath and has a single heartbeat is counted as a live birth. So if it dies in the next minute, it counts towards our perinatal mortality statistic and lowers our apparent life expectancy. Most of the world does not do this. In Switzerland an infant must be 30 cm long before being counted as a "live birth," thereby dismissing the many premature infants that count toward the statistics. Cuba doesn't bother to waste its precious bureaucracy on a baby until it is 2 to 3 months old. If a baby is still alive at that point, a birth certificate will be issued. Michael Moore, where are you?

Myths and Facts about Cost

It is asserted that the U.S. spends much more than nations with universal healthcare. In fact, we do not. The British pay 112 billion pounds per year for the NHS. Given exchange rates and a population of 61.1 million, this is about $3,232 per year per person, and this does not include the money paid by private citizens for insurance used to escape the NHS. Although a Kaiser Family Foundation study says the average American family pays $13,375 for healthcare, this was through employer-purchased insurance. Buying an individual policy with a $2,500 deductible, I pay $7,500 a year in health insurance for a family of four aged 19-62, or $2,500 per person. And for that fee I get access to top-quality care. The British, for half again as much outlay, get waiting lines, lack of access to primary care, and antiquated hospitals with inadequate staffing and a shortage of equipment. As reported in a recent *Guardian*, referring to intended budget cuts, the chairman of the Royal College of General Practitioners warned, "The NHS shake-up risks wrecking GPs' relationship with their patients by turning them into rationers of care who deny the sick the treatment they need."

What is usually left out of the cost discussion is the great difference in incentive for care depending on who is paying. When individuals pay themselves or through their purchase of insurance, they are motivated to get the most for their money, and those who profit from providing care are motivated to provide it. It is often—mostly falsely—claimed that doctors recommend and provide care solely to make money. But how often do we hear the opposite and truer point that government avoids giving care because care-giving is a money loser?

In America there is profit in performing computed tomography (CT), so we invest in CT scanners, and to pay off the investment we keep the machines well maintained and run them efficiently. There is no place in America where I cannot get a CT scan for a patient within hours. In Canada and other socialized government systems, there is no profit, and in fact, the more a CT scanner is run, the more drain on the government budget. So, there is no incentive to maintain and run the CT machines. In fact, for the government bureaucrat who pays the cost of the CT scanner, it is better if the scanner sits idle and does no studies. Anything else costs more money. As a result, in Thunder Bay, Ontario—a major regional medical center—it takes on average 3 months for a patient to get a CT scan (Lee Kurisko, personal communication, 2010). Nor can this be blamed on some woeful Canadian technology lag, or the cold climate, or any other variable one could conjure up, because a dog or cat can obtain a CT scan within hours in Canada. They are cash-paying patients.

Improved technology often gets blamed for rising medical costs, but note that in areas of life not touched by any government agency, technologic advance drives costs down and quality up. With cell phones and computers, the free market has brought us thousands of improvements in service and capability at a fraction of the cost. In medicine too, Lasik is better today than 10 years ago at less than half the cost because no insurance or government payer drives up the administrative cost, and there is free-market competition.

The real cost problem in medicine is directly related to the 150,000-plus pages of Medicare regulation with monthly updates that carry the force of law, the ponderously slow bureaucracy of the FDA, and the codification of medicine via the AMA's Current Procedural Terminology (CPT) and WHO's International Classification of Diseases (ICD) book. We are being buried in mounds of bureaucratic paperwork that costs a fortune in compliance. My orthopedic office employed seven people. They were needed for billing and Medicare compliance. If patients had paid cash for outpatient visits and my office had not been subject to Medicare audits, I could have managed quite well with two employees. In 1970, after 20 years of practice, my father's files barely filled a small three-drawer filing cabinet. After 16 years of private practice, my records filled a medium storage unit, and I destroyed charts of adults after seven years. Costs, costs, costs.

The FDA, under the guise of making us safer, makes everything vastly more expensive. The price of the obstacles of getting drugs to market has been well described,[6] but the FDA has many other ways of inflating costs. A few years ago, the FDA decided that if hospitals or offices were going to re-use equipment designated for "one-time use," they must re-do the testing procedure, which initially took an average 15 years by the manufacturers, to insure multiple-use safety. This is simply not possible for hospitals to do. Predictably, manufacturers began marking obviously re-usable items, such as carbon fiber external fixators costing $6,000, as "one-time use," and the hospitals were forced into throwing away and re-buying costly items. Does it make sense that Hibiclens antibacterial soap becomes "outdated"? We just threw cases of it away at my hospital, but I have never seen an expiration date on my household dish detergent. And when the FDA demanded that pharmaceutical manufacturers bring factories making long-established preparations up to new standards, they simply closed the factories, rather than lose money. This resulted in a shortage of tetanus toxoid, and increased cost from the one remaining source, now a government-created monopoly. Currently we are short of Fentanyl, a mainstay of anesthesia care, and the antibiotic Levoquin, and have been critically short of Propofol for general anesthesia—what will be next? And are we safer?

Just when you thought the government could not get any more intrusive, or sillier, the Center for Medicare and Medicaid

Services (CMS) is demanding that doctors start using ICD-10. Dr. Tamzin Rosenwasser, a past AAPS president, notes in her recent article "Call a Code: This Doctor's Heart Stopped Beating"[7] that we have gone from 13,000 to 70,000 diagnostic entries, including codes for such things as a "burn due to water-skis on fire, initial encounter." And there is one for drowning while jumping from said burning skis. Codes such as "pecked by a chicken, initial encounter," and "pecked by a chicken, subsequent encounter" would be funny if the implementation of such minutiae did not create such a drain on the capacity to actually practice medicine.

The hours and manpower wasted on regulatory compliance far exceed other costs in the system. Call Stephen Hawking: we may be nearing a previously unrecognized physical barrier—the black hole of regulatory inertia where so much negative government force is applied that no actual medical care can escape the bureaucratic gravitational field.

Coverage versus Access

Most importantly, government does not increase access to care. Having "coverage" and having a doctor are very different, as Canadians know. At first, Canadians were simply in long lines for specialists, but now they stand in long lines—sometimes years—in hopes of signing on to a primary care doctor. Currently two million Quebecers are without a family physician.[8] Yves Boldac, the province's health minister, and a physician himself, says, "Improving access is a key concern for the government."[8] Has he forgotten that the reason for implementing government medicine was to provide improved access?

Despite frequent praise for Canada's "universal healthcare," there are uninsured persons in Canada. Canadians, to be part of the system must be legal residents who file taxes and pay the "premium" or fee for health care. The homeless, self-employed, and illegals do not qualify unless they pay the "premium" to be enrolled. At least 5% of working, non-homeless British Columbians are without health insurance because they have not paid the premium. Recently, in an Ontario Emergency Room, a sign read "Uninsured Canadians (Canadian Resident with no valid health card) must pay $169 before being seen in the Emergency Room. Life-threatening emergencies are, of course, cared for. But the definition of life-threatening may be disputed. A British Columbian psychiatric nurse reported that her emergency department turned away a homeless man who was brought in by the police after trying to jump off a bridge to commit suicide. His problem was not deemed life-threatening, and he was referred to the next day walk-in clinic.

A recent Medicare decision epitomizes how government regulation decreases care, quality, and access. Recently, CMS imposed new credentialing requirements on the technicians who perform Doppler ultrasound testing. This testing is to check for life-threatening blood clots in a person's legs, and has been around for more than 20 years. Prior to the new regulation, patients at my hospital could have the test done in about 10 minutes at a cost of $235 to Medicare. But now, because our technician, who has been doing the test for 20 years, is no longer "qualified" according to the new Medicare statutes, patients must be transported to another facility 45 minutes or more away. The time for the doctor to get results has gone from 30 minutes to well over six hours, and the cost has risen from $235 to more than $3,500 because of the ambulance ride. As for access to care, it is clearly less for Medicare patients, but sadly, even if you are a non-Medicare patient who has bought insurance (i.e. paid money for the privilege of this testing), even you cannot receive the testing at our facility because that would be "discriminatory" against Medicare patients. Presumably, someone at CMS wrote this requirement in the name of quality enhancement or patient safety. But the results are so horrific that some hospitals are practicing civil disobedience and continuing to do the test without further certification of technicians. The rest of us are just praying no one dies as a result of this regulatory nightmare.

Finally, government can never deliver care without choosing who gets what and therefore valuing some citizens above others. The NHS would never allow discrimination against "Peter" in favor of "Paul," but will decide not to treat "Peter's disease" in order to care for "Paul's disease." Government divides the population into disease groups, and allots funds to each group. By any name you want to give it, government rations care.

There is a real cost to the goods and services of medical care, and the reality is that there will always be more medical care available than any one person or any government can afford. The question is, do you and your family decide how to spend your money, or do you give those decisions to a faceless government agency? Under "ObamaCare," 15 non-elected officials decide what treatments will be paid for, and are therefore available. Neither physicians nor patients can appeal their decisions, and only a two-thirds U.S. Senate vote can overturn their ruling.

Government may be inefficient and ineffective in healthcare management, but it is very effective in usurping liberty, while claiming all the while to be making us safer and healthier. Columnist Charley Reese said it best when he opined, "There's no dishonor in being forced by a superior power into slavery, but it is an eternal disgrace to voluntarily surrender one's liberty for a filthy bowl of oatmeal and the promise of security by liars."

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