The Three "C's" of Access to Care

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Everyone in America today complains about healthcare. They do not complain about their grocery stores, or Walmart, or their local veterinarian, but everyone, from patient to physician, is unhappy with American medicine.

What is it they complain about? Cost, complexity, and being treated impersonally probably lead the list. But long wait times to see a specialist, or in some cases even to get a family doctor, lack of portability of employer-based insurance, and the lack of choice in purchasing insurance are all contenders for top slots.

One thing Americans do not complain about is quality. Although the World Health Organization and politicians constantly harp on the need for more government involvement to improve "quality," that is not a source of dissatisfaction for the average American, nor for the many rich people from all over the world who come to the U.S. for medical care every year.

In medicine, before prescribing a cure, we need to correctly diagnose the problem. Treating someone for malaria who has dengue fever would not be helpful. If we look at the so-called "healthcare crisis" as a disease, we should first ask when the disease began. What caused it? What are its symptoms? Applying this to American medicine, we note that the current problems began with government involvement through Medicare, Medicaid, and employer-based insurance plans.

Government intervention has brought us escalating costs from complexity of billing, over-regulation, and mandates. Discriminatory federal tax regulations have created insurance gaps by linking insurance to employment. Low-deductible health insurance plans have resulted in a desire to "get our money's worth," and thus we have overuse and further spiraling costs.

So let's look to a time when these problems didn't exist, to the golden age of the 1950s and early 1960s, a time of increasing technological competence, lower prices, good cost per medical value, and the kind of personalized medical care epitomized by TV's Dr. Marcus Welby. In those days medical care was based on the "Three C's": cash, catastrophic insurance, and charity. These three can solve the problems of today.

Cash

Cash, or direct payment by the patient, for outpatient and "small-ticket" items keeps cost down through free-market competition and lowering of medical office overhead costs. In my previous private practice I employed seven people, five of whose sole purpose was to deal with third-party billing. If patients had paid cash at the front window, I could have functioned with two employees, a significant decrease in my overhead.

Second, a doctor cannot overcharge the patient who pays cash because the patient can find some other doctor with better cash prices. In contrast, overall health care prices continue to rise (in spite of diminishing payments to doctors) in the Medicare monopoly.

Cash at the window gets rid of all outpatient fraud. A physician, no matter how unscrupulous, cannot defraud the patient at the front desk and charge him for services not rendered because he knows directly what was done. Nor does the physician have to dictate a three-page note to convince Medicare or an insurance company that he did what he claimed on the billing form. Finally, doctors would not have to fear criminal prosecution for choosing an "incorrect" code out of the mammoth Medicare office procedure codebook.

Catastrophic Insurance

This type of insurance used to be called "major medical." It is comparable to car and house insurance. You don't use them for every little repair on your house or car, and truly you hope never to have to use these insurance policies. Catastrophic insurance is meant to protect you from truly catastrophic financial loss. When your roof blows off you call your insurance agent. When a shingle blows off you take out your wallet.

Unfortunately today in medicine, we buy health insurance expecting it to cover every little runny nose or well-child exam. Of course an actuary, the person who can tabulate the risk this year of your roof blowing off, cannot know how many times you will visit a doctor for preventative care. So true insurance becomes pre-paid healthcare, a very different and unpredictable product that inevitably results in a wild spiral of overuse followed by price increases, followed by more use "to get my money's worth."

We need to have health insurance operate like our car and homeowner's insurance. It should only cover the big expenses, while we take care of routine maintenance with cash. With this type of insurance you wouldn't need a "Patient Bill of Rights" since you, not your employer, would be the customer and would be treated as such. If you are not happy with the insurance you could simply choose another insurance company. And you wouldn't need portability legislation because you, not your employer, would own the policy. In researching insurance for my employees I discovered that the private insurance with a high deductible was generally half as expensive as employee-based low-deductible managed-care insurance.

Charity

Americans are historically generous. Charity means that you voluntarily reach into your own pocket, and for centuries Americans did so. But government medicine is not charitable. It is predicated on theft, where citizens using the IRS as intermediary put a gun to their neighbor's head and force him to pay for another person's medical care.

Before Medicare, in the 1950s and 1960s, my father was a Marcus Welby-style small town country doctor. In those days people were not dying in the streets for lack of care. Those who

really needed assistance were helped by their friends, their families, their neighbors, community organizations, and churches. Those who received such aid saw it as charity, not an entitlement, and were grateful, not taking advantage of those who offered the help. Local charity is vastly cheaper than government largesse, which diffuses tax dollars into a ponderous bureaucracy before doling out the meager leavings. And if cash were the basis of outpatient care, and catastrophic insurance the basis of inpatient care, all costs would lessen, and it would be cheaper to care for those truly in need.

Compassion

In truth there really is a fourth "C": compassion. Compassion is intrinsic to the "art" of medicine but plays no role in government delivery of "healthcare." Physicians aren't born with compassion, but develop it as they come to know and care about their patients as individuals. Federal regulators who decide your care from 3,000 miles away have no compassion because they have no personal relationship with patients. Government healthcare is by its nature impersonal.

Government must make choices in what it funds. In aircraft procurement, de-funding means the death of a production line. But in government medicine, where people have no private choices, de-funding a disease or procedure may mean the death of patients. No Medicare or insurance reviewer wants to face the fact that denying care can lead to death. So, to make such a job tolerable, those denied care must be de-personalized. To the officials making decisions at a distance, patients are known by their medical record numbers and their diagnostic codes. A person becomes a "covered life," a financial liability, not Mary Jones.

It is no coincidence that the Jews were given numbers and robbed of all personal identity before being killed. It is no accident that in Germany in 1938, the decision for euthanasia was taken out of the hands of the victims' local physicians and placed into the hands of a distant committee. The British National Health Service, which has condemned many people to premature death through denial or delay of care, for a short time actually tried bar-coding patients.

Ultimately there is always more demand for medical care people may want than any individual or group can afford. The issue is who makes the choice. Rather than being told by some Washington, D.C., desk-sitter that my care is not deemed "medically necessary," I prefer discussing my options with a personal, compassionate physician who knows me, cares about me as an individual, and who can discuss with me the pros and cons, the options, and relative costs of treatments.

Government pundits love to talk of prevention, but most real prevention comes not from a doctor, but from making better lifestyle choices. The traditional role—and, I believe, the real reason for medical care—is to treat disease. And disease is not just illness from germs. It is literally "dis-ease," i.e., suffering. Government, no matter how massive and computerized, will never provide a sympathetic ear, a caring touch, or any compassion for suffering.

Conclusion

Returning to a system of cash payments, catastrophic insurance, and charity will return doctors and nurses to the patient bedside, allowing them to practice the "art," not just the Medicare-prescribed algorithm, of medicine

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