WSWS speaks with physician on state of health care in America

“People’s needs go unmet—it’s just inexcusable”

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The *World Socialist Web Site* spoke recently to a retired primary care physician about the current state of health care in the US, and the Obama administration’s proposals to overhaul the system. He spoke from years of experience of a system where the majority of patients are dominated by the burden of health care costs, and are often unable to obtain needed treatment and services because of this.

He related the frustrations of patients and doctors alike under conditions where the delivery of medical care is subordinated to the insurance companies’ bottom line. From a physician’s point of view, he also commented on what type of changes he would like to see implemented.

Can you tell me something about your background, and the community of people you served?

“I worked in this Midwest community for almost 30 years. I recently retired.

“I worked in a small group practice of physicians and some physician’s assistants and nurse practitioners. Eventually, the group came to be owned by a pretty large company. We also worked with a reasonably sized community hospital. So I was in primary care all my life.

“The people we served were a rural, elderly, agricultural, small-city factory mix. We have—or had—maybe eight or ten factories here and then some agriculture, which has been declining steadily over the years. And then quite a lot of tourism, which is seasonal, and lots of elderly, lots of Medicare, quite a lot of poor people. Wages are bad here, and so even though people had jobs, they were poor paying and sometimes they would be on Medicaid.”

In your experience, how does the current health care system in America affect the treatment of patients?

“The main problem was always affordability. All of our patients, except just a very few, were underinsured. So we would get questioned by the patient about why we wanted to do a throat culture, or a urinalysis, or some other test. We were asked this almost every day by someone and very often by quite a number of people. They wanted the minimum done, or something done for them that would relieve discomfort, pain, or cure them of some infectious disorder. Cost was just overwhelmingly the issue, because people have no benefits here, no health care plans, or if they do have coverage, it’s so lousy that they don’t get much coverage.

“They wouldn’t be able to pay for it, or they were already in debt to the office, the business that we were working for, the clinic organization. This was common. They or another family member had come to the office and had already accumulated a debt. They were struggling with that, and so it was really common that they were so cost-conscious they didn’t want very much done, because they were already struggling with the debt of previous encounters.

“Also, of course, the logic of that is that they would delay coming in for as long as possible. And since I’ve retired I know this has gotten more problematic. I go into the office myself for health maintenance, and I would certainly assume that nothing has changed but for the worse, in terms of accessibility in relation to cost.”

What do you think of the notion currently being promoted that there is a scarcity of health care in the US?

“I think it is an imposed scarcity. Perhaps in the same way that we don’t have enough teachers, or we don’t have enough classrooms, or we don’t have enough availability of transportation. I mean, at one level of thinking that is true under the current set-up where the banks have been filled up by the US Treasury, leaving nothing behind to take care of the broad spectrum of needs, the list of things that we use to define a modern standard of living.

“Under that set-up, yes, there is an imposed scarcity. But it’s a very narrow way for one to be thinking about scarcity. When we read about Paul Allen of Microsoft and Larry Ellison of Oracle in a competition about who can build the biggest yacht, for many millions of dollars, the perspective of what’s meant by what we don’t have needs to be widened a bit. So, yes, I think it’s an imposed scarcity and one that’s intolerable.

“I think that we’re all trapped under the current set-up, where we can’t get at the resources and assets to provide patients with what they need. I’ve had young workers who have younger adult-onset diabetes coming to me who could not afford insulin, who did not have the money in their pockets, or health care access with a card in their pocket from a health plan to buy their insulin. So they would come in chronically when their sugar was out of control.

“So physicians, health care professionals, health workers find themselves involved in a struggle to meet the needs of patients. It was always a circuitous, very time-consuming thing for the patient to come in and find that they needed something, but then couldn’t get it because they didn’t have the money.

“Patients would walk into the office not knowing what it was they needed to have to feel better, get better, maintain their health, keep their diabetes under control. Then, when they found out what the health care professional told them they had to have, we both came to the realization that there was no means of them getting it. Unless I took money out of my pocket and went with them to the pharmacy and bought their medicines, which was not very tenable most of the time. So people’s needs would go unmet. It was happening widely. It’s just inexcusable, intolerable, outrageous.

“This is all pretty time-consuming, as you can appreciate, in a physician setting. The company holds the expectation that physicians will get visits done in few minutes, out the door, because the company has its own financial priorities. And then the patients come in with two or three things they want to bring attention to, and that gets explored with a careful discussion, and then whatever there is in terms of a requirement for doing

a physical exam and then, if the patient will permit it from a cost perspective, some laboratory work, imaging work or other testing work.

"A plan is laid out and then there is what we always refer to as a 'negotiated settlement' or agreement as what they will agree to do, more and more based on cost. Sometimes other things are tossed in—such as fears, or 'I've got all I can handle with everything else I'm worried about now.' But the driving, number-one issue is costs.

"If this goes on for a few hours a day, which it always did, then the patients get dragged down, the doctors get dragged down. It's not a cheery thing, I can tell you. It's stressful on the patient and stressful on everyone. You want to make them feel better, and you want them to have some measure of promise that they're going to actually get their needs met, whether its correction of their blood pressure, compensation for their heart failure, improvement in the inflammatory disorders they have in their joints, or their knees; a biopsy obtained for a skin problem, or some investigation done for an abdominal pain.

"Whatever it is, cost was always rushing up front and center for a very significant number of the patients, at least half or more of the patients every day. I can't imagine how much more efficient we would all work if we had a solidly funded arrangement of care for everyone, where all we had to focus on was meeting the needs of the patient. What a refreshing idea!

"I can tell you that most health professionals would last longer in terms of how many miles they have in their health care motors before they just say: this is not possible for me to do anymore, I'm going to have to go out and find something else to do. This is too exhausting to run into dead end after dead end after dead end all day long.

If costs were taken out the equation, do you think doctors would perform more procedures, or order more tests, as some have suggested?

"I didn't work in that many places in the world. I wasn't one day working in London, the next day Paris, the next day Dallas, Texas. I only practiced in one region of the world for virtually all of my career. But I think that I had a pretty good idea of how most of my colleagues, at least in this region of the world, the Midwest, thought. And I don't think that they were by nature wasters. I don't think they ran out and said, 'Well, because so and so has this great plan, I'm going to do six-dozen tests, and I don't care what I impose on the system, or the patient.'

"I just don't think people thought like that. I think physicians thought rather critically—what did it seem that this patient was telling me diagnostically? Physicians try to think really rationally, in a well-organized manner; I think it's fundamentally needs-based. What does this person require? Is there something important going on? What can I do to make the patient more comfortable, if it's simply a pain issue, or muscle spasm, etc.? I think it was really needs-based rather than any kind of cavalier recklessness with testing.

"So I think if they had a rational system, if they didn't have to think about—'Well, am I going to actually have the person tossed out of their home if I order this or that?'—I think if they knew that they could just meet the needs of the patient and order tests rationally that that would be a vast emotional, psychological relief to the group that I worked with.

"I would also have to comment that there was quite a lot of defensive medicine practiced. I didn't know a lot of doctors that got sued or litigated against. I never did. But there was a part of a physicians' thinking in his or her day, 'This is a minefield I'm working through today. I hope I don't do anything, or have anything happen to me that means I'm going to wind up in court next year or the year after.' It was always a sort of mortifying fear that physicians had, especially in a somewhat smaller community where when you pull out of your driveway everybody in the community knows it.

"I have to acknowledge that that's a very real fear, and I think it does drive some spending in health care. Maybe a patient shouldn't have undergone a test because a doctor worried that 'if I miss something, then I'm just going to feel terrible, and then I'm going to get sued on top of it.' So there certainly was, and I'm certain that there is, defensive medicine being practiced here and throughout the United States. It's a real thing in our experience.

"Sometimes, it's a complicated kind of big mess, health care in America. Partly it comes from a situation where patients are close to unemployment or they're unemployed, or they're working poor, and then something bad and unforeseen happens to them. So perhaps it's the physician's fault, perhaps it's not the physician's fault. The patient was reviewed carefully, and then still something dreadful happened and they got sick or disabled.

"We live in an unjust order. So the patient is disabled, it's a breadwinner in the household, or it's the only breadwinner in the household. And the only recourse the family feels they have is to try to get money where they think they might be able to get it through litigation, or otherwise they're just simply going to be destitute. Or people lose their house, which is pretty much synonymous with destitution.

"So I think a lot of litigation comes from just desperation. And they have dependents in their household, children or elderly living them; they have to get money somehow. It's a system where more and more people are made so dreadfully insecure about tomorrow, the next day, of having access to shelter, the basic necessities of life, that they resort to litigation."

Do you think the proposals to overhaul the health care system put forward by Barack Obama and being discussed in Congress will bring about a change for the better?

"No, I don't think very many people think that anymore, because people are watching the news. Whatever they want to say, I think that people are seeing through it and that it's very apparent that this has been written by the insurance industry and the pharmaceutical industry. I think there is a significant segment of the health care profession that would like something rational and just done for the population, and it's not going to happen. Because quite apparently, the executive committee presently sitting in Washington is working for the insurance and pharmaceutical industry.

"I think they're hoping that if they just keep saying it often enough, that this is a reform benefiting everyone, that it will be believed. I think it will be believed for a little bit, and then people will run square into their own experience of what this is, and it's going to be very obvious what it is.

"What I see coming is very high insurance costs, high deductibles, worse financial access to care. So I think it's business as usual. I don't think there are very many people who believe this is going to be better, although I know some people here locally who are insisting that it's going to be better.

What's your opinion of the individual mandate, the requirement that everyone purchase insurance or pay a penalty?

"It's an imposed and quite literal insurance tax. I think the universal health care dream that was floated out on the campaign trail last year is past history."

What do you think of the use of comparative effectiveness research (CER) to contain costs?

"I think it's a half-truth. I saw your quotations from [Obama advisor] Ezekiel Emanuel's book. I think that doctors do want to provide for patients diagnostic interventions and therapeutic interventions that have science behind them, meaning that we have evidence, of course, that they work. On our side it was called evidence-based research, meaning that this diagnostic intervention, this set of laboratory tests, this imaging study has been proven to actually discover what we have been told it discovers, rather something that has been concocted to make more revenue. So physicians wanted to have the idea—as much as we could—that what we were doing, diagnostically or therapeutically, was based on some body of evidence that was honest science.

"But when you link this up with a situation where somebody is suggesting a stratified, class-based health care, it has been distorted. That idea of doing evidence-based health care has been brought over to this other set of notions where it's going to be used to do health care delivery discrimination. This group of people at the bottom, 90 percent of the population, will receive this package, and then the aristocracy will get another. I think it's a perverted notion. I think you have to distrust it, because there's a lot less emphasis on getting everyone's needs met and more on cutting costs. It's a kind of narrative that comes down to: let's just reduce costs, reduce costs, reduce costs.

"I can tell you all sorts of people I know who are buying these Medicare Advantage programs, that are sold widely in our area of the world, who are going to have a rude awakening when the $113 billion supplement for that program goes away and they're back to square one of buying high-cost, so-called plans that deliver nothing. Nothing but another high deductible. Experience is going to hit them pretty squarely. Yes, I'm in my later years, and I will get the scraps of whatever is left over from Medicare for my plan."

What would your vision of a reformed health care system look like? What would you like to see changed?

"Designing a really good, rational plan for the entire society would not be all that difficult to conceive. I think scrapping the insurance companies' role in the entire set-up would be pretty high on the priority list of probably everyone we know—except the insurance executives. They would be excused from their duties. It would be interesting to know how they got in the American game specifically, how they got in the middle of everything in our health care system in the first place. What are the origins in America of the health care insurance industry needing all of that health care pie? How did they get here? That's not really talked about a lot, certainly never in the mass media.

"With the behavior of the few hundred families at the top who own everything, I don't see them making any concessions on anything. But I think they would be gone in a just system. And then I think the pharmaceutical industries would be nationalized and there would be basic, fundamental research done to meet the needs of everyone, regarding rational use of chemo-therapeutics. And then there would need to be a comprehensive list of needs reviewed for the entire country. We would need to run preventative, diagnostic and therapeutic needs through a number of rational models as to how that should be met in every segment of the country. And then roll it out, and get it well funded.

"It would take a while to properly do it, because you'd have to train up a whole couple of generations of people to actually staff it. Because, think about it, if you had a rational, functioning system on the ground tomorrow morning you'd have something like 47, 48, 50 million people running in the door to get something they require done that they've been depriving themselves of, because they had no access. All those people would be suddenly there tomorrow, plus the rest of us who are wishing we could get a little bit more done for ourselves, but don't have the dollars.

"So it would take a while to get it all rolled out, but it would be entirely possible. It would just take some really careful work, dedicated planning, and it could certainly be done. Everyone I know has worked hard enough to have decent care, they've more than earned it and probably paid for it, but it's just not there."