Written by **Staff** on July 26, 2012

A Physician's Solution to Healthcare

Whatever happened to Healthcare? Muhlenberg Regional Medical Center, a hospital in central New Jersey, recently closed its doors after 130 years of operation. Though this seemingly equated to a failure in private provision of healthcare, this actually represented a colossal failure of government, as mandates coupled with inadequate funding for Medicare, Medicaid, and "charity care" left this hospital with an apparently unsolvable dilemma: It could not pay its bills.

How did we get there? Muhlenberg's website explained that the hospital emerged from the efforts of seven volunteers who were deeply touched by a local train accident in 1876. After a physician had to perform surgery by candlelight at a nearby freight house, these individuals set out to build a community hospital. They raised funds from their neighbors, friends, and philanthropists who cared about the well-being of area families. The government had nothing to do with it, except to make things as easy as possible for these good people to succeed in their mission.

In the 1950s, the future looked bright. Unemployment was as low as two percent, and most families had private insurance. Hospitals were full of volunteers, providing training for medical and nursing students. Communities held fundraisers, and hospitals were major recipients of private charity. The poor were cared for, as physicians donated their time in hospital-based clinics.

City and county hospitals were built, set up by local governments. Outpatient visits to charity facilities rose some 310 percent from 1944 to 1965. Each indigent patient typically was charged $5 for a visit, the community rallied, and expenses were met. Once their economic lot improved, the poor were happy to transition out of the public hospitals, as there were fewer amenities than existed in the private hospitals. Public hospitals were clean, though not luxurious.

Everything was local — the way healthcare should be. Health insurance was a way to shield one's assets from sudden depletion and was reserved for major medical events. Patients hoped they would not need to use it any time soon. Then, due to a quirk in the tax laws, health insurance became deductible, though only if it was purchased by one's employer. So unlike any other insurance, it became an employee "benefit" rather than a personal responsibility.

Downward Spiral

In 1965, Congress enacted the huge Medicaid and Medicare programs. The idea was to enroll the poor and elderly into these large federal programs and thus provide equal access to all citizens. It was perceived that the poor no longer should be "stigmatized" and segregated into county or city hospitals, but should receive all the amenities that were given to those who paid. Efficient 12-bed wards gave way to two-bed rooms with the concomitant increase in personnel needed to staff them. Local control by municipalities was taken away, and the hospitals were sold to medical schools and private corporations.

From the very beginning, Medicaid and Medicare never covered more than half the cost of the care

these programs promised. Yet the care was provided, and the costs were shifted. While the consumer price index rose 300 percent between 1960 and 1980, the per diem cost of hospital beds rose by 900 percent. The big government programs and employer-purchased insurance contributed to the steep, spiraling inflation of healthcare costs, for no one is as frugal when he is spending other people's money.

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services — *emergency services only* — regardless of ability to pay. This led to a great overuse of the emergency rooms for non-urgent care. The uninsured public learned that they could show up with sore throats and earaches and receive treatment because the emergency rooms learned that it was easier to just care for the people than to spend the time trying to determine the urgency of the patient's illness.

Few could have imagined the unintended consequences that would creep in and eventually destroy our hospitals. Before government intervention, the laws of the marketplace set hospital charges. Patients usually paid their own bills, based upon ordinary, understandable receipts. Hospitals were run by administrators who came out of the medical profession. After all, who would understand what was needed better than a recently retired surgeon? His pay would be similar to any one of his colleagues, not the multiples of millions of dollars now awarded to the professional medical executive class.

Rather than our medical facilities and hospitals remaining local efforts — with many hands working together to create a better community — presidents, governors, judges, and legislators were not able to resist the urge to exert top-down control. Over-regulation, government mandates, and inadequate payments from government programs made Muhlenberg and every other hospital struggle to keep afloat.

As an example, imagine what would happen if a grocery store were mandated to provide food for every hungry person, regardless of ability to pay. People would show up, plate and fork in hand, and demand the highest quality gourmet food, never considering the bill. Politicians would win elections by promising food for all, while reassuring the stores that they would be reimbursed for "uncompensated charity food." But tax rates can only be increased so much, and there would never be quite enough to cover the ever-increasing demand. The store would make a valiant attempt to go on, cutting corners, always aware that lawsuits would be the ultimate result when it could no longer keep up.

Any sane storeowner would simply shrug and close the doors rather than listen to the angry demands of hungry patrons who must wait longer and longer for food and complaints of overworked employees, while being pressured by government bureaucrats and annoyed politicians. Then again, generous campaign donations might ensure that legislators appropriated plenty of tax dollars in the direction of well-connected supermarkets — a recipe for corruption.

The Beginning of the End

The final straw in New Jersey, where this writer practices medicine, was the enactment of the Individual Health Coverage Program of 1992, which actually forms a template for the goals set forth in ObamaCare. With this law we have "guaranteed issue," where no pre-existing conditions can be excluded from insurance coverage. The government dictates what needs to be covered on every policy, and what deductibles or co-pays can be chosen. Each insurance company regularly updates the website with its monthly premiums. This law led to the tremendous increase in the cost of health insurance in New Jersey, and the unacceptably large numbers of uninsured. Families find they must pay $2,000-$3,000 per month for even the most basic plans.

Government programs insisted on the best prices, so the "chargemaster" or sticker prices rose precipitously. Because government and insurance companies refused to pay bills in their entirety, physicians and hospitals were not clear on what they would be paid, and doctors tended to raise their bills to maximize reimbursement. When Medicaid and Medicare pay less than 50 percent of the actual cost of care, and state funds are inadequate to pay for state-reimbursed "charity care," hospitals have attempted to charge the uninsured many multiples of the costs they incur. Today an uninsured new mother will get a hospital bill of $25,000 for the delivery of her baby. Blue Cross pays $5,700 for the same event because insurance companies contract with medical providers for reduced rates. (If government does not get the lowest rate, it claims fraud.)

Hospitals have morphed into revenue centers instead of places where people can serve those who are hurting. They began as places of mercy, where the poor would find kind care. But today we see fewer young people encouraged to volunteer as candy-stripers. Professional CPT coders, chart reviewers, and utilization reviewers plague the physicians with demands and pressures to order more or less tests. Which insurance company will pay more for which code becomes the driving factor in the operation of the hospital. Instead of focusing on the patients, pressures from payers determine care. Good medical care becomes secondary to the ways to obtain the best reimbursement.

Hospitals are required to care for every patient, regardless of ability to pay. Because of the burden of caring for the uninsured, hospitals are always seeking extra funds from the feds or the state to keep the operations afloat. Money flows, the taxpayers are fleeced, and no one seems to notice that the hospital executives are reaping ever-increasing reimbursement packages.

Subsidiarity and Bottom-up Care

Maybe it is time to think outside the box. It is time to unshackle the medical community so that it can get back to the simple task of caring for patients. It is time to restore the common-sense concept of *subsidiarity*, where those closest to the problem provide the greatest input in solving it. People ought to be responsible for their own medical care, paying for routine services with their own funds just as they would pay for the routine maintenance of their cars.

If there is a greater need — for a specialist consultation or an MRI — the family could chip in to help. The church or local community could have a fund to help those who cannot help themselves. If a medication is needed long-term, it would be wise to have the doctor find the best medicine at the lowest price. Shop around for the best deal. This way of thinking should be the norm.

In order for health insurance to become affordable, it needs to be rarely used and reserved for major medical events — like accidents or operations. Insurance should be a way to cushion one's assets and bank accounts from sudden depletion. No one hopes to use his homeowner's insurance, but maintains his home, to lessen the chance of it being needed. We do not plan to use our auto insurance, but drive carefully and maintain our vehicles so that accidents can be avoided and we will not need to make that phone call to collect from the insurance company. Additionally, plans with high deductibles could be selected, which would result in lower premiums.

Of course, some people who propose to maintain the status quo rightly claim that few ultimately escape the need for medical care; therefore, health insurance must be different from other forms of insurance. But this is no reason to make even the smallest of medical transactions the concern of some third party. As a matter of fact, in the Oath of Hippocrates, it was clearly understood that the very best care is rendered when done privately. Personal fears and issues can be addressed best when the patient is

confident that his privacy will not be violated. New medical graduates recite these lines:

> I do solemnly swear by that which I hold most sacred … that all that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

ObamaCare and the government programs are pushing for electronic medical records, where every transaction will be displayed online. But all the passcodes and safeguards in the world cannot possibly prevent the violation of privacy that will come. Those who are "entitled" to look at the record of any individual are ever growing in numbers.

Breaking Free

When my husband John and I started our medical practice in 1988, we learned early on that caring for the poor via the Medicaid program was a quick way to financial ruin. Reimbursement, which came months after the visit, was so low that it cost more money to process the claims than we received from the government. Yet, we wanted to care for the poor. It occurred to us that the poor would do well to have the benefit of the community when they found themselves sick and with no resources. A plastic Medicaid card was cold and impersonal, hardly what they needed, and the frustration of not being able to find a participating physician was rejection that would only compound their despair.

But more importantly, we wanted to enlist the help of people who would demonstrate compassion in a way that would provide a lasting impact. We had listened to caseworkers tell of their frustration in being trained to keep people trapped in poverty, since their jobs and the viability of the welfare programs required a constant pool of new sign-ups. One story tells of a caseworker instructing a young client to get pregnant, for this would instantly qualify her for Medicaid, and then she would be able to get braces to straighten her teeth.

My husband and I studied *The Tragedy of American Compassion*, by Dr. Marvin Olasky, enlisted the help of fellow parishioners in our church, and determined to open a non-government free clinic at our church. A 900-square-foot house on the church grounds had been flooded by Hurricane Floyd in 1999, and the church leaders agreed to allow us to configure the rooms in the most efficient way possible for a medical facility. Volunteers stepped up to help with time, skills, and money, so by the time we opened the doors of the Zarephath Health Center in 2003, it was debt free.

Today, despite being open only 14 hours a week, we see 300-400 patients per month utilizing a volunteer staff of physicians, nurses, and support personnel. We are amazingly efficient; we use no CPT codes, or ICD-9 codes, which define the type of illness a patient has and what medical procedure was done and can be billed for, and no billing of the patient or the government. The actual cost to provide care, including the money we need to pay for the utilities and office and medical supplies, amounts to just $15 per patient visit. A free-will offering box is located at the front desk to collect patient "donations," and generous donors easily make up the difference between what patients pay and what the visits cost. When the patient leaves the premises, the transaction is complete. Both the giver and the recipient are ennobled, as the generosity of the physicians and nurses is met with genuine thankfulness by the patient.

Better yet, other volunteers take an interest in each individual, finding out more of their circumstances, seeking to find what has led them into their tight financial state, and what might be done to alleviate their pain. Support groups and practical help for single moms, church groups similar to Alcoholics Anonymous, drug addiction counseling, a clothes closet and food pantry, genuine friendship, and Bible

study and prayer groups all contribute to a culture of caring that causes many people to return and get the help that eventually gives them hope and helps them out of poverty.

In the summer of 2011, the Zarephath Health Center moved out of the small house and into a newly configured 5,000-square-foot facility complete with five exam rooms, a large classroom, and ample storage for donated items.

Who Do We See?

It is 5:00 p.m. on a Wednesday evening. People are beginning to line up at the door of the free clinic, which opens at 7:00. Some have been at the clinic before, while others are coming for the first time. They strike up conversations, unloading their tales of losing jobs, struggling with homelessness, and wondering where their next meal will come from. Friendly volunteers work the lines, offering a compassionate ear. A clothing and food pantry are right next door, and the patients are invited to check them out. There is a certain camaraderie that comes from a common theme — life is hard.

One unemployed patient comes with diabetes and high blood pressure. We supply him with test supplies, medicines, and dietary advice and work to teach him ways to prevent complications of his diseases.

Another patient is sitting on the exam table, and his eyes light up when we come into the room. His story goes back three years or so, when he came into the office with such large nasal polyps he could barely breathe. He could not sleep and was exhausted, so he came with disability papers for me to fill out. He was in his 50s, and he doubted he could ever work again.

He had not been able to find a doctor to help him. He was marginally employed. He had qualified for charity care at the hospital, but the surgeon's fee of $1,600 was more than he could handle. It occurred to me that all I needed to do was find a doctor, explain the situation, and offer to have the Zarephath Health Center pay a negotiated fee. Nine hundred dollars was agreed upon, and the man received exactly the help he needed.

Now he has cancer. The local hospital is getting him the oncology treatments he needs, but he cannot find a primary care physician who takes Medicaid. When he asked if he could still come to the Zarephath Health Center, his eyes filled with tears when we told him we would be honored to still see him.

We asked about his support system, and he said he has a few friends. But now he wants to come to the free men's breakfast held monthly on a Saturday morning. He wants to meet more people who care — who will be there for him as times get harder. He will meet men who understand his plight — who have been in difficult spots but have found that there is hope and real practical help in the faith community. He will find friends with a genuine motivation to care.

As we see the next patient, she tells of the Lasik eye surgery she recently had in New York City. We gently explain to her that anyone who can pay for Lasik surgery ought not be coming to our free clinic. She sheepishly agrees and takes the information that directs her to the private practice of some of our doctors. Since these doctors take no third party insurance, she can be assured that the fees are similar to what she would pay to service her car.

A young woman in her early thirties was in tears as she told her tale of hardship. She has a job, but is about to lose her apartment. Her husband is in jail for six months for driving while intoxicated. The night before, her cousin collapsed on her living room floor, barely breathing from a heroin overdose. He

was rushed to the emergency room.

“How is he doing?” we asked. “Oh, he got better. In fact, you will be seeing him next!”

That next patient, her cousin, denied using drugs, but claimed he went to the emergency room with a panic attack. We had the ER report, but it was useless to argue. Lying is a trait firmly established in drug addicts.

I was able to access the state narcotics website, which tells of the meds, the doctors, and the pharmacies utilized by individuals. I noticed that he had gotten 12 doses of Percocet, a narcotic painkiller, from different ER doctors on separate occasions. He said that his teeth are painful, and he cannot afford a dentist.

You can imagine his amazement when we invited him back to be the first patient seen by a dentist in our newly configured dental room. A donated chair and equipment had just been set up, and the dentists were ready to volunteer.

It is our hope that the woman and her cousin will get the help and support they need. We cannot solve all their problems, but we have the support groups to help them. They know that everyone is volunteering, and the kindness is palpable.

What Have We Learned?

Our experience at the Zarephath Health Center has taught us many things about the poor. First, we have learned that the causes of poverty are as numerous as the patients we see, so any large government programs will have guidelines that fail to address the real needs. These programs develop bigger and bigger bureaucracies that attempt to weed out fraud and abuse. But the inefficient use of taxpayer funds compounds the inherent inadequacy to address the real needs of the poor. In fact, welfare programs tend to trap people in poverty so that they have every incentive to remain on the government dole. People feel alone, disenchanted, hopeless, and often angry.

Back to the Future

Susan Olasky, *WORLD* magazine writer, visited the Zarephath Health Center earlier this year and made an insightful observation. She had recently read *Cutting for Stone*, a novel by physician Abraham Verghese, and saw something in our clinic that reminded her of this book. She saw something personalized.

She wrote:

> Dr. Verghese concluded that today’s system is bad for budgets, doctors, and patients. Tending to the iPatient, he writes, “can’t begin to compare with the joy, excitement, intellectual pleasure, pride, disappointment, and lessons in humility that trainees might experience by learning from the real patient’s body examined at the bedside.” Verghese describes the careful physical exam as ritual, which “strengthens the patient-physician relationship and enhances the Samaritan role of doctors — all rarely discussed reasons why we should maintain our physical-diagnosis skills.”

Verghese concludes with a cry for better medical training to produce better clinicians, those who understand “the bedside is hallowed ground, the place where fellow human beings allow us the privilege of looking at, touching, and listening to their bodies. Our skills and discernment must be worthy of such trust.” But that’s unlikely to happen unless we make our medical system hospitable once again to doctors like the Ecks.

A Simple Plan

The Federal Tort Claims Act of 1996 provides free medical malpractice coverage for professionals while they are volunteering at a free clinic. Freed from the specter of frivolous lawsuits, the physician can offer common-sense care and expect compliance from the patients.

Why not devise a similar plan with state government involved as well? We could set up a system where the physicians donate, say, four hours per week in free care. A surgeon might be asked to take on one charity case per week. Then, to protect the professionals who donate their time and expertise, each state could agree to provide full medical malpractice protection for their entire practices. Such coverage is already provided for physicians who work or teach in medical school university hospitals. The state would not be laying out money for medical malpractice insurance, but just agree to pay the costs of litigation and payouts in the event of a true injury. If a patient wanted to sue his physician, he would find himself suing the state instead. Experience has proven that far fewer claims would be made and litigation would be far less common and less costly. Any physician who makes serious errors is dropped from the FTCA coverage, and the state would do the same thing.

The result? Poor patients would get care at no cost to the taxpayers. Physicians would be rewarded with lower office overhead, not having to pay expensive medical malpractice premiums. Taxpayers would not have to fund the enormous Medicaid bureaucracy or payments for actual office-based care to the poor. In this system, unnecessary defensive medical tests would be eliminated.

We are not proposing that all the current government programs like Medicaid or SCHIP be eliminated in the short term, but we believe that all of these programs could eventually be replaced by a far more personalized and charitable network of non-government free clinics (NGFCs). As more and more physicians choose to become involved in the program and more and more churches and civic groups chose to start NGFCs, supply would meet demand. Health insurance premiums would drop for everyone. The number of lawsuits would diminish.

It is time to think “outside the box,” come up with workable solutions, and lower the cost of healthcare for all. President Obama said he is willing to entertain any reasonable proposals. Let’s start the discussion. Congress, if it is serious, needs to work toward lowering costs and balancing budgets. Real charity care and real protection for the physician — a perfect combination!

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