

Modern Medicine at the Crossroads

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This year marks the 50th anniversary of Public Law 89-97, the Social Security Amendments of 1965 that created Medicare and Medicaid. I graduated from medical school that year.

Over the last 50 years the federal government has become increasingly involved in medicine, functioning both as a third-party payer and patron of biomedical research and clinical trials.¹ And starting 25 years ago, modern medicine has come to adopt a new type of probabilistic medical thinking named “evidence-based medicine.”²

Healthcare spending in 1960 was 5.2 percent of GDP, \$143 per person—equivalent to \$1,125 in 2013 dollars. Lawmakers projected that Medicare would cost \$12 billion a year by 1990. It cost \$98 billion that year. In 2013, the annual cost of this healthcare program for people 65 years of age or older, and people under age 65 who are disabled or have end-stage renal disease, was \$585.7 billion (and growing at a 3.6 to 4.1 percent rate annually). Medicaid is not far behind. The annual cost of this joint federal-state program, established to finance medical care for the poor, was \$449.4 billion (and growing at a 6 percent annual rate).

The total amount spent for healthcare in the U.S. in 2013 was \$2,900 billion, 17.4 percent of GDP, which amounts to \$9,255 per person. This is a nearly nine-fold increase, adjusted for inflation, compared with what Americans spent on medical care before enactment of Medicare and Medicaid. (It is a 65-fold increase, \$9,255/\$143, in nominal dollars.)

At first Medicare was a bonanza for private, fee-for-service physicians and surgeons, especially procedure-oriented specialists like orthopedists and cardiovascular surgeons. Medicare paid in full hospital bills and the “usual and customary” fees physicians and surgeons charged for their services. Medicare beneficiaries, the consumer, gave little thought to medical prices, since a third-party, the government, paid the bill. And possessing a deep well of funds provided by U.S. taxpayers, the Health Care Financing Administration (HCFA), the bureaucratic precursor to the Center for Medicare and Medicaid Services (CMS), did not question the prices doctors and hospitals charged for their services. For a while.

Price Controls

With healthcare costs continuing to rise, Congress began to impose price controls. For hospital bills, it created (in 1983) the Medicare Prospective Payment System (PPS) based on Diagnosis-related Groups (DRGs). PPS pays hospitals a fixed amount for treating a particular diagnosis, irrespective of the number of nights a patient might stay in the hospital and the resources used in that patient’s care. It uses the World

Health Organization’s International Statistical Classification of Diseases (currently ICD-9) diagnostic codes, where each code is assigned a specific monetary value.³ Many private payers in addition to Medicare have adopted the DRG form of cost reimbursement to hospitals.

Beginning with the 1984 Deficit Reduction Act and subsequent acts, Congress imposed a price freeze on the amount Medicare would pay for physician services. In 1989 it established the Resource-Based Relative Value Scale (RBRVS) for physician services. Medicare pays doctors for each procedure they do (instead of by diagnosis, as with hospitals). The RBRVS employs five-digit Current Procedural Terminology (CPT) codes covering some 8,000 procedures. Only the American Medical Association may publish the codes (at a multimillion-dollar profit), as per government decree. An “expert panel” assigns a specific value to each coded procedure based on the amount of time a provider spends with the patient, along with other factors such as the intensity of the service, skill, practice expense, and the cost of malpractice insurance.^{4,5} RBRVS prohibits balance billing, in which doctors adjust fees according to the patient’s ability to pay. When I was a general surgery resident at Roosevelt Hospital in New York in the 1960s, attending surgeons there would charge their wealthy Park Avenue patients relatively high fees while making themselves available to perform surgery free of charge on the hospital’s indigent patients.

In addition to lowering physician payments through legislative measures like RBRVS and enforcing price controls that do not take into account the depreciating value of the dollar, rules and regulations flourish. By 1999 there were more than 110,000 pages of Medicare-related federal rules and regulations, twice the number of pages as the U.S. tax code. These pages include all new Medicare legislation and regulations implemented since 1965; mushrooming fraud-and-abuse regulations; the Balanced Budget Act of 1997, creating the Medicare Part C private-plan option; various HCFA manuals, HCFA *Federal Register* pages and administrator decisions; and carrier manuals, coding manuals, carrier newsletters, intermediary communications, intermediary Medicare bulletins, etc.⁶

The Medicare bureaucracy deems what is medically necessary or appropriate and what constitutes a medically improper or unnecessary service. Providers are forced to jump through an increasingly complex array of federal hoops that prescribe exactly what they can and cannot do for their patients. As one attorney puts it:

Physicians find it difficult to discern what medical services are covered by Medicare. They face rising costs for services and equipment, yet also face caps on Medicare reimbursements. They must spend

considerable time and money to satisfy complex and confusing Medicare regulations, that are traps for the unwary, and they fear costly inquiries, investigations, and audits, and prosecutions by Medicare enforcement authorities. They find the transformations in the medical marketplace wrought by an increasingly intrusive federal regulatory establishment to interfere with their exercise of independent professional judgment and limit their freedom to serve the best interests of their patients.... Medicare is transforming the way health care is delivered in the United States—away from individualized treatment, where successful patient care is the paramount objective, toward bureaucratized treatment, where strict adherence to uniform federal rules is the chief concern. Cost containment pressures necessarily discourage tailored care in favor of one-size-fits-all approaches. Medicare burdens are hastening the arrival of the day when physicians will be able to practice only if they are affiliated with large hospitals or managed care groups that can afford the risk managers, accountants, and lawyers needed to ensure compliance with Medicare regulations.⁷

HIPAA, HITECH, and FFS RAC

Government-run medicine is papered with acronyms. In addition to those above, other notable ones are ACA (PPACA), ACO, ARRA, CER, CHIP, CMP, COBRA, EHR, EMR, EMTALA, FCCER, FFS RAC, GPO, HIPAA, HITECH, ICD-10, IPAB, MAAC, MACR, MIPS, MMA, NCF, PCORI, PHI, PQRI, RVU, SGR, SMP, and VBP. CMS catalogues 4,417 healthcare-related acronyms on its website and explains what they all mean.⁶

Two particularly draconian ones are HIPAA and HITECH. They trap unwary physicians. The 1996 Health Insurance Portability and Accountability Act (HIPAA) imposes civil monetary penalties (CMP) for various newly defined healthcare offenses, which include “incorrect coding or medically unnecessary services.” In a realm of highly complex rules and regulations, honest billing errors, like mistakenly using the wrong code for a service selected from among 8,000 existing CPT billing codes, will result, if discovered, in a CMP limited to \$100 per violation, up to \$25,000 for all such violations during the same calendar year.⁶ The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) increased these fines, culminating in the 2013 HITECH Final Rule that raises the CMP to \$50,000 for each violation and up to \$1.5 million for identical violations during a calendar year.⁹ The federal government employs the threat of arbitrary penalties and prosecution to collect unwarranted settlements from doctors “guilty of clerical errors.” (In the case of a psychiatrist who had “grossly negligent billing practices,” an appeals court ruled that “the government’s definition of claim permitted it to seek an astronomical \$81 million worth of damages for alleged actual damages of \$245,392.”)⁶

Doctors who provide services to Medicare and Medicaid patients expose themselves to a substantially increased risk of civil and criminal sanctions. A physician courts trouble when depositing Medicare and Medicaid payments into a bank account with other practice funds. If the government

then alleges that this doctor has obtained the comingled Medicare and Medicaid money illegally, prosecutors will seek to obtain a conviction for money laundering, providing grounds for “asset forfeiture”—confiscating all of that physician’s practice funds.¹⁰

Along with a Part D prescription-drug benefit, the 2003 Medicare Modernization Act (MMA) created the Fee for Service Recovery Audit Contractors (FFS RAC) program. CMS outsources this program to four private companies and pays them a contingency fee for every overpayment they can find. Functioning like bounty hunters, these companies audit the records of (Medicare-participating) fee-for-service physician offices and hospitals, seeking to identify and recover improper Medicare payments. In this league, there is also the Senior Medicare Patrol (SMP). It offers financial rewards to Medicare beneficiaries who report Medicare fraud, waste, and abuse to the government.

Affordable Care Act

The “Patient Protection and Affordable Care Act,” (ACA), Public Law 111-148, decrees how medicine is now to be practiced in the United States. Ratified in 2010, ACA becomes fully operational in 2018 when its final provision, a tax on high-cost, “Cadillac” insurance, goes in effect.

ACA proponents point to the work of John Wennberg et al. at Dartmouth (my alma mater). These investigators found huge variations in medical care among communities throughout Vermont that were “without apparent rhyme or reason.” Hospital admission rates for most causes of admission varied two- to three-fold. Most remarkable, common surgical procedures like tonsillectomy and hernia repair performed per 10,000 persons (with adjustments made for age composition in the 13 hospital-service areas surveyed) varied as much as ten-fold. Wennberg and his colleagues postulated that differences in beliefs among physicians and surgeons regarding the indications for various procedures and their efficacy best explained these variations, rather than any differences there might have been in the local incidence of disease.^{11,12}

A few months before Congress passed ACA and President Obama signed it into law, the *New England Journal of Medicine* published online a perspective on the matter, written by Stephen Swenson, along with the CEO of Seattle’s Virginia Mason Medical Center, Gary Kaplan; Donald Berwick, former CMS administrator and enthusiast about England’s National Health Service; and nine other co-authors. They wrote:

Our current health care system is essentially a cottage industry of nonintegrated, dedicated artisans who eschew standardization. Services are often highly variable, performance is largely unmeasured, care is customized to individual patients, and standardized processes are regarded skeptically.... The gap between established science and current practice is wide.¹³

ACA’s stated goals are to provide universal access to healthcare, improve the quality of healthcare, and find ways to slow or reduce the cost of care. ACA stipulates that all providers and hospitals must start using electronic health records (EHR) or face penalties. The information acquired from

government-connected EHRs will enable central planners to measure healthcare performance and standardize care.

By one count this legislation is creating 159 new healthcare bureaucracies.¹⁴ One is the Patient-Centered Outcomes Research Institute (PCORI). Its mandate is to:

assist patients, clinicians, purchasers and policymakers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which disease, disorders and other health conditions can effectively and appropriately be presented, diagnosed, treated, monitored and managed....

Replacing the Federal Coordinating Council for Comparative Effectiveness Research (established in 2009 as part of the American Recovery and Reinvestment Act), ACA authorizes PCORI to coordinate and increase funding for Competitive Effectiveness Research (CER). Proponents of CER say it will help government experts to develop evidence-based guidelines and best practices for delivery of appropriate, cost-effective care. It is also intended to help reduce “practice variation and health disparities.”^{15,16}

A central component of ACA is the Accountable Care Organization (ACO). Like the Health Maintenance Organization (HMO) in the 1990s, the ACO is the latest iteration of government-run managed care. Providers and hospitals that work together and agree to take responsibility for the complete care of a group of Medicare patients (5,000 or more) stand to benefit financially. To be registered as an ACO such groups must use EHRs, follow centrally issued practice guidelines, and submit to process and outcome quality measures. A registered ACO will earn a monetary bonus if it spends less on its Medicare patients’ care than that spent on them in the past. If an ACO spends more on them than in past years, however, it will be assessed a monetary penalty.^{17,18} As of January 2015 there were 457 registered ACOs throughout the country.¹⁹

Despite its title, the 384,000-word Patient Protection and Affordable Care Act deals chiefly with subjects other than “patient protection” and “affordable care”—things like taxation, regulations, subsidies, expansion of Medicaid, special interest-group favors, replacing fee-for-service with value-based purchasing, penalties, punishments, and (more) price controls.¹⁴ Along with complex rules regarding eligibility for individual and small employer tax credits and other tax-related rules, ACA gives IRS the power to audit a person’s health records in addition to Form 1040. During the first half of 2014 expansion of Medicaid coverage accounted for 71 percent of all net new health insurance issued. Medicaid also has absorbed many people who once had private insurance that did not meet ACA requirements, accounting for 80 percent of all new Medicaid enrollees.²⁰ More than 20,000 pages of regulations peppered with threats of fines and/or prison sentences have been added to this law so far. With regard to its affordability, in 2016, seven years after passage of ACA, a bronze health insurance plan for a family of five with an annual income of \$120,000 will cost \$20,000 a year.²¹

One thing ACA is having trouble getting implemented, owing to widespread opposition, is the Independent Payment Advisory Board (IPAB). As described in §3403 of

the Act, IPAB is a 15-member president-appointed group that determines what treatments, procedures, tests, and medications Medicare will cover. The decisions this board makes automatically become law and are not subject to judicial review or congressional oversight, except by a super-majority during a limited time frame. (An IPAB repeal bill titled Protecting Seniors’ Access to Medicare Act of 2015, as of May 2015, has a sufficient number of co-sponsors to ensure House approval.)

Value-Based Purchasing

The 1997 Balanced Budget Act established the Sustainable Growth Rate (SGR), designed to keep Medicare expenditures from growing faster than the GDP. If followed, it would have required a 21 percent cut in Medicare physician payments in 2015. But recent passage of the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act (MACRA) recently rescinded the cuts and revoked the SGR. Instead, this 263-page bill initiates a transition from “fee-for-service” healthcare to “value-based reimbursement.” The new law stipulates that by 2019 Medicare is to have put in place a Merit-Based Incentive Payment System (MIPS). Payments to providers will be based on quality, resource use, “clinical practice improvement activities,” and “meaningful use” of certified EHR technology.

MACRA funnels money into organizations like the American Board of Medical Specialties (ABMS), American Board of Internal Medicine (ABIM), and the National Quality Forum (NQF), charged with directing clinical practice improvement activities. These non-governmental organizations (NGOs) will determine whether physicians and other healthcare providers meet requisite improvement activities by compelling them to take frequent, high-cost Maintenance of Certification (MOC) examinations, an activity that will be a prerequisite for Medicare payment.

Along with various bureaucratic practice controls placing physicians under the thumb of government regulators, this new law also seeks to codify population-based care—optimizing care for populations of patients with common conditions. Lawmakers have designed it to steer physicians away from fee-for-service practices into new forms of managed care led by ACOs.

Department of Health and Human Services (HHS) Secretary Sylvia Burwell, in a blog post on the HHS website, writes: [The goal is] “to move away from the old way of doing things, which amounted to, ‘the more you do, more you get paid,’ by linking nearly all pay to quality and value in some way to see that we are spending smarter.” She adds: “This is the first time in the history of the program that explicit goals for alternative payment models and value-based payment models have been set for Medicare.”²²

Policymakers use “quality” and “value” interchangeably. The customer ascertains the value of a product or service by analyzing its worth to him or her relative to its cost. Value is subjective. In healthcare, however, policymakers define what constitutes value, what is “value-based,” without regard to what the consumer—the patient—might think. Quality is more objective. The entity that produces a product or service

determines its quality, which can be objectively assessed.²² The Resource-Based Relative Value Scale reflects a Marxist-oriented, objective labor theory of value, paying physicians based on the amount of time they spend with a patient. MACRA likewise bases physician reimbursement on a labor theory of value.

Practice Guidelines and EBM

Proponents of value-based medicine say: “A high-value care system embraces the appropriate use of scientifically informed guidelines, standard practice, teamwork, checklists, and accountability and welcomes payment for value, not just for volume.”¹³

“Scientifically informed” guidelines play an important role in modern medicine. Soon viewed as practice requirements, they become the standard of care, and as such, assume medico-legal significance. Doctors who choose not to follow the guidelines risk financial retribution and malpractice exposure. Although “evidence-based” and judged “established science,” a number of them still have been shown to be wrong.

One guideline I had to follow as a heart surgeon tells providers to maintain tight control of blood sugar in their critically ill patients. Investigators have shown, however, that intensive glucose control in such patients does more harm than good. Instead of enhancing quality of care, this practice increases mortality.²³ Another one stipulates that patients with pneumonia should receive antibiotics within four hours of arrival at the emergency room. Health authorities made this guideline a “quality measure” for evaluating a particular hospital’s quality of care. But here too researchers have shown that this practice does more harm than good. Patients who have congestive heart failure or asthma can have chest X-ray findings that mimic pneumonia. In a guideline-propelled rush to dispense high-dose antibiotics for pneumonia, some of these misdiagnosed patients given antibiotics will develop antibiotic-induced colitis. Healthcare experts write off this guideline/quality metric with the epithet, “a flawed performance measure.”²⁴

Doctors in academic medical centers write practice guidelines. They base them on clinical trials that randomize populations of patients with a given condition into treatment and placebo groups and choose treatments that are statistically shown to work best. According to the tenets of evidence-based medicine (EBM), epidemiological and biostatistical ways of thinking provide what its proponents consider “best evidence.” EBM downgrades traditional forms of medical evidence, notably a doctor’s clinical experience and understanding of pathophysiological mechanisms of disease, both unquantifiable.²⁵

Evidence-based medicine applies the principles of epidemiology to individual patient care, basing that care on statistical trials. Probing EBM, co-author Clifford Miller and I conclude, “EBM has failed in the real world of medicine, in terms of its use in making medical decisions and in proving causality. It has been successful politically. Health service managers, public health professionals, biostatisticians, health

economists and politicians continue to prosper using the statistics that EBM provides, acting to rein in the purported dangers of passive smoking and low-dose radiation and to promote the claimed benefits of low fat diets, statins and influenza immunization.”²⁶ As Bruce Charlton and Andrew Miles put it, “EBM stands revealed as statistical rather than scientific; its success more to do with managerial dominance than medical desirability.”²⁷

Unassailable Medical Paradigms

Government-funded research fosters conformity to prevailing views. Twenty-six federal granting agencies manage 1,000 grant programs. Researchers quickly learn that the best way to get their work funded and published is to avoid dissent from orthodoxy. Grant-review study sections, whose members’ expertise and status are tied to the prevailing view, do not welcome any challenge to it. A scientist who writes a grant proposal that dissents from the ruling paradigm will be left without a grant. Successful applicants follow the ethic of “keep it safe and survive” and propose research that will please the reader-peers and avoid projects that might displease them. A National Institutes of Health (NIH) pamphlet on grant applications reinforces such behavior, stating, “The author of a project proposal must learn all he can about those who will read his proposal and keep those readers constantly in mind when he writes.” Noted scientist Gerald Pollack, professor of bio-engineering at the University of Washington, states: “We have evolved into a culture of obedient sycophants, bowing politely to the high priests of orthodoxy.”¹

Peer reviewers whose expertise and status are tied to the prevailing view on a given subject are not likely to welcome a challenge to it. The system is inherently biased to supporting prevailing views. As one observer puts it, “peer review outlaws paradigm change.”¹

State-sanctioned paradigms in the biomedical sciences that have gained the status of dogma and are not to be questioned include: a) cholesterol and saturated fats cause coronary artery disease; b) mutations in genes cause cancer; c) a retrovirus called HIV (human immunodeficiency virus) causes AIDS (acquired immune deficiency syndrome); d) the damaging effects of toxins are dose-dependent in a linear fashion down to zero, where even a tiny amount of a toxin, such as radiation or cigarette smoke, will harm some people (i.e., the linear no-threshold hypothesis); and e) vaccines are safe and effective. In the real-world of medical decision-making, each of these dogmas deserve scrutiny. The government-controlled peer review grant system is a key tool for protecting paradigms like these. Researchers questioning them will not get funded.¹

Disproving any one of these paradigms will have profound consequences for modern medicine. With regard to the cholesterol hypothesis of heart disease, there is now substantial evidence showing that this hypothesis is wrong and that prescribing statins does more harm than good.²⁸ An equally strong case can be made proving beyond a reasonable doubt that HIV does not cause AIDS.²⁹

Industrialization of Medicine

Thirty years ago nearly 80 percent of physicians were self-employed and owned their practices. But by 2011, half had become hospital employees.³⁰ Now almost every newly trained physician and surgeon will seek a position as a salaried employee of a hospital or in a managed-care system like Kaiser Permanente. To safely practice medicine today and stay out of trouble, doctors need coders, claims filers, compliance monitors, risk managers, accountants, and lawyers, which only a large healthcare organization can afford, working with them to ensure risk-free compliance to the myriad Medicare, HIPAA, ACA, and MACRA regulations that now govern the practice of medicine.⁷

The drive to codify medical practice is turning the medical profession into a commodity. Like an interchangeable commodity, clinical practice is becoming increasingly uniform in an audit chain that begins with acquisition of evidence (medical history, symptoms, signs, test results), which a medical worker enters into a computer. The programmed EHR makes a diagnosis and stipulates the specific treatment that the medical worker/provider shall follow.³¹ Doctors are becoming like assembly-line workers, practicing medicine according to federally prescribed guidelines. On a number of these medical assembly lines, nurse practitioners and physician assistants can replace MDs.

Centrally connected and monitored EHRs are an essential component of industrialized medicine. Today, unfortunately, when a patient has a doctor appointment he will be disheartened to find that the doctor spends much more time typing and looking at his computer than he does in evaluating the patient. A former classmate writes of this in our Harvard Medical School Class of 1965 50th Reunion Report: "We introduced the electronic medical record about eighteen months ago and for my brother and me [both otolaryngologists], it has been a nightmare. We've had to cut down on patients we see, some of whom we've seen for over 40 years.... There obviously are some benefits from the computer [EHR], such as sending prescriptions, but the interference in medical care overshadows this." Many physicians say that entering patient data into their EHR takes two to three extra hours daily.

Richard Maybury describes what it is like to see his family doctor now:

Each visit to him has become torture, for him and us. Mostly he stares at the computer screen trying to follow the orders of the Obamacare computer gods, and gets ever further behind schedule. His tension is heartbreaking to watch. The reality is that our doctor doesn't work for my wife and me any longer, he works for the government. Its ever-changing computer system is the patient that gets all his attention.³²

As in other parts of the economy, crony capitalism (business success resulting from close relationships between business people and government officials, who, among other things, help block competition) is rampant in today's medical-industrial complex. The big pharmaceutical companies contribute more money to politicians of both parties than any other business, and they benefit accordingly. Government

payments through MACRA to crony medical societies (ABIM, ABMS) are another one. But perhaps the most egregious example of crony capitalism in modern medicine is the Group Purchasing Organization (GPO).³³

Five GPOs in the U.S. control more than \$300 billion annually in drugs, devices, and supplies for some 5,000 hospitals (charging prices 22 percent higher than those hospitals can get on their own).³⁴ A 1987 Medicare anti-kickback "safe harbor" provision exempts GPOs from criminal prosecution for taking kickbacks from suppliers. This yet-to-be-repealed legislation rigs the entire healthcare supply chain. Kickbacks paid by suppliers to GPOs can exceed half of the suppliers' annual income for a single drug. In a 2012 report, investigators Patricia Earl and Phillip Zweig write:

Over the last decade, it has become abundantly clear to objective participants in the healthcare supply industry that the kickback-based GPO business model benefits no one except top GPO and hospital executives, "K" Street lobbyists, academics-for-hire, and powerful politicians seeking campaign contributions. Indeed, some portion of the vendor kickbacks winds up in the campaign coffers of members of Congress, who in turn make sure the GPOs get to keep their kickbacks. So it is no wonder that politicians of both parties feed at the GPO trough and preserve this venal enterprise.³⁴

Two Laws

In the free-market semiconductor industry, businesspersons heed Moore's Law to guide long-term planning. It states that the number of transistors that can be placed inexpensively on integrated circuits doubles every 18 months to 2 years, which has been proven to be the case for the last 40 years. (One smartphone today has more computer power than all the computers NASA used to send a man to the moon in the 1960s.) In government-regulated healthcare, Eroom's Law applies. "Moore" spelled backward, Eroom's Law states that the rate of decline in the approval of new drugs per billion U.S. dollars spent is fairly similar over different 10-year periods. In fact, the number of new drugs approved per billion U.S. dollars spent on research and development has halved roughly every nine years since 1950.³⁵ That over-regulation and big drug company lobbying make it difficult for smaller drug companies to gain traction helps explain why pharmaceutical productivity keeps declining. If government were to start regulating the production of integrated circuits, the Law of Eroom would take effect and replace Moore's Law.³⁶

A second law impacting government-run healthcare is Gammon's Law. Named after the British physician Max Gammon, it states that "in a bureaucratic system an *increase in expenditure* will be matched by a *fall in production*. Such systems will act like 'black holes' in the economic universe, simultaneously sucking in resources, and shrinking in terms of 'emitted production.'"³⁷ I saw Gammon's Law at work directing the heart surgery program at a VA hospital for 11 years.

Over the last 50 years the number of occupied beds in the U.S. has decreased, despite a growing population, while the number of hospital staff per 1,000 occupied beds has increased eleven-fold.³⁸ And costs have skyrocketed. In 1971 the ratio of

outpatient administrators to practitioners was three to four. In 2010 it was 5.1 administrators to one practitioner, a seven-fold increase. At the beginning of the 20th century, physicians accounted for about one out of three healthcare workers; by the 1980s, the ratio had fallen to one out of 16.³⁹

At the Crossroads

The closing stanza in Robert Frost's poem "The Road Not Taken" reads: "I shall be telling this with a sigh / Somewhere ages in ages hence: / Two roads diverged in a wood, and I – / I took the one less traveled by, / And that has made all the difference."

Traveling the government road in medicine stifles innovation, inundates healthcare workers with regulations, and rations care. Costs soar, despite price controls, draconian monetary penalties, and bounty-hunter recovery audit contractors.

Designed to replace fee-for-service payment, the ACA's centerpiece, the Affordable Care Organization is destined to fail—like the similar managed-care HMO did 20 years earlier. One physician writes: "The ACOs will fail because they aren't premised on attracting investment to change how healthcare is delivered. They are just moving around the current pieces. Doctors will find themselves the pawns in this game. But it's the patients who, faced with declining services and restricted access, will find themselves in checkmate."¹⁸

Further down this road lurks the Complete Lives System. Its champions were unable to get this incorporated into the Affordable Care Act. But on the way to a complete single-payer system, they will make sure that it gets enacted. The Complete Lives System restricts care for older persons. Advocates hold that it is better to spend limited societal resources treating three 25-year-old patients than using them to treat one 75-year-old man, since that older person already has had more than his fair share of life years.⁴⁰

The government road ends with the Sovietization of American medicine.⁴¹ Redistribution of wealth will be coupled with redistribution of life years. As American economist Milton Friedman puts it: "Bureaucratic structures produce high cost, low quality and inequitable distribution of output. The U.S. medical system has become in large part a socialist enterprise. Why should we be any better at socialism than the Soviets?"³⁷ This kind of system is not sustainable.

The other road, the "one less traveled by," leads to freedom. Friedman writes: "The inefficiency, high cost and inequitable character of our medical system can be fundamentally remedied in only one way: by moving in the other direction, toward re-privatizing medical care."³⁷

A sign on the freedom road reads, "There Is No 'Right to Healthcare.'" Government proclaiming a right to healthcare, or anything else that human action produces, violates the 13th Amendment to the Constitution prohibiting slavery and involuntary servitude. Ron Paul explains:

The supposed right to medical care can only be guaranteed at others' expense. The transfer can only be arranged by force. This creates oppressive bureaucracies, encourages over-utilization of resources, and leads to technological stagnation and

inevitably to rationing and deprivation.⁴²

A citizen has no more a right to healthcare than he does a house, a flat-screen TV, or the free services of a plumber for a water contamination emergency.

A medical industry free of any government control and regulations would enable it to function, like the computer industry, more in accordance with Moore's Law than to its stifling opposite, Eroom's Law. And with medical care shorn of its "black hole" of bureaucracy, Gammon's Law will also no longer apply.

Austrian economist, libertarian theorist, and political philosopher Hans-Hermann Hoppe proposes a radical, but perhaps ultimately necessary four-step solution to America's healthcare crisis. He writes:

To cure the problem requires not different or more government regulations and bureaucracies, as self-serving politicians want us to believe, but the elimination of all existing government controls.... *Tax credits, vouchers, and privatization* will go a long way toward decentralizing the system [italics mine].... But four additional steps must also be taken:

1. Eliminate all licensing requirements for medical schools, hospitals, pharmacies, and medical doctors and other health care personnel. Their supply would almost instantly increase, prices would fall, and a greater variety of health care services would appear on the market. Competing voluntary accreditation agencies would take the place of compulsory government licensing....

2. Eliminate all government restrictions on the production and sale of pharmaceutical products and medical devices. This means no more Food and Drug Administration, which presently hinders innovation and increases costs.... [Our country's robust legal profession will keep drug companies in line.]

3. Deregulate the health insurance industry. Private enterprise can offer insurance against events over whose outcome the insured possesses no control.... [Like insuring one's home against fires and floods, buy insurance that covers expenses for major injuries and illnesses, not like current misnamed health "insurance" that covers routine doctor visits.]

4. Eliminate all subsidies to the sick or unhealthy. Subsidies create more of whatever is being subsidized. Subsidies for the ill and diseased breed illness and disease, and promote carelessness, indigence, and dependency. If we eliminate them, we would strengthen the will to live healthy lives and to work for a living. In the first instance, that means abolishing Medicare and Medicaid. [Private charity will once again play an important role in medical care.]

Only these four steps, although drastic, will restore a fully free market in medical provision. Until they are adopted, the industry will have serious problems, and so will we, its consumers.⁴³

Conclusions

Major changes in American medicine will continue to occur during the next 50 years. Many obstacles prevent the medical-

industrial complex from turning onto the freedom road. At some point, however, the currently traveled government road will wash out and become bankrupt, either gradually as its healthcare programs become more and more smothered in paperwork, or abruptly. With the U.S. economy deeply in debt and faltering, hyperinflation and economic collapse could occur unexpectedly at any point, swiftly dismantling American medicine as it is currently structured.

Free-market medicine offers us the best chance for preventing disease and developing cures for existing, currently incurable chronic diseases, where longevity with well-being is the ultimate goal.

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