

A few months ago, I received a submission for publication in Common Sense that advocated a single-payer system for health insurance. It was unsolicited, but the board members who forwarded it to me felt it was a good candidate for publication. The problem became how to balance it? After discussion, it was decided to have a point-counterpoint debate. E-mails were sent to the membership seeking counterpoint submissions. The counterpoint article published here came as a result of that call for submissions. Since the time of the call for submissions, I learned that the "point" article was originally published in the California-AAEM newsletter. E-mail requests to its editor asking for permission to publish it failed to get a response, but I decided to publish it anyway. I thank Cal-AAEM in advance. I would also like to thank those authors of other counterpoints that were not chosen for publication for their fine efforts. -Howard Blumstein

AAEM Point/Counterpoint: Single Payer, National Health Insurance

POINT

by Ken Weinberg, MD FAAEM

More than 43,000,000 people in the United States are without health insurance, and the numbers are projected to grow even greater. As emergency physicians across the country, we have special insight into the problems of the American health care system. We experience first hand the immediate effects of this mounting lack of insurance. We play the costly role of primary care providers for uninsured patients having no regular source of medical care. We work under dangerously overcrowded conditions, as increasing numbers of uninsured patients come to us at the primary care site of last resort. The emergency room is no substitute for ongoing comprehensive care that so many of our patients are denied. We also see, more clearly than anyone else, that emergency care for the acutely ill and injured is threatened by the growing numbers of uninsured who are forced to use emergency facilities, in the absence of any alternative.

HEALTH CARE IN AMERICA IS SICK:

There are more than 43.6 million Americans, many of them young children, who are uninsured for the full twelve months of the year. Substantially more, according to one study more than 80,000,000—one out of three of those under the age of 65—have no insurance for a portion of the year, and two-thirds were uninsured for six months or more.

Almost everyone is insecurely insured, afraid of losing their jobs and, as a consequence, losing their health benefits as well. Many are “locked” into their jobs simply to hold onto their health benefits, when they might be employed more productively and happily elsewhere.

Those who are insured are covered through a confusing mélange of HMO’s, PPO’s, Medicaid and Medicare, each with different rules and regulations. Physicians waste precious time and money dealing with these complex and intrusive financing mechanisms.

Insurance company bureaucrats tell patients and physicians what specialists they may see, what treatments they may undertake, and what drugs they may use. Those of us who have spent years in specialty training should not be questioned about our professional decisions by number crunchers motivated by the need to maximize insurance company profits.

Administrative costs in the private, for-profit insurance system range from 15-30 per cent to cover their marketing expenses, unnecessary administrative procedures, excessive CEO salaries, and profits. They increase our costs as well, as we are confronted with a myriad of conflicting rules and hundreds of insurance forms. In contrast, Medicare, the government-run insurance system for the elderly, offers patients their choice of doctor and hospital and has administrative costs of fewer than 3 per cent!

Finally, we have a climate where the financial constraints of the new “managed care” cause patients to feel that they can no longer trust their physician to put their interest first, and now all physicians feel the need to practice defensive medicine, causing them to over-order tests and procedures.

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COUNTERPOINT

by Ann Loudermilk, MD FAAEM FACEP

Solving the problems of health care won’t be easy. But let us make sure the cure is not worse than the disease. As implied in advocating for “evidence based medicine”, we should be promoting “evidence based social policy” as well. There is plenty of historical evidence that cast doubt on the desirability of a single payer (socialized) system. Who do you suppose will be the single payer? The very people who complain about the low payments and complicated documentation of Medicaid/Medicare are pushing for an expansion of the same system expecting it to be different. It will only be worse because there will be NO competition to encourage improvement.

We should view medicine as a necessity like food, water, clothing, etc. We all work to provide these things for our families. What happens when we “socialize” those necessities? They become complicated, mediocre, and unaccountable. I was in England many years ago on a preceptorship and saw first hand the poorer quality of socialized medicine and the energy and money spent by consumers to find better care. And can anyone deny the inefficiencies in government run systems? So one not only pays taxes to support an inefficient system but also spends their own money to get a better product. Take education. My lower middle class parents paid extra to send me to a Catholic school because they saw the value of a good education. I am not saying the intention is not noble, but we must find the best solution, not just what *seems* to be the easiest.

Do we spend too much on our Medical system in the USA? Apparently not, because many people are spending billions on health food supplements, vitamins, alternative care, etc out of their own pockets. The problem is not money available; it is how it is spent. There is plenty of money in the system, as we all know. But when you separate the payer from the provider of a service, there is no incentive for cost/quality control. The government and insurance companies have assumed the control and given us many “unfunded mandates” including wasteful paperwork and a bloated ineffectual regulatory system. To compare evidence, look at the food industry. There is no socialization of this basic need, but we provide for those of us unable to provide for themselves. As my foreign friend says, “I want to go to a country where the poor people are fat”.

It won’t be easy to change this behemoth of a system but I believe we must return to the philosophy of patient centered care/control. We have to change the attitude that medical care is an entitlement. As tedious as it might be to provide/purchase ones own medical care, it will be better than having the government or ones employer do it. Let’s not be so patronizing. If people are able to raise kids, buy cars, and provide for their families, they can figure out how to provide for their health. It won’t all be perfect but it will beat having some bureaucracy control your medical care.

We have many historical examples on how to successfully deal with social issues without socializing a whole system. So let us use the evidence, not well intentioned emotional rhetoric, to guide our reform of a mostly successful health care system. 



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AAEM's GOVERNMENT RELATIONS RESOURCES

Advocacy is more than just understanding the issues. To make a difference, you have to make your voice heard. The involvement of individual emergency medicine physicians is vital to the success of AAEM's grassroots efforts. To assist you in your government relations activities, AAEM provides the following services and information:

- **AAEM E-Mail Alerts**

AAEM E-Mail Alerts provide strategic information to affect key policy issues of concern to emergency medicine. If you would like to receive future Alerts, send a note to aaemgov@aol.com or sign up directly from the homepage of AAEM's Legislative Action Center accessible at <http://capwiz.com/aaem/home>.

- **Legislative Action Center**

The Legislative Action Center located on AAEM's Web site www.aaem.org is "one-stop" shopping for federal legislative and regulatory information. It contains the important issues that AAEM is tracking for you, recent votes, current bills, and other relevant items. You can search the congressional database by name, state, committee, or leadership, and send messages to your congressional delegation directly from the site.

- Additional features include:

"Sponsor Track" which attaches information on relevant bill sponsorship on Members' bio pages; A "Vote Scorecard" listing every Member of Congress and how they voted on bills of interest to AAEM; "Megavote" provides you with a weekly e-mail on the voting patterns of your Representative and Senators; A searchable "Guide on National and Local Media" including newspapers, magazines, and TV networks and stations; users can send e-mails, faxes or printed letters to newspaper journalists, radio talk show hosts, and television commentators; and detailed "Campaign Contribution Data".

- *Washington Sentinel*

The *Washington Sentinel* – AAEM's monthly newsletter on legislative and regulatory issues of concern to emergency medicine. You can receive the *Washington Sentinel* as a downloadable PDF document by sending an e-mail note to aaemgov@aol.com.

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As a result of this, health care costs in the US consume close to 15% of our GDP, as compared to 7-10% in countries in most of the rest of the world, the majority of which have national, universal health care. Moreover, we rank among the lowest of the industrialized countries in measures such as infant mortality, infant birth weight, and longevity and patient satisfaction.

I am an advocate for single-payer national health insurance, universal health care that would cover everyone. This is the only way to address the systemic problems of health care in the United States. Health care should be a right not dependent on financial status or the vagaries of employment, particularly in an economy that creates fewer and fewer long-term jobs with decent benefits.

Everyone should have access to a regular source of care so they will only show up in emergency rooms when there is a true emergency. As physicians in the richest, most powerful nation in the world, we are troubled by the fact that vast segments of our population cannot afford the health care they need and are unable to pay for their prescription drugs. What is our response to seeing so many patients who have put off treatment until they are forced to head to the nearest emergency room? And how do we feel when we find that medical bills are the cause of half of all bankruptcy cases in this country?

In a time when tort reform has become the rallying cry in the battle over onerous malpractice fees, we should adopt a plan that will put physicians and patients back on the same side, where the high costs of settlements would be slashed because the costs of long-term care responsible for so much of those high settlements would be included in the budget for coverage that all of us would have?

The savings from switching to a single payer, Expanded and Improved Medicare for All system would pay for healthcare and prescription drug coverage for everyone. As AAEM has taken the lead in espousing democratic principles within our specialty, so should we take the lead in espousing proper healthcare coverage for all in our society. ☩

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medical, pediatric, and OB/GYN experience. Internal Medicine residents have minimal surgical, trauma, pediatric, orthopedic, and OB/GYN experience, and so on. These residents have limited exposure to the breadth of patients seen in the ED, managing patient flow, and performing many ED procedures such as LPs, vaginal deliveries, procedural sedation, etc.

Many non-residency trained BCEM physicians are likely outstanding doctors, and some may be better than many of their residency trained ABEM/ABOEM-certified colleagues. However, at the end of the day, we should be doing what is in the best interest of our patients. It takes supervised experience to become a good emergency physician. It is not fair to patients when unsupervised physicians "learn on the job." I'd imagine many BCEM physicians performed their first (or second or third) chest tube, vaginal delivery, difficult airway, etc. without supervision. This has the potential for disastrous outcomes. How do you fix mistakes when you don't know what you did wrong?

AAEM and AAEM/RES are taking a strong stand on this issue. As the only EM specialty society requiring ABEM/ABOEM-certification for full membership, this issue related to one of the core parts of our mission statement. In addition, we are reaching out to other organizations such as ACEP, EMRA, CORD, SAEM, AACEM, for their help. We are prepared to represent our membership in each state where this issue arises. As we take this battle to individual states where BCEM physicians bring this issue forward, we will need our local members to assist us in representing our case. Please keep informed through AAEM's communications to you, and we hope you will offer to participate if and when we come to your state.

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