Presidential Address: Discovering the Right Questions—Our Call to Action—Who Will Define Health Care Rationing, and How?

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Will the citizens and legislators of our country be accurately informed in enough detail to decide wisely on the proposed health care plans? If we cannot afford all health care for all people, how can we make the government use the words "rationing health care" and be certain that the rationing is done by the stakeholders (patients and providers)? Changes in the health care system are needed and it must be improved, but does that justify totally changing a system providing the best care in the world for 200 million people? Or should we build on and improve that which is good and extend it to the remaining 10–15% who are currently without insurance? Can the government guarantee good health? Does this imply we are to guarantee health, then food, and then housing and clothing? Or, rather, should we guarantee the right to pursue a job that allows the purchase of health care insurance, just as we have the right to purchase housing, food, and clothing? Can we guarantee health to our citizens, or must we guarantee the right to pursue good health? How much should we spend on health care? Is the health care industry a growth industry with the product a healthier population? If so, should it be punished or encouraged? Is what we spend out of line with what is spent on entertainment, tobacco, and alcohol? When viewed from that perspective is health care too expensive or a bargain? Will the individual citizen accept his/her individual obligation to change habits and lifestyle? Do the people of this country really want a health care service with the regulatory simplicity of the tax law, the frugality of the Pentagon, the efficiency of the Post Office, and the compassion of the IRS? To be consistent with the Vice President's efforts to downsize government should government involvement in health care be increased or decreased? Are the proper innovations underway on the state level? Is federal law necessary now at all, or should Washington just monitor the emerging new programs at the regional and state levels? If England and Sweden are backing away from socialism and starting to privatize, and if major cities in our own country are acknowledging governmental failure and inability to deliver cost-effective quality service for such simple things as trash collection and maintenance of park systems, how can our federal government run health care? What can we learn from the Rochester, NY health care system and from Oregon about empowering the stakeholders in a system of regional control? How can we foster the Integrated Delivery System concept? How can we empower the patients, the hospitals, and the physicians to make these decisions locally and regionally, without politician and government interference and without oppressive government micromanaging regulations? If health care professionals are not responsible for the societal disruptions of drug abuse, AIDS, crack babies, violence, alcohol, and tobacco, should the government's cost analysis charge these costs to a health care budget, or are they better charged against social program budgets? If we subtract all these costs resulting from violence, AIDS, drugs, alcohol, highway speeding, etc., and subtract the cost savings

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from meaningful tort reform, would our health care costs be increasing at less than inflation? If so, are our health care costs as adjusted for liability, population demographics, drugs, violence, etc., growing faster or slower than those of Canada and Germany? Which penalizes our industry more in national and international sales competition—the cost of health care or product liability? Will increasing primary care cost more money than it saves? Who will pay for the necessary increased educational costs in medical school and residencies for those primary care physicians? Who will pay for the continuing medical education? Nurse clinicians and physician assistants cost less; should they fulfill a very simple level of primary care and triage patients to specialists for proper definitive care? Would it be more cost-effective and better quality care to eliminate the generalist physician? Is the true generalist physician with today's complex medical knowledge an impossibility, like the solo violinist trying to play Beethoven's fifth all by him/herself? Will this country look at long-term cost–benefit analysis of medical research? Will this country provide legal relief from product liability and for new and emerging health care research products and technologies? How much can society save by investing in good medical research and in good health care? (J Hand Surg 1994;19A: 169–180.)

This year comes to me the honor and the challenge to speak to each of you. I speak to you from the heart, with sincerity and concern of an issue far bigger than any of us has previously faced—the future health of our citizens. President Clinton has launched a health care plan promising all care to all citizens—at no total increase in cost to society.[1] He has not used the words "health care rationing," but as *U.S. News & World Report* pointed out recently, if total cost is not increased, health care is to be rationed.[2] By whom? How?

Today, I insist we expand our horizons beyond hand surgery to our broader profession of the healing art, to our profession's obligation to the patients of today and tomorrow, and to the obligations of each of us as citizens.

In the last 140 years what changes have we seen in medicine! Only 140 years ago, we operated without anesthesia. Operative sepsis was "laudable pus," with surgical infections occurring in 90% of patients.[3] Death in childbirth was common, there was no treatment for diabetes, and established hand infections often resulted in amputation.

In the last 30 years we have gone from polio epidemics to polio vaccine, amputation stump closure to replantation, inability for effective nerve repair to nerve grafting, and nonfunctional limbs to free tissue transfer with function restoration.

We are now on the brink of gene treatment of inherited disease, genetic manipulation of tumors, allograft limb transfer, and limb bud regeneration in humans.

The future potential for medical science is almost without biologic or technical limit, but we and our patients are face-to-face with economic reality. This country cannot, by private or government mechanisms, afford to provide all possible treatments to all patients. We as physicians need to make these tough choices with our patients—together physicians and their patients need to ask difficult questions and be prepared for uncomfortable answers. And we must be certain the government is honest with the people. As *U.S. News & World Report* states ". . . . over the long run, Clinton's proposed financing couldn't possibly foot the bill; sometime after the year 2000, either the benefits would have to be cut, other government programs killed, or taxes would have to rise. Clinton's advisers understand this, but they should let the public in on the secret. In health care, over the long run, we'll get only what we pay for."[4]

In the crisis days of World War II, Churchill implored in his speech at Harrow School "Do not let us speak of darker days; let us speak rather of sterner days . . . These are not dark days; these are great days and we must all thank God that we have been allowed, each of us according to our stations, to play a part in making these days memorable . . . "[5] Today, this next year, each of us must play our part.

Many in Washington ask the wrong questions, such as "how can we control physician fees?"—yet physician fees account for only 19% of the dollars spent on health care, a percentage unchanged for the last 25 years. In fact, if doctors lowered their fees by 50%, the nation's health care bill would decrease only 2%.[6] Let me make one thing crystal clear today, I speak not of physician fees—but of much more important issues.

We must ask hard questions with no easy an-

swers. Edward George Moore in 1903 eloquently stated ". . . The difficulties and disagreements of which history is full are due mainly to a very simple cause; namely to the attempts to answer questions, without first discovering precisely what questions it is you desire to answer."[7] Our answers can be no better than our questions. I challenge us all, especially the younger physicians, with questions in three areas: first, health care cost; second, educational changes; and third, visions for leadership.

First, as to the cost of research and cost of health care, who will make these decisions? Will the citizens of this country be accurately informed to decide wisely? Or will the government tell us what is "best"?

Wise and well-intentioned people may be able to solve these challenges, but each of us has a deep uncertainty, a sinking feeling as we watch showcase politics in Washington. Do we want Washington's pork barrel system to determine health care? How can we help the honest and well informed on the Federal, State, and local level to get the accurate and true message to the people, our patients?

What are many of today's politicians telling the public? They speak of access—they mean rationing. They speak of quality—they mean cost control. With the help of the media, they blur these words for the people of this country. "We had best remember the caution of Adlai Stevenson in 1952, "Those who corrupt the public mind are just as evil as those who steal from the public purse."[8]

Clinton proposes to fund coverage for eye glasses, prescriptions, annual physicals, well baby care, cholesterol screening, etc.—without an increase in cost. This implies withholding necessary specialty care for cancer, arthritis, endocrinology, hand surgery, complex cardiology, etc. The politicians have disguised the rationing of health care behind words such as "Network," "HIPC," "access," "cost control," and "accountability."

First, let us look at research funding. In this milieu of rationing and cost control would penicillin have been developed? With current cost–benefit standards who in their right mind could justify federal research funding to study how mold grows in a petri dish! And, even if penicillin were developed, in today's tort law, after the first few allergic reactions—especially if anaphylactic—would penicillin be withdrawn from the market and class action lawsuit filed?!

Would the Salk vaccine for polio have been developed and marketed? Would today's legal tort system make it practical for any prudent drug company to test the vaccine? Hardly! Rather, in today's politically correct thought, would those in authority demand clinical guidelines and outcome studies on who should have access to the iron lung and for how long? Yet, how many untold billions of dollars have been saved from the use of polio vaccine in this country! How much suffering has been spared our people! How wisely spent those research dollars for that vaccine!

When we look at the cost of health-related research, we must convince Washington to look at this as a short-term investment for later major savings. For example, the research and production costs to develop penicillin were so difficult and costly, yielding such small amounts, that the urine of patients receiving this miracle drug was collected, the penicillin recrystallized, and the antibiotic used again! What great initial expense, but look at the enormous cost savings to society over the subsequent years as penicillin became less costly and plentiful, as inpatient treatment became outpatient, as routine deaths became rare from illnesses such as pneumococcal pneumonia. Recent examples of savings in health care from research include research in HIV detection, psoriasis, and peptic ulcers (Table 1).[9]

Benjamin Franklin said "If you think education is expensive, try ignorance." With apologies to Ben I would say "If you think good health care research is expensive, try sickness."

In addition to looking at long-term cost savings, we must provide legal protection for the penicillin and Salk vaccines of the future! Recall that only a few years ago in this country DPT vaccine for infants almost became unavailable because no U.S. company would take the risk of suit!

As John Kennedy wrote in the introduction to *The Quiet Crisis,* "The nation's race . . . between wisdom and waste has not run its course. . . . The nation's battle to preserve the common estate is far from won."[10] In research, we must look at (1) a long-term cost–benefit analysis and (2) legal relief.

Passing now from the research sphere to the clinical, we must force Congress to ask the hard questions and have the vision for the hard answers.

I suggest three very important questions in health care economics: (1) How much should we spend on health care? (2) *Can* the government guarantee good health for our citizens? and (3) What must be the individual responsibility of each citizen, (a) for some "out of pocket expense" and (b) for healthy life style?

How much should this country spend on health care? Should the cost be a dollar limit? A percentage of GNP? Or might we better ask "Is this a good and prudent growth industry, with the product a healthy population?" The health care system we have works well for 200 million people. Yes, we need to improve

Table 1. How Biomedical Research Saves Money: Three Case Studies

Therapy	*NIH Funding (in millions)*	*Annual Savings (in millions)*	*Ratio*	*Source*
Monoclonal antibodies and HIV detection—discovery of monoclonal antibodies spawned hundreds of products, including one to test the blood supply for HIV; its use each year results in 890 fewer cases of HIV infection. Costs saved include treatment and lost income.	$6.7	$63.7	1:9	FASEB
PUVA treatment for severe psoriasis—NIH research determined that a combination of ultraviolet light in the A range (UVA) and a drug called psoralen (P) was an effective and inexpensive treatment of chronic psoriasis.	$19.5	$57.5	1:3	NIH
Antibacterial peptic ulcer therapy—NIH-funded research correlated a bacterium with chronic ulcers. An antibacterial drug was identified that can end an expensive lifetime battle with the disease.	$26.8	$760.0	1:28	NIH

it, to be more efficient and to be more cost conscious, to cover the uninsured in a community-based rating system, but do not disrupt and risk destroying the best health care in the world now serving 85% of our people.

It should be noted that there are legitimate questions about the size and income of the pool of uninsured. ". . . One half of the uninsured go without coverage for less than five months, and 70% for less than nine months."[11] Of interest, "Nearly half have household incomes above $20,000, and 17% earn more than $40,000. What this suggests is that many young workers are turning down health coverage. They'd rather have the cash wages. . . ."[11]

Clinton stated that health insurance premiums drive the cost of our products above a level to compete internationally.[1] It is an accident of history that health care is funded by employers. During World War II, employers and unions used health care benefits as a way to increase employee compensation without violating price and wage controls.[12] More recently, with tax-free health benefits, employers provided health insurance to avoid employee taxes.[12] Health care costs for industry are high because of 50 years of union–company contract negotiations, not because health care is poorly delivered!

In fact, a lead article in the Washington Post states, "with surprising unity, a broad range of economists—both liberal and conservative—who disagree on other aspects of the President's plan dismiss the administration's competitiveness claim as over blown. . . . 'It's got nothing to do with competition,' Harvard University economist Martin Feinstein told Congress . . . Health care accounts for a small fraction of total business spending—less than 4 percent by most estimates. . . . the relatively high levels of health care spending at most of the nation's traditional manufactures reflect work force demographics rather than the escalation of health costs in the economy as a whole. Because auto unions protected the jobs of workers with the most seniority during the layoffs of the 1980's, the age of the average employee at the "Big Three" U.S. automakers has climbed to well over 40. Older workers have more health problems and thus are more costly. . . ."[13]

Furthermore, if cost competition for our country's products is an international economic issue, the insurance and tort systems involved in product liability had best be wary! Seventy percent of the price of a Cessna airplane is for product liability insurance.[14] U.S. litigation costs are 95% of the price of DPT vaccine and have enabled foreign competition to seize the market.[14,15] A recent article in *Science* states that the U.S. has lost its international lead in contraceptive technology because of product liability.[16]

In recent surveys of the chief executive officers of the nation's leading companies the following facts about product liability have emerged: 50% of the responding companies discontinued product lines; nearly 40% withheld product lines including beneficial drugs; and 50% reported product liability had a major impact on international competitiveness.[16] Ninety-one percent of executives believed new product innovation had been constrained by fear of liability law suits.[17]

Two recent quotes are significant. "At a time when the U.S. desperately needs superior new products to better compete with Japan and other countries, the majority of the executives surveyed expressed the opinion that manufacturers have chosen to stay with the tried-and-true rather than (develop new and better products and thus) risk being the

target of litigation."[16] "Foreign countries do not need to devise and implement trade barriers against American companies; the legal system in the United States accomplished that more efficiently than any foreign government plan could have envisioned."[14]

But to return to health care, the total cost of health care today is $800 billion a year, or 12% of the GNP. This is a lot of money. The people need to know the dollars are spent frugally and wisely. Patients must have dollar benefit for a dollar spent. We must eliminate overuse, underuse, and misuse. As we do this, we must protect the quality of health care.

Data from the Bureau of Labor Statistics are very informative: we are overstating our health care costs.[18] There are two factors in this, acknowledged by the officials compiling the data. First, the medical price index, as compiled by the Bureau of Labor Statistics (BLS) uses "list" prices—those on the hospital and physician invoices. Almost all of the real prices—that is, what is actually paid—are discounted. The size of this error is large. Hospital costs are increasing at a far slower rate—at 70% of the quoted BLS index.[18] The typical physician discounts at 70–80% of "listed fees."

Second, quality improvements show up as cost increase in BLS data. Two examples follow. (1) Patients spend much less time in the hospital—up to 20–40% less time for many complex procedures such as coronary bypass graft or total hip replacement. This accelerated care may increase the cost per day, but the overall cost to get the medical result for the individual patient may decrease. Therefore, the BLS price index should reflect the cost of the hospital stay, not the per diem. (2) Many patients are now treated ambulatory, rather than inpatient. These cost reductions are not reflected in the BLS index. For example, in one West Coast hospital, the cost of an anterior cruciate ligament reconstruction dropped 75% from $13,355 as inpatient to $3,507 as ambulatory patient. "Again, this measurement problem tends to lead officials to overestimate price changes in the industry, creating the appearance of a "crisis" where perhaps one does not exist."[18]

Furthermore, in any cost analysis, what are the costs to society of withheld definitive specialty care? How much cost do we save with a healthy population? How many dollars would we lose from sickness?

In cost analyses, note that much of health "cost" is jobs, that is, employment for nurses and secretaries, jobs for technicians in laboratories and in radiology, jobs in the drug industry, jobs in the implant industry, employment for therapists, and even jobs in the insurance industry. Recent articles in *The Wall Street Journal* and *The New York Times* document significant loss of jobs in the pharmaceutical industry in 1993.[19,20] Computer projections and independent economic analysts suggest job reductions in the health industry from 200,000 to as many as 1,000,000 over the next 5 years.[21]

If the housing industry or the farming industry flourished, would we try to ration housing construction? In fact, our government subsidizes housing and farming. Furthermore, Washington limits farm production in some areas to keep food prices up! If Washington is so concerned about the underprivileged, why do they inflate food costs?

If the Detroit auto industry led the world in innovation, research, and technology would the government be allowed to take it over and rachet it down, to force loss of jobs? To the contrary, our government under Carter's leadership loaned the Chrysler Corporation money.

Now let us put health care costs to the individual citizen in perspective. For example, in 1987 we spent $500 billion for health care, $107 billion of which was "out of pocket." That is a lot of money! Let us note other out of the pocket expenses that same year by our citizens: $20.5 billion for pets, toys, and playground equipment; $21.8 billion for tobacco; $27.2 billion for beer, wine, and whiskey; $34.7 billion for cosmetics, jewelry, and personal care items.[22] This total of $104.2 billion out of pocket for pets, toys, tobacco, alcohol, and cosmetics was almost the same as the $107 billion out of pocket for health care in 1987. In fact, our citizens spent $112.3 billion for entertainment in 1987; that alone was more than was spent for "out of pocket" health care![22]

In 1987, another $433 billion was spent "out of pocket" by citizens for automobiles, gas, and auto repairs—four times the health care "out of pocket."[22]

To see how these numbers have changed, let us look at similar 1991 data (Table 2).[23]

In the same interval, health care costs increased at a similar rate as that for tobacco and for entertainment. In fact, our citizens spent over $100 million last summer alone just to see the film "The Fugitive."[24]

Table 2. Out of Pocket Spending Comparison (in billions)

	1987	*1991*	
Alcohol	$27.2	$29.08	(7% increase)
Tobacco	$21.8	$27.02	(24% increase)
Cosmetics	$34.7	$39.07	(13% increase)
Entertainment	$112.3	$145.1	(29% increase)
Auto expenses	$433	$474.6	(10% increase)

John Glover stated in his Presidential address to the Western Surgical Association in 1991 "Whose crisis is this, anyway?—Does it really belong to the patient if the average household spends about the same for entertainment as for health care, and four times as much for transportation (as for health care)?"[25]

Now having asked how much "should" we spend on health care, let us consider an economic and moral issue. *Can* the government guarantee health care? This is an economic issue. *Should* the government guarantee health care? This is a moral issue. Is it more economically morally sound—and more in keeping with our Constitution—that we guarantee the right to pursue a job, the salary of which allows the worker to buy housing, food, clothing, *and health care* at a prudent cost? We subsidize housing to a point, but we do not guarantee everyone the same type of house. We have food stamps for the poor, but we do not regulate the food prices at stores where the food is purchased; we do not tell the grocer how to stock the shelves, nor do we ask food stores to provide all food to a neighborhood for a fixed price, and then have everyone in the neighborhood come in anytime day or night and take food off the shelf. Can you imagine how out of control the grocer's budget would become—unless the grocer rationed food to the customer. We do need to address the uninsured problem; for low income families, would "health stamps" to pay for insurance for these people be simpler and less expensive?

Dr. Alan Gregg, former Vice-President of the Rockefeller Foundation in a lecture at Columbia University, pointed out "The table of life that traditionally has rested on the tripod of food, clothing, and shelter can now rest more securely and reasonably on four legs: food, clothing, shelter, and medical care." Why has the government singled out medical care as the only one of the four legs to guarantee, be it by employer or government? The *Wall Street Journal* stated that President and Mrs. Clinton's "overriding goal is to create a new middle class entitlement that puts another 14% of the economy under the sway of government and thus of politicians."[26]

Will housing and food be next? We already have low income housing and food stamps—but these provide help to those who need it, not total payment by the government—and help only to those relatively few who need it! Can you imagine the tax burden to all citizens and cost to all employers if the government promises that our society will guarantee housing, food, clothing, and health care for all citizens?! Yet that is what Clinton is proposing as "security" for health care. Is this the first step on a very slippery downhill slope?

The successes of our great history are based on freedom, choice, opportunity to work—on challenges, not promises. Kennedy said in his acceptance speech in 1960 to the Democratic Convention, "The New Frontier of which I speak is not a set of promises—it is a set of challenges."[27]

Gerald Ford admonished us in 1960 "If government is big enough to give you everything you want, it is big enough to take away everything you have." Even Franklin Delano Roosevelt, the great social reformer and architect of his New Deal, stated in 1938 "The only sure bulwark of continuing liberty is a government strong enough to protect the interests of the people, and a people strong enough and well enough informed to maintain its sovereign control over its government."[28] Or as Ronald Reagan stated with more humor, "If you crawl into bed with the government, you should expect more than a good night's sleep."

Our Constitution and Bill of Rights guarantee and pledge to all citizens life, liberty, and pursuit of happiness. We can not guarantee comfort, housing, food, clothing and long healthy lives—all paid for by someone else. We must guarantee the right of each person to work hard to pursue these goals. And we must assure our citizens that for a dollar spent in health care, or housing, or food, they receive a dollar's worth of benefit!

Clinton in his address on health care to Congress held up the proposed new government laws and regulations creating a new federal health care bureaucracy as the way to eliminate waste, streamline paperwork, and simplify health care delivery.[1] The federal government has never been known for efficiency, and frugality, and simplicity! We have all marvelled at the "frugal" Pentagon with the $800 toilet seats. We have all noted the "efficiency" of the Postal Service as it fails to compete with Federal Express or UPS. We have all seen, and surely we are struck by, the immense complexity of the tax laws and the "compassion" of the IRS. (As John Kennedy so wryly commented, "Washington is a city of Southern efficiency and Northern charm."[29]) Do the people of this country really want or need a health care service with the frugality of The Pentagon, the efficacy of The Post Office, the regulatory simplicity of our tax laws and the compassion of the Internal Revenue Service?

Today both England and Sweden are backing away from socialism and starting to privatize. Major cities in our own country, such as Philadelphia, are acknowledging governmental failure and the inability to deliver cost-effective quality service even for

such simple things as trash collection and maintenance of park systems—and they are solving it by privatizing these services.[30] As David Rivkin points out, "No American, whatever his policy views on health care reform, should rejoice at the disappearance of the last fragments of the principle that the federal government is one of limited powers. It is indeed ironic and sad, that as the rest of the world is discovering the virtues of limiting their governments, the U.S. seems hellbent on unleashing its own."[31]

The Rochester, NY health care system, in the past year so often held up as a model for this country, was achieved by cooperation among the Medical Society, physicians, hospitals, industry, and insurance. Note that (1) it is based on cooperation, not competition and (2) no government was at the table. In fact, we had to convince the government to let us proceed! We had to ask for exemptions from government regulations. In Rochester we have community-based rating. Our uninsured rate is at 6%, less than half the national average. According to the data from Rochester Blue Cross/Blue Shield, our average health care cost for a family of four was $2,730 in 1992, compared to the national average of $3,968, and compared to the Clinton's proposal estimate of $4,600![32] Furthermore, with Rochester's regional planning we have 3.1 hospital beds per 1,000 people (vs. 4.9 U.S. average) and 107 hospital admissions per 1000 people (v.s. 140 U.S. average).[33]

Having now asked how much should we spend and can/should the government guarantee health care, let us ask what are the obligations of the individual citizens? We have already asked if it is reasonable for each person to pay for health care as much as for entertainment. What are the major factors driving up health care costs today? To a large measure they are individual citizen behavior and general societal ills.

Let me share an example of individual behavior. A few years ago I attended a dinner meeting of physician, industry, and insurance leaders. The head of the area's largest insurance carrier stood before the group criticizing the medical profession for poor cost awareness—what a paradox! For there he stood grossly overweight, florid of face, sweating, smoking throughout his talk, had had several martinis, and was soon to drive himself home with his elevated blood alcohol!

Two true stories illustrate the societal problem. The Dean of a well-known medical center from a large city confided to me that his medical center faced a financial crisis. Female drug addicts, forced to prostitution, become pregnant, deliver at his hospital, and then sign out against medical advice leaving the cocaine-addicted, underweight, premature babies behind with no one to take the baby home if it survives—at total cost in excess of $300,000 per infant. A study at the Curtis Hand Center has shown that 43% of patients with hand injuries tested positive for drugs or alcohol.[34]

What are the factors driving up health costs? Three are societal and unavoidable: (1) The aging population—Willard Gaylin points out "the child who would have died from polio or measles or pertussis will grow up to be a very expensive old man or woman."[35] (2) Adequate salaries for nurses and other hospital employed professionals and (3) Unionization of some hospital employees with upward pressure for salary and benefit increases. Other factors reflect a sick society with lack of individual responsibility: (4) Tobacco products (tobacco causes 400,000 deaths yearly). (5) Alcohol (The problems from alcohol cost Medicare more than heart disease.[36] Twenty-seven percent of all serious nonfatal motor vehicle accidents are alcohol related.) (6) Drugs. (7) Unconscionable pursuit of litigation by plaintiffs' attorneys with the costs of defensive medicine and liability insurance. It is estimated that serious tort reform would save 25% of the health care budget.[37] (8) Violence and (9) AIDS (at a time when government privacy laws forbid established public health measures of epidemiology, mandatory testing, and notification of contacts).

If we consider a "health budget," what is the rate of health care cost increase if these nonmedical factors are excluded? Probably less than the cost of inflation! These rapidly escalating costs to society should not be charged to the health care budget, but they are; they would be more appropriately charged against budgets of social programs. These costs can not be controlled by the health care provider. Do not blame the physician and hospitals for these problems, nor hold us responsible to fund them!

The public can greatly influence health costs—but it rests with each citizen to observe: wise diet; proper exercise; limited alcohol consumption; no use of tobacco; safe speed on the highways; no drugs; safe sex.

Another premise to be challenged is that an increase in primary care will save money. Is this a valid assumption? It may improve quality of care if everyone has a personal physician, but will it be less costly? If the goal is for every citizen to have a primary care physician, this may increase the health care budget, unless that primary physician functions as a stringent "gatekeeper"—rationing care!

As the Democratic Senator Kerrey said "for 50 years or more, the government has been intervening in the health care system, always saying we want

to make it easier for people to get the care they need. Every time, we have increased the demand for health care services and often we have restricted the supply of service givers and then we're shocked—shocked—when prices go up."[38]

This increase in primary care physicians will save money only if there is less care by specialists, that is, less definitive care for complex problems. This is called rationing. Are our citizens ready to withhold open heart surgery over the age of 60, withhold renal dialysis for those over 65, withhold any hand surgery for patients who are no longer in the work force?

If anyone of us needs an electronic tune-up or new transmission in one of today's complex cars, do we go to the corner gas station where we buy our gas and morning cup of coffee? No—we go to a specialist. Why? It is cheaper to do it right the first time!

Similarly in health care, rationing may increase overall society costs from unnecessary disability. We must note the half life of medical science is estimated at only 7 ½ years. The generalist can be likened to the cobbler at his bench trying to keep up with the industrial revolution. If the primary care physician misses a median nerve laceration, the secondary repair will not do as well as a primary repair and the lack of sensory return may preclude a return to employment. What are the job implications for that citizen? What are the disability costs over a lifetime? Probably far more than "health savings"! What about a missed diagnosis of macular degeneration, resulting in unnecessary blindness, a missed thoracic aneurysm resulting in death? What secondary expense from poor results (and what a bonanza for liability attorneys)!

And now having considered some major cost factors for health research and health care, let us turn to medical education. A marked increase is proposed for the role of the generalist. What are the educational implications and costs of this? Society longs for the myth of the "old family doctor"—a glorified deification, "the bearded doctor keeping a bedside vigil, the laying on of gentle hands, the waiting horse in the snow" (Guzzardi 1961). The Art was long, the Science short. But in those good old days less was expected of medicine. The family grieving over a loved one's death would implore "Why did God take our child away?" Today, they charge "What did the doctor do wrong?"

Today, people want a return to more Art—but does that mean we are to sit idly by and watch science and technology taken away from our patients? Our patients deserve both the Art and the Science.

Today's primary care doctor cannot possibly keep up to date with medical knowledge. Guzzardi (1961) likens this to "a lonely violinist trying to play Beethoven's Fifth all by himself." No matter how talented and dedicated the violinist—or the practitioner—it *cannot* be done—unless we make major increases in the education of the primary physician, both initially and annually.

If we accept that we need more primary care physicians, so that every citizen has a personal physician, and if this physician is to be a "gatekeeper" for all medical and surgical diagnoses and treatments, what is to be the medical education for the generalist to play Beethoven's Fifth as solo violin?

What are the implications for the medical school curriculum? For residency training? For Continuing Medical Education? How are these true generalist physicians to be educated and then kept up-to-date? Is this possible? If not, then necessary care will be withheld from patients, and poor care given by well-intentioned primary care doctors who attempt to do more than that for which they are qualified.

We as specialists have a real educational challenge. (1) All specialist clinicians must gain access to the medical school curriculum for large blocks of time. The medical students must learn much more Surgery, Orthopaedics, Hand, Urology, Obstetrics and Gynecology, Plastic Surgery, Ophthalmology, Otolaryngology, etc. For example, one of every three patient visits to a physician's office is for a musculoskeletal complaint (including hand). Yet in no medical school curriculum is adequate time devoted to proper examination of the hand, of the shoulder, of the hip/knee—let alone treatment algorithms! Are we prepared to have medical school 5 or 6 years for generalists? If so, who will pay for this? (2) Why do physicians who are to know the most (something about everything) have the shortest residencies? The primary care residencies will certainly need to be increased in length to 5 or 6 years. The Residency Review Committee (RRC), Accreditation Council for Graduate Medical Education (ACGME), and American Board of Medical Specialties (ABMS) must get involved and not yield these decisions to the government. Part of Clinton's plan is to take decisions on residency training away from the ACGME, ABMS, and RRC and place it in Washington via a government health panel without physician membership. (3) After residency, how can meaningful continuing medical education programs be in continuing medical education place for the true generalists to keep up-to-date in all areas?

What are the cost implications? (1) Can we increase by another 25% the debt of each medical school generalist graduate from a 5th year of medical school? (2) Who will pay for the lengthened residency for the generalists? (3) Who will bear the cost

of prolonged yearly continuing medical education requirements for generalists?

Physician assistants and nurse clinicians cost less. Should they fulfill a very simple level of primary care triage function with all definitive care by specialists? Would it be more cost-effective and better quality to eliminate the generalist physician?

My goal is to stimulate your thoughts, to force some painful choices. What must be our visions? Henry Miller (1891–1980) said "The tragedy of Greece lies not in the destruction of a great culture, but in the abortion of a great vision."

By vision, of what do I speak? I do not speak of fuzzy reverie, nor daydreams of "what if" and "the good old days." I do not speak of "leave us alone, we are OK." Rather, I speak of powerful insight, imagination and new thoughts based on hard analysis.

Abraham Lincoln stated in 1838, "Towering genius distains a beaten path. It seeks regions hitherto unexplored."[39] Twenty years later, Lincoln again challenged "Let us have faith that right makes might, and in that faith let us to the end dare to do our duty as we understand it."[40] Churchill spoke in 1943 at Harvard "The empires of future are the empires of the mind,"[41] or as John Kennedy said 20 years later, "In a time of turbulence and change, it is more true than ever that knowledge is power."[42] We as physicians must have faith in our profession and in our visions. We have that knowledge of what is best for our patients. We must make that our power—we must seize it to improve our health care system—for the good of our patients.

Willard Gaylin says "It is a lot easier and safer for politicians and policy makers to talk about delivery systems, health product procurement procedures, and third-party payments than about what care to give a desperately ill child or whether a kidney patient over the age of 50 should be eligible for a transplant."[35]

The principles and details of good patient care are too important to be defined by the government in a vacuum without our input. Thomas Jefferson, reportedly one of Clinton's heros, commented on the United States Congress "That one hundred and fifty lawyers should do business together ought not to be expected."[43]

We all agree that definite improvements are needed in our health care system. The solutions to an improved system must come from those involved—physicians, hospitals, nursing homes, and patients. These are the stakeholders. Empower them, not the politicians and government. In 1775 Edmond Burke in a speech before Parliament exclaimed "It is not what a lawyer tells me I may do; but what humanity, reason, and justice tell me I ought to do."[44]

We must act as individuals via American Society for Surgery of the Hand, via American Society of Plastic and Reconstructive Surgery, via American Academy of Orthopaedic Surgeons, via American College of Surgeons, via American Medical Association, via county medical societies, via state medical societies, and via our patients and education of our patients—especially those influential in government, in business, and in the AARP. We must act as individuals and contact our legislators—force them to ask the correct questions! All physicians and our patients must get involved in multiple areas—our knowledge is power and can have an impact. How must we get involved? We must give freely of our time and energies. Do not wait to be asked; step forward, volunteer, take initiative.

We must recognize we are talking about rationing health care and be certain our patients recognize that is what the government is proposing. We must look hard at the Rochester, NY model and the Oregon system as ways to ration care appropriately, adding the concept of an integrated delivery system. What must we do? Use the "rationing" word. We must force the people, the citizens—and yes the government—to step up to the plate and use the words "ration health care." Not as the politicians would ration—but as we understand would be best from our professional experience and wisdom for our patients—and the public must accept rationing and be involved in deciding what is to be covered.

Gaylin, a Professor at Columbia College of Physicians and Surgeons succinctly states "What medical services can our society afford to provide to everyone? Here lies the political minefield that the Clinton Administration has apparently decided not to cross. . . . The Clinton plan will offer a very generous package of "basic" health care benefits made available to everyone. . . . the Clinton task force has indulged in the wishful thinking that we can have it all—as long as we get the flow charts and system theory right . . . The Clinton Plan (does) little to disturb the self-deceptive and self-destructive belief that we can meet every health need: (all primary care and) artificial organs, genetic screening, transplants, AIDS drugs . . . surgery for tennis elbow . . . intensive care for the elderly as well as for the two pound fetus . . . But we cannot do everything for everybody."[35] He continues, ". . . if we must have allocation, the process should not be hidden from public view . . . It requires open discussion and wide participation. When what we are rationing is life itself, the decisions must be subject to public scrutiny and debate. The first step is to admit the

cruel necessity of rationing health care. The second is to set limits on health care according to principles of equity and justice."[35]

For example, can we justify hospitalization for the terminally ill AIDS patient—or are they better cared for at home or in a hospice? In how many hospitals do we now see elderly demented patients with a history of myocardial infarction, arrhythmias, and congestive heart failure admitted to an Intensive Care Unit?—and then labeled "Do Not Resuscitate"! They should be cared for and made comfortable at home or in a hospice. What about the cost of the care for the Siamese twins recently separated in Philadelphia?

This health care system must be autonomous at the city or regional county level and not micromanaged by the State or Federal level. The current Rochester System is an excellent example—a system developed locally, by the key stakeholders—physicians, hospitals, patients, industry, and local insurance companies without the government—and I might add, with community-based rating, very low rates of uninsured, and a cost per family ($2,730) only two thirds the cost of that proposed by Clinton at ($4,600).[32]

We need to look at the proposed Rochester System and look at an Integrated Delivery System with a complex of primary care generalists, specialists and subspecialists, physician assistants, R.N. clinicians, hospitals, ambulatory facilities, home care nurses, nursing homes, and hospices—with patients in this system cared for in the most efficient quality manner. This is managed cooperation, not managed competition!

We must look carefully at the systems being proposed by John Kitzhaber, MD, the Health Commissioner of Oregon. In an eloquent address in June 1993, he focused on the tough but key question What should be covered? How shall we allocate our resources? As Kitzhaber described Washington's current posture, "The administration is crying about the cost of a dinner party, but has never decided on a guest list or a menu."[45,46] The Clinton Plan proposes coverage for prescriptions, eye glasses, routine physicals, etc. This is extraordinarily expensive to the third-party payers because of the frequency of these services. Perhaps the public would pay for eye glasses and have funds for the definitive care of the very expensive complex problems or long-term care! The Rand Corporation data suggest that a yearly $1,000 co-pay by a family of four would reduce health care costs by 30%.[37] For no matter what we do, serious illness does occur (and these real expenses are what patients want covered) and death does approach.

Even one of Clinton's own pillars of the Democratic party, Patrick Moynihan, calls Clinton's numbers "fantasy." As Thomas Huxley said, "Facts do not cease to exist just because we choose to ignore them."

Kitzhaber emphasizes the process is key to determine what is to be covered. He advises do not "develop" a plan and then try to "sell" it—rather the process must be based on a consensus of all stakeholders at the local or regional level—physicians, patients, and the community.[45,46]

As to what is covered, Kitzhaber suggests, at the community or state level, the patients and physicians need to confront hard choices, face up to health resource allocation, and be empowered to (a) develop a priority list and (b) determine the dollars available by a budget. The amount of dollars available will set the cut point on the priority list. If the stakeholders, that is, the patients, physicians, and hospitals, believe the cut point should be more inclusive, then more funds are voted by the patients and the care givers in that region who are involved. These processes bypass the politician and the insurance industry. If care is to be rationed, the patients and the physicians in the region or community, that is, the people involved, not politicians at a distance, decide what is to be covered.[45]

During the next weeks and months—perhaps even the next year and a half—there will be many discussions and debates. These will occur not only in Washington, but in each of our states, in each of our cities, in our local medical societies, on the radio and television, in the newspapers, on talk shows—and with our patients and our neighbors at home. Get involved.

Do not be self-serving and argue about fees. Changes in health care are needed. We each must force the real issues into the open in these debates with facts and with the right questions.

- What is best for our patients? We must preserve the right of each patient to select a personal physician and the physician's right to select the best treatment for that patient. As Benjamin Franklin stated in 1759, "They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety."[47]
- Is the health care industry a growth industry with the product a healthier population? If so, should it be punished or encouraged?
- How much should this country spend on health care? Is what we spend out of line with what is spent on entertainment, tobacco, and alcohol? If people spend as much on entertainment as on health care, is health care too expensive, or

a bargain? Will each patient/family accept some individual financial obligation?

The health care professionals cannot be held responsible to finance society's evils out of a health care budget. Should the costs of sickness from the society disruptions of drug abuse, AIDS, crack babies, violence, alcohol, and tobacco be charged to budgets other than health care?

If we subtract from the 14% of GNP health "budget" those dollars saved from tort reform (25% of health budget),[37] the 30% savings from a $1000 deductible,[37] and then subtract all the nonmedical costs such as those resulting from violence, AIDS, drugs, tobacco, speed, our health care costs would be comfortably under 7% of GNP. Therefore, is the true health budget in this country less than Canada's/Germany's and growing slower than inflation?

To provide all treatments to all patients is too expensive for our country, regardless of payment system. How can we force Washington to use the word "rationing"? How can we help patients to understand rationing?

Can—should—the government guarantee health care? Or rather, should we guarantee the right to pursue jobs that then allow the purchase of health care insurance, just as we have the right to purchase housing, clothing, and food? Can we guarantee health to our citizens? No. Must we guarantee the *right* to pursue good health? Absolutely.

Admit that our health system can be improved. We need to have community-rating for insurance. We must improve efficiency. We must avoid overuse, underuse, misuse. We must have insurance coverage for the uninsured. Changes are needed, but does that justify totally changing a system providing the best care in the world for 200 million people, or should we build on and improve that which is good and then extend it to the remaining uninsured 10–15%?

Will the individual citizen accept his/her individual obligation to change habits and lifestyle?

How can we have tort reform to eliminate costs of defensive medicine?

How much can society save by investing in good medical research and good health care?

If we increase the role of primary care, how will the major necessary educational changes be funded?

Which penalizes our industry more in national and international sales competition—the costs of health care or legal regulation and product liability?

Health care must be efficient and cost effective. The tax law, the Pentagon, and the IRS represent the opposite of simplicity, savings, and quality in health care. Therefore, to be consistent, to achieve our goals, should there be increased or decreased government involvement? Major local and regional changes are already underway in Hawaii, Oregon, Washington, Vermont, Michigan, and Minnesota. Is federal law necessary now, or should Washington just monitor what is already happening? What do we learn from Rochester and from Oregon about the value of regional control? How can we foster the Integrated Delivery System concept to empower the true stakeholders, the patients and physicians, to make these decisions locally and regionally, without politician interference?

In closing, I leave you the words of two philosophers. First from Piglet, the friend of Winnie the Pooh.[48] As Piglet challenges us:

Let us find a way
Today
That can take us to tomorrow
Follow that way,
A way like flowing water

Let us leave
Behind
The things that do not matter,
And turn
Our lives
To a more important chapter.

The sun is high,
The road is wide,
And it starts where we are standing
No one knows
How far it goes,
For the road is never ending

It goes away,
Beyond what we have thought of;
It flows away,
Away like flowing water.

Or, more succinctly, through 2300 years rings the challenge from Hippocrates:

Life is short;
and the art long;
The occasion fleeting;
Experience deceptive;
and judgment difficult.

Let us help to make the coming changes in health care changes for the better. Seize this power of our knowledge, see the opportunities of this fleeting moment in our country's history, exercise difficult judgments, and make an impact. Our patients deserve our efforts.

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