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DELIVERING HEALTH CARE IN A FINANCIALLY BROKEN SYSTEM

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Won over by the forces of individual freedom, deregulation, and globalization, economic agents today increasingly avow a way of thinking that measures economic performance in financial terms alone, especially short-term profits and return on investment, often to the exclusion of other considerations such as employment security, environmental protection, workplace safety, corporate governance, truth in lending, and living wages, not to mention the much broader considerations of world poverty, hunger, and disease.

Quite apart from the effects that it is having on the structure of the global economy, the new financial way of thinking is also changing the rules and the codes of ethics according to which ordinary companies conduct their affairs on a day-to-day basis. This development has become deeply embedded in mainstream economics today largely due to long years of unstinting advocacy by Nobel laureate Milton Friedman who is widely known and respected for his libertarian views and who adamantly insisted that the company's one and only objective is to produce a profit for its owners/shareholders.

The enshrinement of short-term gain as all-important, which we refer to as financialization, increasingly is evident even in the U.S. health care system. This development takes the form of chains of proprietary hospitals acquiring publicly owned but financially strapped hospitals which they must turn around in order to keep faith with their shareholders, ordinary employers struggling with ever-higher health care costs and private insurance companies holding down health insurance premiums by denying claims or cutting reimbursement to health care providers.[1] In a practice known as "cherrypicking" free-standing surgical centers admit paying patients and turn away nonpaying patients who have no option other than the emergency rooms of full-service hospitals.

Included in the financialization of the health care system is the "no new taxes" mentality of state and federal legislators responsible for oversight of the Medicare and Medicaid programs which deal with ever-increasing health care costs by the same means employed by private insurers – cut reimbursement to providers or worse yet deny claims for reimbursement. Financialization leads at times to physicians refusing to accept Medicare and Medicaid patients, especially when the reimbursement does not cover the physician's out-of-pocket expenses.

The financialization of health care at times draws in others not directly involved in the health care system. To illustrate, recently in Louisiana a publicly owned hospital with revenues

[1] Hospitals in turn shift to their paying patients the cost of providing services to nonpaying patients and patients for whom reimbursement is insufficient to cover their costs.

insufficient to cover its expenses was purchased by a proprietary chain for more than $80 million. After covering its indebtedness, about $50 million was left for assignment to a newly-established local health care foundation to support projects that would provide health care that otherwise would not be available to the public. Driven by financialization, the local parish (county) government insisted and got a $5 million share of the $50 million threatening to bring legal proceedings to block the sale unless its demands were met. Those monies will be used by local officials for whatever services they so choose.

What is not so readily visible are the other aspects of the financialization of health care that are having devastating effects on access to care and its quality. One way is a reversal of the time-honored practice of subspecialists taking call for unassigned patients admitted to the emergency room in need of a subspecialist such as an orthopedic surgeon to set a broken bone or a neurosurgeon to manage severe head trauma. This reversal has been carried out by subspecialists joining a surgical center, or even forming one of their own, that effectively sidesteps those patients by simply not offering emergency care. The justification for this reversal is evident in the following question: 'Why should I (a subspecialist) leave my office with 40 paying patients in the waiting room, all of whom have to be rescheduled, in order to look after a nonpaying patient who has been admitted to an emergency room whom I do not know and who does not know me?'

It is a matter of public record, for example, that a patient in Louisiana was transported by ambulance more than 150 miles from one city to another for a broken thumb because the orthopedic surgeons in the sending city simply refuse to see patients in the emergency room. More recently, two children were transported 100 miles from Monroe to Shreveport because Monroe surgeons would not accept the children as their patients. Both needed an appendectomy in the middle of the night. This reversal even involves patients already admitted to a hospital, at times in critical or intensive care units, and under the care of a hospitalist who needs a subspecialist consult such as a neurologist but cannot find one available locally or willing to take the time for a consultation, especially in the middle of the night. The hospitalist is forced to transfer that patient to another hospital where the subspecialists are either on staff or willing to consult even knowing beforehand that they may never be paid for that consultation.

Financialization forces primary-care physicians to close their office-based practices because a combination of nonpaying patients and inadequate third-party reimbursement has made it increasingly difficult to cover even their fixed costs. In some cases, self-employed office-based physicians are not even able to pay themselves a salary; they survive precariously on the care they render to patients they admit to hospital. Knowing full well how important primary-care physicians are to admissions, hospitals are employing them directly to assure a stream of inpatients to protect their bottom line, even though caring for patients in a hospital is more expensive than treating them in an office or clinic.

Financialization is turning the practice of dermatology into cosmetology. The plain fact is that treating facial wrinkles, removing body hair, eradicating tattoos, directly selling various creams and gels pay more than treating facial cancers, psoriasis, and eczema simply because patients are willing to pay out of pocket to improve their appearance. This trade is so lucrative that physicians trained in areas other than dermatology, and even those with no medical school training at all including those who are referred to as medical aestheticians (licensed skincare specialists), are opening clinics to provide what today is being called aesthetic dermatology.

Financialization even extends to the time-honored practice of professional courtesy where one physician looks after a professional colleague without charging the usual fee. Today the physician very well might ask 'Why should I provide office-based treatment for a colleague that costs me $51 out-of-pocket and at the same time forego the usual $50 office fee?' Financialization clearly denounces professional courtesy.

Financialization is forcing formerly full-service hospitals to quietly close units such as pediatric intensive care units and drive off highly-skilled specialists such as pediatric neurosurgeons because they are a financial drain on hospital resources and at the same time to ballyhoo other units such as cardiac care units because they turn a profit. Another less-well-known practice that is rationalized by financialization and is known as "dumping" is the stabilizing and transferring to other hospitals of patients who show up in the emergency room and are in need of inpatient care but are not able to pay for that care.

There is an instructive parallel as to what is happening today in health care in what began happening 30-40 years ago in Catholic elementary and secondary education. For decades American Catholics, including poor immigrant families, had access to quality educational instruction because Catholic schools were staffed overwhelmingly by nuns, priests, and brothers who with little regard for their own financial well-being dedicated their lives to educating children. The vocational crisis in the American Catholic church has seen the closing of countless Catholic schools during this period, narrowing access to a Catholic education to all but those who are able to pay the substantial tuition necessary to hire teaching staff from among the laity. What in the past was given in Christian charity has been replaced to a large extent by the first principle of exchange in routine marketplace and workplace transactions: *for both parties what is gotten must be more highly valued than what is given up.* In other words, both parties must experience economic gain. Otherwise exchange collapses.

In health care today, financialization means that what is gotten by the provider must be more highly valued than what is given up. Thus the practice of professional courtesy makes no sense to the provider because nothing tangible is gotten in exchange for the service rendered (given up). Similarly, for the physician who refuses Medicare or Medicaid patients where the service rendered is not fully reimbursed (what is gotten in exchange is less than what is given up). Financialization explains why subspecialists refuse to accept unassigned patients who present in the hospital emergency room and refuse to consult with professional colleagues. Financialization is driving up the cost of health care and narrowing access to care because increasingly the services rendered have to pass the exchange test: what is gotten must be more highly valued than what is given up. It appears quite likely that financialization has become an integral part of U.S. health care and quite unlikely that the system will revert to the old ways of selectively providing care without expecting payment in return.

Financialization -- the putting of short-term gain ahead of all else – little by little is destroying health care in the United States because too many Americans are unable or unwilling to pay for what is arguably the most advanced health care in the world because they regard that care as an entitlement. Thus financialization is turning the exchange principle – what is gotten must be

more highly valued than what is given up – on its head: what is gotten by the patient is taken with little or nothing given up.[2] The U.S. health care system is financially broken.

Two reports, one by the National Resident Matching Program and one by the World Health Organization, are indicative of the brokenness of the U.S. system. The NRMP which matches medical students to residency positions reported that only 42 percent of the available family residency positions in 2007 were filled by U.S. medical school seniors. The rest were filled by international medical graduates, osteopaths, and other types of applicants. In internal medicine, U.S. graduates filled 56 percent of the available residency positions. In obstetrics/gynecology the fill rate for U.S. graduates was 73 percent; pediatrics had roughly the same fill rate. Between 1997 and 2005 the number of residency positions in pediatrics dropped from 464 to 376. Even so, nearly nine percent of the pediatric residency positions in 2005 remained entirely unfilled. While interest in these primary care specialties is falling, the so-called "lifestyle" residency programs – dermatology and anesthesiology – are filling more than 90 percent of the available positions with U.S. graduates.

In what some regard as a misleading report, the WHO stated in 2000 that the United States ranked 1st among 191 nations in terms of health care expenditures per capita, 37th in terms of health care performance, and 54-55th in terms of how the financial burden of the system is shared.

Further evidence of the brokenness of the system is found in a 2005 report on personal bankruptcy and health care in which the investigators examined a cohort of households filing for bankruptcy in five federal judicial districts and estimated that roughly 50 percent experienced medical bankruptcy even though about 75 percent had health insurance coverage at the onset of their health-care problems.

The broken U.S. health care system is like an old car that at one time was a top-of-the-line muscle car but due to neglect has been reduced to a beat-up wreck that limps along belching blue smoke from its tailpipe. If the owner is a person of means, the remedy is simple enough. If not, the solution is to pour more oil into the engine in the hope that somehow it will continue running. In time, however, the engine will die and the car will stop running. Similarly, we can continue to pour more money into health care without improving performance as the WHO report suggests and even adopt universal health insurance coverage without making health care affordable as the bankruptcy study indicates. Driven by financialization, the system will limp along until it collapses and then it will become clear to all that the problem is systemic.

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[2] We do not include in financialization other practices all of which are fundamentally unjust if not at the same time illegal: the fraud perpetrated by patients and providers who file false claims, patients who file legitimate claims and are paid by their insurance company directly but do not pay their providers, and providers who defraud one another in a complex system of accounting that allows a physician in practice together with others who provide services to the same patient to post the entire insurance payment for that patient to his/her personal account denying the other consulting physicians their due. Also not included is a scheme by which a physician in practice with others draws a salary beyond what he/she actually earns by direct patient care but does not reimburse his/her associates.

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