Estimate of the Situation

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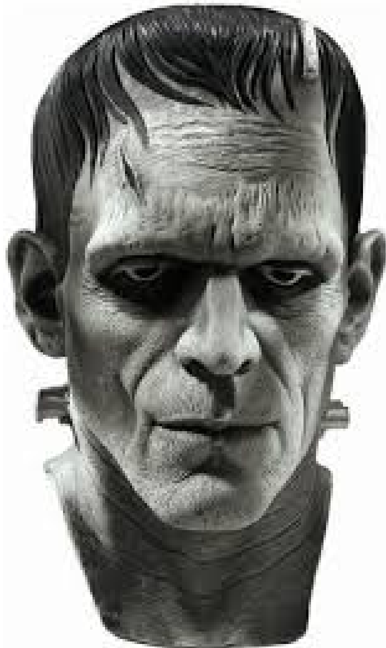

Frankencare: The Silent Death of Human-Sized Medicine

Previously these pages have described the negative financial impacts of the Third Party Payer System, including *The Patient Protection and Affordable Care Act* or *PPACA* (aka "Obamacare"), on people, small rural communities, the profession of medicine, hospitals, state governments, and the national economy. Although the economic effects of the Third Party Payment System have been destructive for decades, the addition of the PPACA to the system creates serious new moral and ethical issues. These issues have received virtually no attention because the law's terrible complexity masks their impact, effectively hiding them from public view.

Two competing cultures with irreconcilable and opposing values have emerged in the United States. The traditional American culture focuses on the value of every individual human being. The progressive culture concerns itself with the collective. The PPACA is blatantly redefining the role of medicine, surreptitiously imposing the progressive culture's values on physicians, hospitals, and ultimately the entire population.

Subsidizing the bottom line of Third Party Payers has always been the goal of the Big Insurance, Big Data, and Big Government consortium that spawned the PPACA. If allowed to stand, its creators (government and gigantic privately-owned insurance and software corporations) will reap great financial benefits but at tremendous costs to millions of real people and to the traditional political and social culture.

To understand what is happening, it is important to know the main players and understand their motivations. The main players include the federal government (including both political parties) and giant corporations, especially the largest health insurance and software companies. Consider what is at stake for each.

> Software Companies: According to a 2012 *Forbes Magazine* article, Duke University Health System and Boston-based Partners Health Care paid Epic $700 million each for Epic's EHR software product. Other sources put the cost to Duke at $750 million. *Healthcare Informatics* reports that Epic is currently vying with IBM for a Department of Defense HealthCare Management Systems Modernization contract worth $11 billion.
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> Health Insurance Companies: It is difficult to obtain information about how much private health insurance companies have profited as a result of their participation in the PPACA. As reported in another Forbes article, "The five largest health insurance companies – WellPoint, United Health, Aetna, Humana, and Cigna – … earned over $3.3 billion in profits [between April and June 2011]." Not bad for three months work.

Government: Although it was claimed that the PPACA was enacted to give millions of Americans access to health care, in reality leaders in both the Democrat and Republican political parties saw the Act as a way to extend the life of the technically bankrupt but very popular Medicare program. To appease its base, the Republican leadership never misses an opportunity to point out that "Obamacare" was passed with no Republican votes and that Republicans have introduced legislation to overturn it more than 50 times. True enough, but very misleading. The PPACA was enacted in 2010. The Republican Party regained control of the House in 2011. The Constitution requires that all money appropriations bills originate in the House. *If the Republican House leadership really wanted to end "Obamacare", they could have stopped it cold at anytime from 2011 on through the appropriations process, regardless of what the President or the Senate might want to do. All they need do is stop funding it.*

The very largest health systems and Fortune 500 corporate employers also have an important, if lesser, stake in preserving the PPAC although their enthusiasm is beginning to wane somewhat as circumstances develop.

Consider carefully the full implications of the PPACA’s implementation steps currently underway.

- **Population Health Management:** According to PPACA’s advocates, Population Health Management is the key to accountable care and healthcare reform. Population Health Management massively expands the health system's reach into virtually every aspect of daily life. Out-of-office (in the home) contacts initiated by “High Performance Care Teams” will be the norm. Population Health Management Teams will monitor and track everything affecting the health of the population with a focus on health behavior and lifestyle changes.

The idea of population health management is totalitarian in every sense. The population is an abstraction. It doesn’t have “health”. To imagine that physicians and hospitals should somehow be held accountable for a population's health and the behaviors that affect it is as absurd as it is arrogant. The notion that the Third Party Payer System, by deputizing health care professionals, should attempt to control the private behavior of people in their homes is positively Orwellian. If this aspect of the ACA's assumed span of control doesn't alarm you, it should.

- **Accountable Care Organizations (ACOs):** An ACO is officially defined as a set of health care providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.

The first question that should be asked is, “accountable to whom?” The answer is, “to the system”. The key words here are “collectively” and “population”. The very name “Accountable Care Organization” is a semantic hand grenade, subtly (and falsely) intended to convince the public that private practice physicians and hospitals won’t accept “accountability for the cost and quality of care” unless supervised. ACOs, along with Medical Homes, are envisioned as playing a pivotal role in population health management. It could not be more clear. *Physician and hospital subsidies to the bottom lines of government programs and insurance companies will continue to increase in size because the PPACA is designed to increase them.*

- **Value-based Medicine and Evidence-based Medicine:** According to the National Institutes of Health's official definitions:

> "Value-based medicine is the practice of medicine emphasizing the value received from an intervention. Value is measured by objectively quantifying: 1) the improvement in quality of life and/or 2) the improvement in length of life conferred by an intervention.
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> "Evidence-based medicine often measures the improvement gained in length of life, but generally ignores the importance of quality of life improvement or loss. Value-based medicine incorporates the best features of evidence-based medicine and takes evidence-based data to a higher level by incorporating the quality of life perceptions of patients with a disease in concerning the value of an intervention. Inherent in value-based medicine are the costs associated with an intervention.
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> "The resources expended for the value gained in value-based medicine is measured with cost-utility analysis in terms of the US dollars/QALY (money spent per quality-adjusted life-year gained). One way of addressing this variation – and giving patients the care they want and need – is to move to a reimbursement system that is value-based. We speak of it as "the value equation": Quality over Cost over Time."

These ideas are so problematic that it's hard to know where to begin. The idea that the value of a human life can be measured in dollars is in and of itself ethically and morally corrupt and dehumanizing. Further, when "evidence-based medicine" dictates treatment options, the physician is treating a diagnosis code-related statistic, not the patient. The physician is transformed from a professional who exercises judgment to a clerk whose compensation depends upon the extent to which bureaucratic dictates are followed.

The concepts upon which both "Value-based Medicine" and "Evidence-based Medicine" are based are fraudulent. Both schemes rest upon the technically-incompetent assumption that the relationship between interventions and outcomes is known and can be measured for all disease entities across all demographic groups. It isn't and it can't.

Human beings differ from one another in thousands of ways, physiologically and psychologically. Thousands of highly-variable factors affect outcomes, some known and some unknown, and those factors affect different disease entities and different human beings in different ways. To imagine that the Third Party Payer System is capable of using a non-existent understanding of the relationship between intervention and outcome to restrict a physician's choice of treatment to an individual patient is both absurd and dangerous, regardless of how many terabytes of computing power the system has at its disposal.

- **Value-based Payments:** Value-based payment incentivizes providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize as compared to what purportedly would have been spent under the fee-for-service system.

If one believes that physicians and hospitals order unnecessary treatments under the traditional fee-for-service system to line their pockets why wouldn't the same physicians and hospitals withhold necessary treatments under the value-based payment system to line their pockets? The value-based payment system actually incentivizes physicians and hospitals to withhold care to those patients most at risk of adverse outcomes (the very ill, the infirm, and the aged).

Physicians and hospitals should understand that the primary goal of the PPACA is to reduce costs to Third Party Payer System. To participate is to enter a rigged game in which the House changes the rules whenever it wishes. Every physician practice and hospital that closes its doors moves the System toward that goal by reducing the number of spigots through which its bottom line flows.

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