

Obama & Health Care

Sunday, February 15, 2009



Democrats, Health Care “Reform,” And Your “Duty To Die”

by Austin Hill, Townhall.com

Welcome to the Era of Obama. You now have a duty to die.

I’m not saying that someday you will die (that’s a given).

And I’m not saying that you should be given the “right to die” - - the freedom to take your own life, or to direct your Doctor to put you out of your misery - - that’s something entirely different.

I’m saying that someday, if current trends continue, your United States Government will determine that you have a “duty,” an obligation, to die.

It’s bad enough that hundreds of congressional members voted to spend nearly one trillion of our dollars, without even reading the so-called “economic stimulus bill” and without knowing fully what our money is being spent on. It’s even more horrific to know that more of our tax dollars are being allocated to the Office Of Health Information and Technology, a division of the Department of Health and Human Services, and that the bill also provides for the beginnings of a nationwide “health records database” that will track the healthcare of every person in the country.

As recently as last Monday, President Obama was praising the nationalization of health records, and the “conversion” of health records to electronic formats, noting that managing electronic data is less costly than managing hardcopy documents. But unfortunately, the creation of a nationalized health records database also creates another means of “cost cutting” - - namely, the denial of medical treatments to severely ill and elderly patients.

Language in the health care sections of the “stimulus bill” stipulates that the Department of H.H.S. will provide “appropriate information to help guide medical decisions at the time and place of care,” and also allows for “penalties” to be assessed to physicians who “spend too much” on individual patients. Essentially, we now have the beginnings of a governmental agency that eventually will, by force of law, determine which persons will be eligible for health care, and what treatment they will receive.

As noted in a recent Bloomberg news article, the way in which the Office Of Health Information and Technology is being expanded emulates the plans put forth in “Critical: What We Can Do About The Health Care Crisis,” a book authored by former Senator (and would-be HHS Secretary) Tom Daschle. In the book, Daschle praises the Western European nations for, among other things, the ways in which they have “nationalized” health care, and have ‘contained’ health care costs.

Yet, not surprisingly, Western Europe’s utopian ambitions to “insure everybody” and make healthcare “free” have by no means been realized. In fact, the nationalizing of healthcare in Europe has led to worsening government deficits, and increased healthcare costs, and efforts to contain those costs have resulted in the denial of treatment to those persons not expected to live much longer - - that is, the elderly and the seriously ill.

This “need” to deny people health care has frequently, in Europe, been cast in terms of one’s “duty to

die.” The idea is that, once you have lived “long enough,” after you have consumed your “fair share” of the earth’s resources; and when your combined age and health conditions make it “obvious” that further efforts to prolong your life just simply “aren’t worth it;” you will then have a responsibility to accept these consequences, and to accept that you’ll just have to get along without life-sustaining healthcare.

In other words, once a government employee has determined that spending healthcare resources on you will not produce much of a “return on the investment,” you will then have a “duty to die.”

Forget the notion that the Doctor-patient relationship is “sacred,” or that you will make “private” decisions about your health care, in consultation with your Doctor. If Democrats continue the trend of “Europeanizing” our American health care, the office of the National Coordinator of Health Information Technology will eventually be overseeing your healthcare, making sure that if your Doctor spends “too much” on you, they will face federal “penalties,” the likes of which have yet to be fully defined.

For over three decades, the Democratic Party has insisted that it is wrong for government to “interfere” with a woman’s medical decisions with respect to the child in the womb. Now, President Obama and congressional Democrats are insisting that government must be involved in everybody’s medical decisions. Worse yet, their proposals threaten human life on yet another front: not only are unborn children threatened by their policies, but so, also, are the ill and the elderly.

If Americans continue voting for “more government” as a means to “cure” all our societal ills, we will continue to move closer to the point where anonymous government bureaucrats determine when you have lived “long enough,” when you have consumed your “fair share” of resources, and when it is “obvious” that you won’t live much longer.

President Obama and the Democratic Congress are determined to take us to this point.

Tuesday, February 17, 2009



Obama Gives What the Doctor Did Not Order

by Phyllis Schlafly, TownHall.com

Barack Obama forced a bitter pill down the throats of Americans that the doctor did not order and patients do not want. Obama snuck into the stimulus bill a new system for rationing medical care, and he got Congress to ram it through the House and Senate without reading it.

Maybe Obama, Harry Reid and Nancy Pelosi thought no one would notice what they slipped into H.R.1 since rationing medical care has nothing to do with stimulating the economy. But former New York lieutenant governor Betsy McCaughey sounded the alarm in her Bloomberg.com article aptly entitled “Ruin Your Health With the Obama Stimulus Plan.”

She described how stealth provisions provide massive new funding of billions of dollars to an Office of the National Coordinator of Health Information Technology to monitor treatments and decide which are cost-effective and which will be permitted or denied. Currently, patients make that decision without government interference as long as the care is safe and effective.

Congress thus legislated a fundamental shift away from the “safe and effective” standard and replaced it with what a bureaucrat thinks is cost-effective or has “clinical effectiveness.” Americans are waking up from their political anesthesia to realize that Obama’s “change” really means government control over access to medical treatments for our illnesses.

Liberals love to control and ration as much as they love to tax and spend. Al Gore has spent nearly a decade spewing the nonsense of “global warming,” which is a device for government to control and ration energy.

Team Obama may have overplayed its hand in bringing control-and-ration to medical care. The news has spread like wildfire on the Internet and talk radio, and nonpolitical patients in doctors’ waiting rooms can be heard talking about it.

The United States is different from Canada and England in an essential respect: Here a patient can get a diagnosis and life-saving treatment within days, if not hours. Ted Kennedy (age 76) received immediate surgery for his otherwise inoperable brain cancer, a use of scarce medical resources that rationing would not allow for an ordinary patient.

American patients who have cancer or other life-threatening problems need and get prompt care, and we don’t want that to “change.” In Canada, England and elsewhere, patients are deemed by the government to be unworthy of treatment due to age or severity of illness, and they die while sitting on waiting lists for rationed care.

There is more funding for this new Big Brother bureaucracy in the stimulus bill than for all the armed forces combined. Wasteful pork includes billions to pay for the U.S. Census (which Team Obama is already planning to manipulate), and silly carbon-capture demonstrations (to appease the global warming lobby).

Meanwhile, the stimulus bill lays the foundation for new federal surveillance over electronic medical records, with an online medical record for each and every American. The bill establishes a massive new “federal coordinating council for comparative clinical effectiveness research” to devise ways to ration care based on the bureaucrats’ review of patient data.

There can be no patient privacy in a national database of medical records because government, insurers, employers, ex-spouses and hackers will find ways to access it. Doctors will spend more time surfing the Internet and typing in data than listening to patients, and of course there will be inevitable computer mistakes.

The declining American Medical Association (AMA), which is increasingly a shell for leftwing advocacy, tried to downplay the outrage of giving a government bureaucracy access to everyone’s medical records and punishing doctors who don’t treat as the government wants. But there is no denying the harm of this new system that facilitates government oversight of an electronic database and gives bureaucrats (who never went to medical school) the power to punish doctors who provide “too much” care.

Doctors who resist the government’s guidelines will be controlled by slashing their fees. Doctors will lose their autonomy, just as Tom Daschle sought, and some patients will be left with nowhere to turn for their illnesses.

Our medical system has long been the envy of the world. That’s why foreigners come to the United States for our superb medical care, spending more than a billion dollars a year here.

A true stimulus bill would seek to multiply that revenue by encouraging more private enterprise in medicine rather than installing a new bureaucracy to build and oversee electronic medical records, control doctors’ decisions, and ration care.

In 1993, Hillary and Bill Clinton tried with all their might to impose a government takeover of all health care, and the 1994 midterm elections repudiated their efforts. The midterm elections of 2010 could be just what the doctor ordered.

Wednesday, February 18, 2009



What Obama Is Doing With Your Medical Records

by Terence Jeffrey, Townhall.com

The so-called “stimulus” President Obama signed Tuesday is so unwieldy it had to be posted in two PDFs on the House Appropriations Committee’s Website along with another two containing an “explanatory statement.”

The law totaled 1,071 pages; the explanation, 421.

Yet, 216 of the law’s 1,071 pages deal with a project not directly aimed at short-term economic stimulus, and these 216 pages were themselves divided into two distinct parts (139 pages in “Division A” of the law and 77 pages in “Division B”).

Together, these 216 pages provide the legal framework for collecting every American’s personal medical records into a federally coordinated electronic system.

As first pointed out in a Feb. 9 Bloomberg.com commentary by former New York Lt. Gov. Betsy McCaughey, it is reasonable to assume that this electronic-records system, together with a provision that creates a “Federal Coordinating Council for Comparative Effectiveness Research,” sets the stage for the creation of a nationalized health-care system that engages in British-style rationing.

But even if Congress and the president restrain themselves and pass no further law in pursuit of socialized medicine for the United States, the provisions already enacted in this law raise significant questions about the right to privacy and the right of doctors to practice medicine according to their best judgment.

Division A includes a section called “Title XIII—Health Information Technology,” which provides for “the development of a nationwide health information technology infrastructure.”

In the law’s jargon, this infrastructure is supposed to allow for the “enterprise integration” of the “qualified electronic health record” of “each person in the United States by 2014.”

What do “qualified electronic health record” and “enterprise integration” mean? A “qualified electronic health record,” the law says, “means an electronic record of health-related information on an individual that -- (A) includes patient demographic and clinical health information, such as medical history and problems lists; and (B) has the capacity -- (i) to provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources.”

This mandate that your “electronic health record” (EHR) be able to communicate with “other sources” goes to the definition of “enterprise integration.” This term, the law says, “means the electronic linkage of health care providers, health plans, the government and other interested parties to enable electronic exchange and use of health information among all the components in the health care infrastructure in accordance with applicable law.”

The law directs an existing bureaucracy created by President Bush (the “Office of the National Coordinator for Health Information Technology”) to put together a plan for building this system so that it achieves the “utilization of an electronic health record for each person in the United States by 2014.”

In plain English: Over the next five years, the Obama administration intends to create a federally run electronic exchange that includes every American's "medical history and problems lists."

Now, before you run out to the nearest federal office and sign up to put the "medical history and problems" lists for yourself, your spouse and your children into the government's "nationwide health information technology infrastructure," you should know the law does not require you—as an individual—to do this.

The "explanatory statement" for Division A explains this. "To the extent that this section calls the national coordinator to ensure that every person in the United States have an EHR by 2014, this goal is not intended to require individuals to receive services from providers that have electronic health records and is aimed at having the national coordinator takes steps to help providers adopt electronic health records," says the explanation. "This provision does not constitute a legal requirement on any patient to have an electronic health record."

But if the national coordinator cannot make you—an individual—submit your records to the system, how is the poor guy going get "an electronic health record for each person in the United States by 2014"?

This mystery created by 139 pages in Division A is solved by the 77 pages in Division B: The secretary of health and human services is given a carrot and stick to make doctors and hospitals create EHRs for their patients. Doctors and hospitals that make "meaningful use" of EHRs by the deadline get bonus payments from Medicare. Those that do not get diminishing Medicare payments.

What is "meaningful use"? That is at the discretion of the secretary of HHS, but the law says it will include "electronic prescribing," "the electronic exchange of health information to improve the quality of health care" and submitting information "on such clinical quality measures and such other measures as selected by the secretary."

Lastly, the law directs the secretary to ratchet up the "meaningful use" test as time goes on. Or as the "explanation" politely puts it: "The secretary would seek to improve the use of electronic health records and health care quality by requiring more stringent measures of meaningful use over time."

In other words, once the secretary has your medical file in the system, he is supposed to make your doctor do ever more with it at his command.

Tuesday, February 17, 2009



How About A Stimulus For Life?

by Cal Thomas, Townhall.com

Thanks to former Lieutenant Governor of New York Betsy McCaughey and her recent essay on Bloomberg.com entitled "Ruin Your Health with the Obama Stimulus Plan," we know of another problem with the just-passed stimulus bill, one that may threaten the lives of many Americans.

McCaughey discovered buried in the bill a new bureaucracy called the National Coordinator of Health

Information Technology. Among other things, it means that a Washington official will “monitor treatments to make sure your doctor is doing what the federal government deems appropriate and cost effective.” Some of that occurs now, but this would take it to a whole new level.

The idea comes straight from former HHS nominee Tom Daschle’s 2008 book “Critical: What We Can Do About the Health-Care Crisis” in which he says that doctors are going to have to give up their autonomy and “learn to operate less like solo practitioners.” Inevitably, this means the government will decide who gets life-saving treatment and who doesn’t. It is survival of the fittest in practice. Thank you, and belated happy birthday, Charles Darwin.

In 1979, six years after *Roe v. Wade*, philosopher and theologian Dr. Francis Schaeffer and the about-to-be surgeon general of the United States, Dr. C. Everett Koop, wrote a book, “Whatever Happened to the Human Race?” In chapter three, “Death by Someone’s Choice,” the authors write, “Will a society which has assumed the right to kill infants in the womb—because they are unwanted, imperfect, or merely inconvenient—have difficulty in assuming the right to kill other human beings, especially older adults who are judged unwanted, deemed imperfect physically or mentally, or considered a possible social nuisance?”

No one should be surprised at the coming embrace of euthanasia. After the Supreme Court deprived the unborn of their right to live by declaring them nonpersons, it was only a matter of time before other categories of human life deemed to be inconvenient or unwanted would also face extermination in order to benefit the government, the healthy and the wealthy, who prefer not to be disturbed in their pursuit of pleasure, personal peace and affluence.

Schaeffer and Koop predicted “the next candidates for arbitrary reclassification as nonpersons are the elderly.” That 30-year-old prophecy, deemed hyperbole and alarmist by many at the time, now seems to be coming true. In 1993, Hillary Clinton, as chair of the Task Force on National Health Care Reform, pushed the bureaucratic-heavy Clinton Health Care Plan, quickly labeled “HillaryCare,” which was long on government oversight, short on patient choice. A Democratic Congress defeated it a year later. Now we have the National Coordinator of Health Information Technology and a Democratic Congress and President Barack Obama appear ready to resume their assault on all but the fit and those who do not burden government with their need for treatment. “Medicare now pays for treatments deemed safe and effective,” writes McCaughey. “The stimulus bill would change that and apply a cost-effectiveness standard set by the Federal Council.”

I called Koop, who is now 92. He reminded me that in 1988 he had an ailment that left him a quadriplegic. Surgery restored his limbs, but “if I’d lived in England, I would have been nine years too old to have the surgery that saved my life and gave me another 21 years.” Koop fears the United States is about to embrace English socialized medicine with government authorities deciding who lives and who dies. He says the idea of government second-guessing doctors sickens him.

Great inhumanities are usually ushered in at the extremes in order to make the public more accepting. Abortion on demand followed the 1973 *Roe v. Wade* case where Norma McCorvey, Jane Roe, “alleged” she had been raped, resulting in pregnancy. Technology allows people to abort a “defective” baby in the womb, “selectively reduce” implanted embryos to the desired number, or even abort a female when a male is wanted.

Euthanasia will not originate with your beloved grandmother or parents. It will start in a public hospital with a 100-year-old woman who has multiple health problems and “wants” to die so as not to “burden”

anyone. Public opinion polls will determine that a majority favor letting—even helping—the old girl die. Yes, there are times when a patient and his family may decide to forego treatment and allow death to occur, but that decision should not be made by a government official. Once that door is opened (as it was with abortion) there will be no closing it and dying will become a patriotic duty when the patient's balance sheet shows a deficit.

They'll probably have a clergyman available to bless the government's decision and make everyone feel better about it.

Monday, February 16, 2009



The Future of Health Care — Interview With John Goodman

by Bill Steigerwald, Townhall.com

It's hard to find anyone who likes America's health care system, including John Goodman, president and founder of the National Center for Policy Analysis. But you'll never find Goodman saying that health care is better in places like Europe, where socialist governments provide "free" universal health care for everyone.

Goodman—dubbed "the father of Health Savings Accounts" by The Wall Street Journal—has written nine books, including "Handbook on State Health Care Reform" and "Patient Power: Solving America's Health Care Crisis."

To find out what he thinks America's health care system should look like—and why Europe's government health systems are the last things we should copy—I called Goodman on Wednesday, Feb. 11, at his offices in Dallas:

Q: Many people—mostly people who think health care should be provided free to everybody by the government—point to Europe as a model. Should they?

A: The people who praise European health care say that the average country in Europe spends half as much as we do and they have very similar health outcomes. What they don't tell us is that the typical European country is disguising costs, shifting costs, to hide what it really spends. And if we look over the last 40 years at the average spending per person in real terms, the growth rate in the United States is right at the European average.

Q: How does what Europeans get for their money compare with what Americans get for their money?

A: Well, life expectancy looks as good or better in Europe than it does in the United States. But life expectancy is primarily determined by genes and how people live their lives, not by doctors and hospitals. If you look at things that doctors can do something about, like cancer, and you ask, "What is the five-year survival rate for major forms of cancer?" we are the best in the whole world.

Q: Do you have the sense that most Americans know what Canadian or European health care systems

really are like?

A: No. Americans don't think about the health care systems of foreign countries. But the health policy community is heavily dominated by people who would like to socialize the entire American health care system. They are constantly pointing to the health care systems of other countries and claiming that those systems work better than ours.

Q: Are they blind to the facts or what?

A: Remember, we are at sort of a stalemate. The people who would like to have national health insurance have not won. They haven't eliminated private-sector health care in this country. So we're at an impasse. I do believe we need reforms but they need to be pro-free-enterprise reforms.

Q: What is a market-driven reform you would like to see?

A: Our institute originated the idea of the health savings account. There are 12 million people now managing their own health-care dollars. That seems to be working very well and those types of plans are growing very fast. We'd like to see consumers control more dollars and we think that wherever the patient is in control of dollars the markets work better. ... When patients are managing their own dollars, they are more careful, more judicious consumers. They compare prices. That helps the employee but that also helps the employer.

Q: Is there anything in European health care systems that we can copy or at least learn from?

A: We're always looking at what is happening in other countries. There are some interesting models. I think the most interesting model outside the United States is the Swiss health care system. In Switzerland, everyone is required to have health insurance but it's mainly private insurance. It's also individually owned and portable insurance, so people can take it with them from job to job. I think in our own country we're going to have to go to a system of individually owned portable insurance because I think the employer-based system probably can't survive in its current form.

Q: Would the system you'd like to see here be like the Swiss system?

A: I think we can improve on the Swiss system but the idea of individually owned portable insurance is, I think, a characteristic of an ideal health care system.

Q: What would be the practicalities of an individually owned portable system?

A: We've actually proposed a way that at the state level we can move in that direction. We would allow the employer, instead of buying group insurance, to be able to buy individual insurance for all the employees. Then the employees could take their insurance with them when they leave and go from job to job. It has to be thought through carefully and you have to make sure that the sick people are not left out in the cold but we think all this is doable.

Q: One of the problems in Europe that most people here do not know about is that they're promising a lot more health care in the future than they are going to be able to pay for. Can you explain what the problem is over there?

A: Looking to the future, Europe is in worse shape than we are because they have promised health care to everybody; they have aging populations; they have health care costs rising at twice the rate of growth of income, just like we do; and they have put no money aside—there is no saving, no investment for future health care spending.

Q: Their economies are sluggish at best, so are they going to suffer sooner and in worse ways than we

will? We're basically doing the same thing, but at a slower rate, is that true?

A: Right. We at least are replacing our population, even though we are doing it in large part with immigrant families. But in Europe the fertility rate is very, very low. They are not replacing their populations and so the typical European country is going to see its population peak and then fall. As they move through time, the burden on taxpayers will just grow and grow. Basically, the average European country has an unfunded liability in today's dollars that's four times the size of its national economy.

Q: Obviously, something is going to have to give. What is most likely to give?

A: When you make promises you haven't funded—and we're going to have the same problem here as well—you either have to raise taxes or cut benefits or do both. There will be some combination but there's going to be a lot of pain. The pain is that retirees are not going to get all the health care they thought they were going to get and taxpayers are going to get hit with a higher tax bill than they thought they were going to pay.

Q: So there's no free lunch and there's no free health care, either?

A: No. There are decisions that are being made today that are going to create extreme financial difficulties for our children and grandchildren.

Q: So you think that in the United States the nationalizers of health care have not necessarily won the day?

A: Oh, no. Oh no, no, no. Not at all. Most Americans do not like the idea of government taking over the whole health care system. They're going to try to do it by stealth. Right now all seniors are on a government plan. And by the time this new program SCHIP (State Children's Health Insurance Program) gets under way, we'll have more than half the children in a government health care plan. So gradually through time, more and more people will be enrolled in government health care.

Q: If you had a chance to sit down with President Obama and badger him about government health care policy, what would be the most important thing you'd stress to him?

A: We need to liberate the patients and the doctors because right now everybody's trapped in a very dysfunctional system. There's huge waste and inefficiency. We ought to let the market work in health care the way it works in so many areas of our economy. You do that by allowing patients to control more of the dollars and by allowing doctors to re-package, re-price their services and compete the way other professionals compete.

Q: Are not the eye-care and dental-care industries looked at as freer markets that ought to be copied?

A: "Free market" is probably not the best term. For LASIK surgery and cosmetic surgery, these are markets where there is very little third-party payment. So all the payment is by the patient and the physician is completely free to choose a price, to choose a package, and they compete in those markets the way professionals compete in other markets—and it works! The real price of those services has gone down over the last decade. You can get a package-price in advance. You know what you are going to pay. You can compare prices. You can often compare quality as well.

Q: On your blog someone asked if 21st-century democracies are capable of creating a fiscally sound set of social welfare programs that don't cannibalize or wreck their own economies in the long run. How would you answer that?

A: We're going to find out. On the plus side, about 30 countries have reformed their social security

retirement plans. Chile is the most notable, but 29 other countries have also created private (social security) accounts and are in the process of reform.

But no country has really tackled the health care problem and set up a way that people can pre-fund the health-care expenses that they know they will have in their retirement years. We'll see if the countries can do that and still remain democracies.

Q: And are you an optimist or a pessimist about this?

A: Well, you have to be an optimist. Why would I be doing what I am doing?