

9/11

Another reason to “ungate” health care

by Lawrence A. Danto, MD, FACS, Stockton, CA

The recent tragedies in New York City, Pennsylvania, and Washington, DC, still overshadow and preoccupy most aspects of American life. This is particularly the case with regard to the health care industry and efforts to reform it. Participants at the September 2001 State of the State of Health Care Forum in Massachusetts were warned that not only has Congress set aside prescription drug and patient rights initiatives, but mounting job losses and dwindling government revenues threaten access to health care across America more than ever. Said Thomas A. Scully, Administrator of the U.S. Centers for Medicare & Medicaid Services, “National defense is going to take priority over everything.”

While it is important to focus on an appropriate response to terrorism, we must also protect ourselves and get on with our lives—securing a free

and stable future. Not only do we owe it to those who sacrificed their lives, but, even more, we owe it to the survivors—to ourselves. If we don’t move on, we will end up losing this global war to the terrorists.

Lessons of history

Interestingly, there is a strong historic association between world war and changes in the socio-economic structure of health care delivery. Before World War II, health care delivery was based on a simple, fee-for-service system. If patients could afford care, they received it; if they couldn’t afford treatment, for the most part, they didn’t receive it. The notion of selling health insurance was unborn.

During WWII, all industrialized nations (except the U.S.) either suffered mainland attack or were

in constant fear of the very real prospect of injured civilians from such an attack. It became immediately apparent that private economic concerns should not affect the emergency triage of domestic casualties. The global response was to create national emergency health care systems whereby the national government economically, administratively, and physically supported emergency health care.

As peace settled back in place, these same nations, in response to the postwar economic recession, high rates of unemployment, and the continued need to provide basic health care services, transformed their wartime emergency health care systems into national programs that could deliver basic care to all citizens at all times. These countries recognized that a modern national workforce depends on effective access to basic health care.

On the other hand, the U.S., protected by two vast oceans, was free from the threat of mainland attack during WWII. The arsenal of democracy emerged from that global conflict with a surging economy and near universal employment. Our response to funding health care was to continue the prewar fee-for-service system and to support it with the employment-based system of privately funded health insurance that had been developed during the war and used to attract scarce workers into wartime employment. This system functioned beautifully during the two postwar decades in which the U.S. economy was booming and supporting the world economy as well. Further, it made some sense when most workers expected a lifetime of employment by one firm. However, as the industrialized world recovered, we began to lose our economic advantage and, at present, our average job tenure is three to five years—physicians included.

The rest of our economic history is easy to recall—continued and unavoidable global health care inflation. Our knee-jerk response has been to set arbitrary limits on health care spending by allowing managed care, capitation, and gatekeeping to become the watchwords and primary focus of the health care industry. However, the cost of care has continued to rise as it must in any free, technocratic society with an aging population. Sadly, there are now restrictions on essential services even for those of us who are employed and well-insured. The vast majority of Americans

now have access to care only with the approval of a gatekeeper.

Even so, HMOs, unable to squeeze any more profit out of the system, are losing money and only the largest and most aggressive are able to stay in business. Private managed care is in a definite state of decline and this administrative experiment has caused the health status of the U.S. citizenry to decline from first to last place among the major industrialized nations, according to the *2001 World Health Report* of the World Health Organization.

Emergency room crisis

An even more critical issue is the closure of numerous emergency rooms throughout the nation. As Frank Staggers, Jr., MD, president of the California Medical Association, recently said, “We dearly need to preserve our emergency [health care] system so it will be available when we need it.” True enough, but the problem is more complex than it first appears.

Many ER closures have occurred because, for various reasons, institutions have failed to provide adequate staffing and technical support for the emergency rooms they provide. As any surgeon knows, it is dangerous, unethical, and even illegal to hang an ER sign on the side of a hospital unless the institution is truly capable of providing the level of care it is advertising. These so-called ERs, quite frankly, need to be closed.

On the other hand, there are millions of uninsured and underfunded patients who are afraid to go to the doctor or to the ER until it's too late. There are millions more insured and well-funded patients who have to call their gatekeeper before going to the doctor or ER. The dangerous fact is that our financial mindset often slams the gate to lifesaving care, and the portal often stays closed until it's too late.

The sentinel example of this tragedy is the unfortunate postal worker who, suspecting he had contracted inhalation anthrax, instead of simply going to the emergency room, went to “his doctor.” His doctor happened to be employed by the largest and oldest private HMO in the country. Without an appropriate workup, he was told he probably had a virus and to treat himself symptomatically.

In effect, this person ended up being denied ac-

cess to care by someone at least perceived as a gatekeeper. Only after his illness worsened at home did he call 911 to ask what he should do, but by then it was too late. Think of this astounding reality: Our patients are now so conditioned by decades of gatekeeping from employment-based managed care that, even when faced with death, they first ask permission before seeking care.

The tragic events of September 11 are bringing the eye of public concern to focus on the longstanding inadequacies in our system of health care. Because our government is the only entity capable of responding to terrorism, it is the only one that can mend the gaping holes in our health care safety net.

Surviving a 360-degree war

For the first time since the Civil War, parts of mainland America have been attacked and devastated by an act of war. For the first time, we know how the rest of the world has been living—with the terrible reality of continual civilian casualties. Our protective oceans have finally been bridged, and the course of U.S. history has been wrenched in an unexpected direction. For the first time, we are at war on all fronts—a “360-degree war.”

Like December 7, 1941, and November 22, 1963, the attacks last fall will be forever recognized by the date on which they occurred—the simple, stark designation of 9/11, the universal emergency number. The loss of life was enormous, as was the threat of seriously injured victims. It has already become apparent that because of our restrictive health care system, survivors of domestic terrorism face medical expenses and lost wages while they recover.

In truth, we are all survivors of 9/11, and we are threatened by its legacy. Further, in the foreseeable future it is likely that all of us will face medical expenses and lost wages while we struggle to live on in the shadow of the horrific events of that fateful Tuesday. Arguably the major socioeconomic lesson is that our private system of managed care instantly failed to meet the needs of this new crisis. The major lesson in government studies is that an ungated and universal system of health care delivery is integral to national defense.

The prospect of an American national emergency health care system has now become a significant part of the societal dust rising from the

rumble at ground zero—the ruins of the World Trade Center. The prospect of large numbers of civilian casualties, not just from physical trauma but from chemical and biological warfare as well, has created a new impetus for a health care reform, and Congress must respond. Emergency care is not a second-priority issue.

Questions such as these remain to be answered: Can we allow emergency rooms to close because not enough patients have access to them? In a time of national crisis, can we afford to have our gate to emergency health care controlled by private concerns? Can we allow private enterprise to significantly affect the emergency triage of our domestic casualties?

The rest of the industrialized world responded more than 50 years ago during WWII. However, in our terrorized and no-longer isolated U.S., employment-based managed care has become a real threat to our security, and the previous questions continue to cry out for answers. Stated in more blunt terms, in twenty-first century terrorized America, in a time of national emergency, can we possibly let private gatekeepers deny care to our injured loved ones?

The nature of surgery is the nature of emergency health care and dealing with disasters. As surgeons we should push especially hard to establish universal access to emergency care, and make an ungated health system the reality for us all. □

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