

Doing the right thing

By John C. Baldwin, M.D.

The recent passage by Congress of a so-called “patients’ bill of rights” has been hailed as a big step forward in the battle to achieve better health care for all Americans. I see it, however, as merely a small step for some. I believe the bill that passed the House with great fanfare on October 7 (and is, as I write, in conference committee) does little more than reflect the failure of the business model to solve the country’s health-care woes.

Disarray: The number of uninsured Americans continues to increase inexorably; the number of bankruptcies among HMOs

and insurance companies is on the rise; HMOs are steadily dropping Medicare patients from their rolls; and we are once again seeing double-digit percentage jumps in health-insurance premiums. In other words, our system is in disarray.

Senator Moynihan put it eloquently when he gave a commencement address at Columbia entitled “On the Commodification of Medicine.” He said viewing medicine as a commodity is a wrongheaded approach. He made an analogy with the national defense, pointing out that if we treated defense as a commodity it would lead to decisions such as, “Well, you buy what you can afford, so certain parts of Boston will be hit by nuclear weapons and others won’t.”

I would suggest that the analogy might even be taken literally—that health care is the national defense. The health of a nation is essential to its ability to ensure not only that the citizenry constitutes a healthy, productive workforce but also that there is a complement of healthy individuals to serve in the armed forces. So investment in health seems to me to be not just analogous to but actually part of the national defense.

Clarification: But instead of addressing the fundamental issues—the increasingly evident failure of the for-profit model and the ever-worsening plight of the uninsured—Congress has focused on this “patients’ bill of rights.” Frankly, I find that almost sacrilegious—at least in the patriotic sense. The real (capitalized) Bill of Rights was appended to the Constitution to clarify certain human rights not specified in the Constitution itself. The Declaration of Independence had referred to “unalienable rights,” and several states insisted in 1789, as a condition of ratifying the Constitution, that these rights be written down. What is recorded in the first 10 amendments to the Constitution is truly a “Bill of Rights.”

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most people mistakenly believe it establishes a right to health care. It does not do that. It is simply a set of regulations stipulating how insurance companies can treat those who already *have* coverage. It contains no statement anywhere of a right to health care. Americans do not have such a right, because it is not written down.

In my view, we need to start by developing a national consensus that there should be universal access to health care. That step of course falls in the political domain.

The second step is where academic medical centers can help. Through prospective analysis of

clinical outcomes at DMS’s Center for the Evaluative Clinical Sciences (CECS) and through the quality improvement efforts of our clinical departments, we have learned a lot here at Dartmouth about what interventions provide the best outcome at the lowest cost. More can be learned through additional research, here and elsewhere.

Cost: The third step in this process is also one where academic institutions can contribute. In fact, we have made a good start here at Dartmouth. Working with David Blanchflower, who chairs the College’s Department of Economics, we have set up the Health-Care Economics Group. It has 12 members—three from economics, three from the Medical School, three from CECS, one from Dartmouth’s Amos Tuck School of Business, one from the Dartmouth-Hitchcock Alliance, and the Commissioner of Health for New Hampshire. The charge we’ve given the group is to look at the cost implications of universal access to health care—at how an open-access, thoughtfully structured medical system *could* work financially.

The fourth and final step is how we pay that cost, and again this falls in the political domain. This involves issues of appropriation and taxation and so on, just as when we’re discussing highways and airports and other investments in the public good.

Heretofore, we have attacked this issue backwards. The Balanced Budget Amendment of 1997, for example, which was supposed to “save” \$160 billion, has had the effect of closing many major teaching hospitals and of bringing many others near bankruptcy. Instead of dealing in isolation with the payment issue, we need to start by developing a national consensus about health care and then work our way through a rational process to figuring out the cost and how we can pay for it.

It’s time once again—as it was in 1789—for those who care about doing the right thing to insist on action: to assert, and to write down, a set of rights pertaining to health care around which a national consensus can be forged. ■

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