Your Money *and* Your Life: The Price of "Universal Health Care"

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Although often recognized as sacred, human life has not been considered the top priority in the hierarchy of values. Human beings have willingly sacrificed life to preserve honor or virtue, to defend the faith or the nation, or to protect family or the family's livelihood (property). Civilized nations have, however, generally recognized the right to life—meaning the right not to be unjustly killed and to defend one's life by force.

Today many clamor to place an additional value above life itself. "Without your health, who are you?" is a popular question. "Without your health, you really have nothing," Internet sites tell us. "Without your health, the rest is pointless. . . . Nothing else matters."

Surely something so important as health should be a right, especially in such an affluent nation, shouldn't it?

American medicine is often criticized for placing too much emphasis on curing disease and not enough on maintaining health. All we need to do is to prevent people from getting sick, or treat them when they are only slightly ill, to prevent costly hospitalizations later—or so it is claimed. "Health care" supposedly heads off "sickness care," saving enormous "resources" and making all of society better and happier. Presumably it also increases life expectancy—overall. (There is little evidence for these assertions, and substantial evidence to contradict them, but that's the subject of another article.)

Still more important, health is the very "cornerstone of a democratic society," according to the crusading reformer John Kitzhaber, M.D., the former governor of Oregon who once practiced emergency medicine. In what he dubs the Archimedes Movement, he plans to use health as the lever to move the earth and "reboot democracy." The overarching (stated) goal is to "maximize the health of the population."

What could be wrong with the popular, noble-sounding goals of maximum health or universal health?

There's ample evidence that Americans don't care very much about their health. They grouse about copayments at the doctor's office or pharmacy and may leave an office in high dudgeon if expected to pay a reasonable bill not "covered" by their insurance. They often refuse to buy medical insurance even if they can afford it. Aside from a subpopulation of health fanatics, many Americans constantly defy the grandmotherly advice that is the proven basis for effective health maintenance. They smoke, drink, take drugs, engage in casual sex, and/or overeat. They do not exercise, eat their vegetables, or conscientiously wash their hands. They may be willing to take lots of pills, but appear to be allergic to anything that interferes with instant gratification or requires self-discipline.

Fortunately, Americans still have the right to practice good health habits—according to their own views, not necessarily the American Medical Association's. They also have the right to liberty or to refuse to take care of their health, and many exercise it. Kitzhaber and his fellow reformers plan to do something about that. Being healthy is not just a right but a duty!

However recalcitrant they may be about unhealthy lifestyles, Americans do care about life when facing a real and present danger of death as opposed to a hypothetical future health problem. At that point they usually want to spare no expense—especially if it is somebody

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else's expense. And here's where human instincts will collide head on with health reformers' abstractions. People naturally tend to place life above health; after all, without life, health is meaningless. As long as there's life, there's hope for improvement. For reformers like Kitzhaber, however, the priority is reversed. *Collective* health is more important than *individual* lives. The implications are profound.

It ought to be obvious that there is an unbridgeable chasm between life and death. Nevertheless, the discontinuity apparently escapes those who set up relative value scales based on "quality-adjusted life-years" (QALYs). The unstated assumption is that at some point on the QALY scale, visible to experts, the value of a life becomes negative—even less than the value of death. While the old-fashioned meaning of "a fate worse than death" has been mostly forgotten, the concept has taken on a whole new and very broad definition.

How can this be?

We don't like to use the term *lebensunwertes Leben* (life unworthy of life) because of its historical association with the embodiment of evil (National Socialism). Instead, the emphasis is placed on optimizing the use of resources. As the Vision Statement of the Archimedes Movement explains, the goal of maximal population health is to be achieved by "creating a sustainable system which reallocates the public resources spent on health care that ensures universal access to a defined set of effective health services"; that is, "care that is effective in producing health." Care that simply relieves pain, reduces disability, or postpones death might not qualify (and, unlike "health care," is certainly not a right, as is operationally demonstrated wherever nationalized medicine has been tried).

Kitzhaber is the architect of the Oregon Health Plan, which prioritizes services and cuts off public funding for all those that fall below a line set by the legislature. It is probably not coincidental that Oregon is the first state to permit physician-assisted suicide. The health plan was supposed to increase access to "basic health care" without increasing costs. Although by 2003, costs were four times as high as at the plan's inception, Kitzhaber's enthusiasm is not dampened: Expenditures are not the only concern.

Spending can always be ratcheted down once a program is entrenched and accepted. Thus while cost containment is important, it can wait. First there's the Vision of how reformers can use the perceived health-care crisis to "heal [sic] the divisions within our society"—as it is "the great leveler." The budget should be used not to "cheat death" but to put bioethics into practice and to "distribute shortfalls equitably." There will, undoubtedly, be shortfalls.

Clearly, in Kitzhaber's view, "health" trumps life. And "health" is not mere physical health but the well-being of society—as manifested by social justice, egalitarian distribution of goods and services, and proper ethics.

Choice Constrained

Proponents of "universal health coverage" are generally dedicated to bioethics—which seems largely concerned with choosing death for oneself or others purportedly because an unhealthy life or severe disability is unendurable. But most other choices are to be constrained.

A "living will is actually a dying will," explains James Pendleton, M.D., a Pennsylvania psychiatrist and a past president of the Association of American Physicians and Surgeons. The British government holds the view that a living will may *not* insist that an incapacitated person be kept alive; this view was recently confirmed by the European Court of Appeals. In the United States hospitals are generally not required to continue care that they consider "futile." Families who disagree with a hospital's decision may be given ten days to try to find another source of care for a patient. "Futile" care is Newspeak for care that is actually effective at keeping the patient alive, although not at restoring mental capacity or health—otherwise, death of the patient would moot the questions.

If the taxpayers are involved, then there is a question of whether it is justifiable to seize money from one person to pay for benefits to another, whatever the efficacy of the treatment. But what if private funds are to be used?

The question of whether a Canadian has the right to use his own money to purchase medical care that is supposed to be covered under the national health plan, but is unavailable, was recently taken to the Canadian Supreme Court by Jacques Chaoulli, M.D. Chaoulli had

been forced to abandon his emergency house-call practice because of the mounting government penalties for accepting private payment. The case was brought, at Chaoulli's personal expense of around $600,000 (and risk of having to pay the government's legal costs if he lost) on behalf of a patient who had to wait a year for a hip replacement.

In a decision that some fear could destroy the government's system, the Court ruled that "access to a waiting list is not access to health care." The decision was stayed for a year to permit the system to adjust to the threat of competition. While it applies only to Quebec, the effects are expected to reverberate across Canada.

"How can you imagine that Quebeckers may live," asks Chaoulli, "and the English Canadian has to die?"

Would Americans be allowed to buy private care if compulsory public insurance becomes law? Advocates of universal coverage usually don't address this question. But Kitzhaber says he would permit people to purchase extra medical care, using "discretionary income"—that which is left after taxes.

Taxes are also a great leveler. For the same miserable public "health insurance" Canadians pay from $305 to $27,000 in taxes each year, depending on income bracket. "The end game is that people with money no longer want to pay the taxes required to provide quality health care to everybody," states Michael McBane, national coordinator of the Canadian Health Coalition, which opposes privatization.

Assumed Right

Americans tend to assume that they have the constitutional right to spend their own money to extend or enhance their own lives. How to get around that obstacle to universal rationing was addressed by the Clinton Task Force on Health Care Reform. The public-private partnership is a promising method, as the Constitution does not apply to private entities. In fact, most Americans have already lost the ability to buy private medical care in this way.

Medicare patients who are enrolled in Part B may not use their money to buy "covered" services outside the system, unless they see one of the relatively few physicians who have opted out completely, because physicians are forbidden to accept the payment. Shockingly, patients enrolled in managed-care plans have also forfeited their rights, but are generally unaware of it because severe rationing is not yet in effect.

The key is the "hold harmless" clause that forbids physicians contracted with a managed-care plan to charge subscribers privately or to "balance bill" (charge more than the plan allows, even if the payment is a dollar or less). The only thing subscribers have the right to purchase for themselves from a contracted provider is cosmetic or experimental treatments. The Lobb family discovered this when Sandra Lobb was refused admission to an alcohol-rehabilitation program, although her physician recommended it and her family was willing to pay. By contract the physician was not allowed to circumvent the plan's utilization-review program. Mrs. Lobb died.

Insurance companies do not make their subscribers aware of this limitation. Only by remarkable persistence was one small business owner, of Cameron's Hardware & Supply in Oxford, Pennsylvania, able to get the insurance carrier to admit to the implications of the "hold harmless" clause, which is probably required by state law.

A Collision of Rights

Rights are enforceable. The only way to enforce a right to an economic good such as medical treatment is through taxation: in other words, to give some a license to steal resources from productive persons to pay for benefits to others. Because of taxation a person has no right to use his earnings to support his own life until he has first "contributed" to societal health. As demands inevitably mount, rationing becomes increasingly stringent. Only those with sufficient means to pay twice for medical care have a way to escape. If legally prohibited from purchasing extra care in their own country, they may be forced to go abroad, as many affluent Canadians do.

Despite the professed benevolent intentions of "universal health care" advocates, they are turning a license to steal into a license to kill those who are not sufficiently healthy by depriving them first of medical care and then of the sustenance that all living things require. The term "health care" is well chosen: it cares for health, and discriminates against the sick.

There are great campaigns underway to coerce peo-

ple into being fully vaccinated and aggressively monitored and treated for diabetes, mild hypertension, nonoptimal blood lipids, and signs of incipient "mental illness." At the same time, people are urged to accept nontreatment plus terminal sedation and dehydration for conditions such as stroke or degenerative neurologic diseases.

There are many stakeholders to be placated in the political process. There are those with crushing liabilities, including governments and business enterprises with underfunded pension plans, as well as family members who don't want their inheritances to be consumed. There are those with the potential to profit from administering small-claims payments, churning well patients through a clinic while diverting the sick ones, providing blockbuster drugs and vaccines to a large proportion of the population, garnering votes for reelection, or writing the guidelines and protocols for approved treatments.

Exploiting human fears of sickness and death is a favorite tactic for politicians and rent-seekers. Promising health while being fully aware of the dark side—premature death, the ultimate leveler—is the supreme hypocrisy.

Persons who want to be in charge of their own life-and-death decisions need to be aware of the price tag on compulsory insurance. Endlessly escalating demands on your money are guaranteed. But worse, you must trade your right to life—and to the liberty and property required to sustain it—for an obligation to measure up to the official standard for health. Or else. Having assumed responsibility for your treatment, the government must assure your worthiness.

It is worthwhile to remember that the world's premier health nuts were members of the National Socialist party. And while the talk is about health, that's merely a lever. The unstated overarching goal is totalitarian control.