RESPONSE TO THE
INTERIM RECOMMENDATIONS
of the Citizens’ Health Care Working Group

Patricia Maryland, Ph.D.
Chair
Citizens’ Health Care Working Group
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Dear Dr. Maryland,

Citizens’ Council on Health Care is pleased to provide you with our comments on the Interim Recommendations of the Citizens’ Health Care Working Group.

General Statement
While we understand that many hours went into the work of the CHCWG, we are disappointed with what seems to be a lack of creativity in the interim recommendations. The interim recommendations will not solve Medicare’s unfunded liability of at least $30 trillion (GAO, 2005). By recommending an insurance mandate and a guaranteed government subsidy to pay for it, the CHCWG all but guarantees higher federal liabilities paid through additional income transfers in the form of higher taxes on American citizens. It also guarantees rationing of care. Furthermore, we are disappointed that millions of taxpayer dollars were spent to devise a plan similar to the national health care plan defeated during the early Clinton administration.

This list of interim recommendations will only exacerbate the cost problems we see in Medicare today by building a Medicare-like entitlement for all citizens.

The CHCWG should provide a final set of recommendations that stay within the constraint of constitutional rights, medical markets, and individualized patient care—the hallmarks of American medicine. In addition, the final recommendations should not include the misleading statistic (Americans get the right care only 50% of the time) and the debunked statistic (98,000 deaths from medical errors) in this Preamble. The final document should also more clearly state who influenced the recommendations (what percent came from the stakeholder/expert hearings, what percent from the community meetings) and exactly how many of the country’s nearly 300 million people attended the 31 community meetings.

When Congress formed the CHCWG, we expect they were looking for creative solutions to turn back the looming tide of unfunded Medicare liabilities while preserving the constitutional life, liberty, and property rights of citizens. We hope that the Final Recommendations will fall in line with those expectations. Following find specific comments about each section of the CHCWG Interim Recommendations.

Values & Principles
The CHCWG does not provide a list of “values” out of which these “principles” are derived. And until the following terms are defined, no one can understand what is actually being proposed. Essential details have been left out. For example, what does it mean by “the right care?” Who decides? At a minimum, the CHCWG should define the following terms:

- “affordable health care coverage”
- “shared social responsibility”
- “a defined set of benefits”
- “a set of core health care services”
- “the right care at the right time and at the right place”
- “appropriate health care”
- “consumer-health care provider relationship”
- “evidence-based”
- “effectiveness”
- “other societal needs and responsibilities”

This section goes on to say that a set of individuals will be “appointed” and will engage in a “process” to determine core benefits available to all people. The words “independent, fair, transparent, and scientific” are no doubt meant to convince the public that the process engaged in will not be political, values-based, or biased against the sick, the injured, and the costly. But the only services available in the core benefit set will be those that the appointees decide are “evidence-based” and that have “expert consensus regarding the effectiveness of treatments.”

Any patient who has unusual needs or physiology, and doesn’t fit some consensus-based criteria of “standard patient,” would no doubt be very worried by this process.

The statement that “additional coverage for services beyond the core package can be purchased” does not provide comfort when put alongside the following statement: “health care spending needs to be considered in the context of other societal needs and responsibilities.” The reference to “efficient use of public and private resources” presumes a constraint on all spending. As in Medicare, perhaps citizens who still have enough money to pay for the health care they want will not be permitted to spend it because the hospital or doctor is prohibited from taking it.

The recommendations claim that nearly 300 million American people share some undefined list of “values” on which a list of six “principles” were based. For example:

- Health and health care are fundamental to the well-being and security of the American people.
- It should be public policy, established in law, that all Americans have affordable health care coverage.
- Assuring health care is a shared social responsibility. This includes, on the one hand, a public responsibility for the health and security of its people, and on the other hand, the responsibility of everyone to contribute.
- Shared social responsibility implies consideration of health care costs.

We disagree. The Values & Principles section is essentially a manifesto for nationalizing the provision of medical treatment in the U.S., for setting up socialized medicine on American soil, for centralizing medical decision-making, for government seizure and redistribution of private incomes, and for federal usurping of the confidential patient-doctor relationship. We do not believe that all Americans would agree to such actions. We do not know what “values” were used, or believe all Americans share these “principles.” Thus, they should not be reported as such.
Recommendation 1: It should be public policy that all Americans have affordable health care.

First, the requirement that “health care” (undefined) be affordable implies that government will impose price controls on the provision of medical care, a proposition that assures a shortage of practitioners and limited patient access to care. Second, the CHCWG clearly understands that the financial impact of the recommendation will be enormous, citing a need for “new revenues” to include money from “enrollee contribution, income taxes or surcharges, ‘sin taxes’, business or payroll taxes, or value-added taxes.” Third, the CHCWG explicitly notes their plan to move to “universal coverage,” a euphemism for national health care.

Recommendation 2: Define a “core” benefit package for all Americans

The recommendation makes clear that rationing of medical treatment will be allowed. Core benefits will be specified according to “medical effectiveness of treatments” as determined by an unelected group of government appointees, unaccountable to the public.

CHCWG says, “Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education and treatment and management of health problems provided across a full range of inpatient and outpatient settings.” If implemented, funds for patient access to medical treatment for acute, chronic, and life-threatening diseases and injuries will be limited by the diversion of funds to wellness, prevention, patient education and management (data systems, executive salaries, bureaucratic oversight activities, etc.) Americans may not agree with such a broad definition, and we question how and why the CHCWG believes that taxpayers are responsible for funding this broad array of activities.

Recommendation 3: Guarantee financial protection against very high health care costs.

This recommendation supports increased taxation and income redistribution by government.


The CHCWG advocates for a federal “unit with specific responsibility for coordinating all federal efforts that support the health care safety net.” This recommendation calls for expansion of government-funded health care, and a likely crowd-out of private medical clinics.

Recommendation 5: Promote efforts to improve quality of care and efficiency.

This recommendation asserts that federal government can and should control the provision of all medical care—and the dollars used for securing medical treatment: “The Federal government will expand and accelerate its use of the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency while controlling costs across the entire health care system.” We disagree. Patients and doctors working together with the patient’s “skin in the game” make the best, and most cost-effective, treatment decisions for the patient. Furthermore, government quality and efficiency improvement activities have thus far focused on cost control. Millions of dollars have been diverted from patient care for the purpose of building reporting systems to send data to the government.

Recommendation 6: Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.
Central planning in health care Threatens life and limb. Given the “principles” and preceding Recommendations, we share the following concerns:

1) Could some patients be not yet “incurable” but physicians be forced by “pay-for-performance” initiatives, “quality” measures, or other financial or licensing pressures to label the patient “incurable” and thus ineligible for more aggressive treatment?
2) Despite all the words on patient choice of treatment options, it appears that the only care available to patients determined to be “incurable” would be treatment that public and private payers determine to be “evidence-based,” according to “expert consensus” and according to end of life “care models.” That care could be very limited.
3) What is the possibility that “end-of-life” care would exclude innovative, experimental, and life-extending treatments?

Conclusion
We had hoped that the CHCWG interim recommendations would support public policies in line with protecting individual freedom and ensuring cost-conscious consumers and patients rather than advocating expanded government intrusion in patient care and the practice of medicine.

However, the CHCWG recommendations favor a centrally planned health care system funded with various income redistribution schemes. Access to medical treatment, as defined in the CHCWG interim recommendations, would be limited according to the decisions of unelected, unaccountable government appointees.

We believe the proposed recommendations will hurt patients, tie the hands of doctors, limit medical innovation, intrude on the patient-doctor relationship, jeopardize the life, health, and financial well-being of all Americans—and not solve the Medicare cost crisis.

Citizens’ Council on Health Care does not believe the CHCWG recommendations are the will of the nearly 300 million citizens of the United States. Nor do we believe that the majority of Americans agree with the values & principles statement, or the plan to nationalize health care. A similar plan was opposed by both Democrats and Republicans and soundly defeated in 1994.

Our Recommendations: We recommend the CHCWG advocate market-based health insurance and medical care for all people including those age 65 and older; medical treatment free of costly bureaucratic regulations and reporting requirements; public policies that encourage personal ownership of lifelong health insurance policies to protect against the financial risk associated with treatment for chronic and catastrophic conditions, personal financial responsibility for routine and minor care, and compassionate physician- and hospital-provided charity for the truly needy.

We encourage the CHCWG to write final recommendations that provide real solutions for the Medicare cost crisis, and uphold the life, liberty, and property rights of all Americans.

If you have any questions, feel free to contact me at 651-646-8935 or twila@cchconline.org. Thank you.

Sincerely,

Twila Brase
President