

June 29, 2009

CCHC FINDINGS – President Obama Implies Support for Health Care Rationing

CCHC ANALYZED – President Obama's statements during *ABC News* health care forum, June 24, 2009

The following CCHC document provides an analysis of the statements and responses made by President Barack Obama during the health care forum televised from the East Room of the White House by *ABC News* on June 24, 2009.

The forum was titled: ***'Questions for the President: Prescription for America.'*** Along with President Obama and *ABC News* hosts Charles Gibson and Diane Sawyer, there were 164 handpicked attendees in the audience. Only 11 of the attendees were allowed to ask a question, and two others provided information when called upon. In addition, Ms. Sawyer and Mr. Gibson asked 10 questions—with several additional interruptions of the President as he spoke.

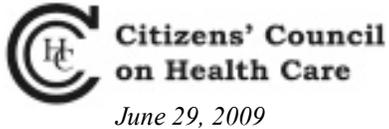
The following analysis of the President's statements and responses to questions is specific to the statements that imply or allude to health care rationing, centralized decision-making, or federal interference in the patient-doctor relationship. The following chart includes the question that was asked, the person who asked the question, the specific portion of the President's response that implies rationing and/or interference in medical decision-making—and CCHC's analysis including concerns for the reader to consider. For those who wish to read the entire transcript, the entire question, or the President's entire response, the *ABC NEWS* transcript can currently be found at <http://abcnews.go.com/print?id=7920012>.

NOTE: Certain words in the document are highlighted in bold letters to make it easier for the reader to find the language and identify the specific concerns noted by Citizens' Council on Health Care.

As a result of President Obama's statements, we also include a list of additional questions we think every citizen needs to ask the President before any national health care reform initiative moves forward.

A handwritten signature in black ink, appearing to read 'Barack Obama'.

President



President Obama Implies Support for Health Care Rationing...But Avoids Using the Word

More Questions Citizens Need to Ask the President:

- Whose 'evidence' will be used to determine 'evidence-based care'? What 'science' will be used?
- How comprehensive is 'choices of doctor'? Who are these 'experts' that will make medical decisions far from the bedside and exam room?
- When does "end-of-life" begin? Who defines 'quality' or 'appropriate care' or 'necessary treatment' or 'waste'?
- What kind of 'incentives' will be used? What kind of 'changes in reimbursement' are proposed?
- Who decides how dollars are 'reallocated'? Who defines 'adequate coverage' and 'adequate' payment?

The following statements are from ['Questions for the President: Prescription for America'](#) ABC News Transcript, televised White House health care forum, ABC News, June 24, 2009.

NOTE: This document contains sequential excerpted statements from the ABC News transcript that relate solely to proposed federal interference in medical decision-making. To read the entire question and the President's entire response to each question, please refer to the transcript.

Question Asked	Question Asked By:	President Obama's Response (Rationing-related excerpts only)	Concerns to Consider (CCHC Analysis)
<p><i>After stating that politicians in countries with national health care do whatever it takes to get the best care when their families get sick, Dr. Devinsky asked, "would you potentially sacrifice the health of your family for the greater good of insuring millions? Or would you do everything you possibly could as a father and husband to get the best health care and outcomes for your family?"</i></p>	<p>Dr. Orrin Devinsky, Epilepsy Specialist</p>	<p>"...[Y]ou're absolutely right, that, if it's my family member, my wife, if it's my children, if it's my grandmother, I always want them to get the very best care.</p> <p>"But here's the problem that we have in our current health care system, is there is a whole bunch of care that's being provided that every study, every bit of evidence that we have indicates may not be making us healthier."</p> <p>"But you don't know what that test is." (asked by</p>	<p>First, President Obama did not answer the question. Second, what exactly is this 'whole bunch of care'?</p> <p>Third, most health care services are not intended for 'making us healthier.' Most treatments are meant to sustain life, alleviate pain, heal disease, repair or improve impairments, and treat injuries.</p> <p>Fourth, does Mr. Obama really mean 'every study'? 'Every bit of evidence'?</p>

		<p>Charles Gibson, <i>ABC News</i>)</p> <p>“Well, oftentimes we do though. There are going to be situations where there are going to be disagreements among experts, but often times we do know what makes sense and what doesn’t...Can we come up with ways that don’t prevent people from getting the care they need, but also make sure that because of all kinds of skewed incentives, we are getting a lot of quantity of care, but we’re not getting the kind of quality that we need.”</p>	<p>Individuals differ in so many ways (physical, physiological, psychological, genetic, temperament, preferences, cultural, willingness to comply) that research cannot sufficiently account for all the unique differences. Studies can be conducted or reported with bias and so-called ‘evidence’ often conflicts. No study is the last word or the only word on a treatment for a unique individual. Even Mr. Obama agrees that experts disagree.</p> <p>Fifth, what does the President mean when he says ‘the kind of quality that we need’?</p>
<p>“What can you do to convince the American public that there actually are limits to what we can pay for with our American health care system? And if there are going to be limits, who is going to design the system and who is going to enforce the rules for the system like that?”</p>	<p>Dr. John Corboy, Neurologist and Medical Professor</p>	<p>“Well, you’re asking the right question. And let me say, first of all, this is not an easy problem... We should be able to design a system in which people still have choices of doctors and choices of plans that makes sure that the necessary treatment is provided but we don’t have a huge amount of waste in the system. That we are providing adequate coverage for all people, and that we are driving down costs over the long term.</p> <p>“If we don’t drive down costs, then we’re not going to be able to achieve all of those other things. And I think that on the issue that has already been raised by the two doctors, the issue of evidence-based care. I have great confidence that doctors are going to always want to do the right thing for their patients, if they’ve got good information, and if their payment incentives are not such that it actually costs them money to provide the appropriate care.”</p>	<p>The President seems to agree with the idea of limits on care and enforcement of those limits.</p> <p>The statement “We should be able to design a system” appears focused on central planning.</p> <p>When the President says ‘choices of doctors and choices of plans,’ does he mean complete and comprehensive choices—or a set of limited choices?</p> <p>The entire response, filled with undefined terms (necessary treatment, waste, adequate coverage, evidence-based care, appropriate care) speaks of outside decision-making—enforced through “payment incentives” (likely penalties) approved by the government.</p>

<p>“How do you get to the point and still assure people, as both of the doctors have asked, that their cousins, their nephews, their husbands, their wives, are going to get everything that is necessary?”</p>	<p>Charles Gibson, <i>ABC News</i></p>	<p>“...And our job in this – in this summer and this fall, in which I think everybody understands we’ve got to move in a different direction, is to identify the best ways to achieve the best possible care in a way that controls costs and is affordable for the American economy long term.”</p>	<p>This statement demonstrates intent to ration health care. The President’s phrase ‘in a way that controls costs’ conditions and limits the phrase ‘best possible care.’ People’s access to the ‘best possible care’ will be limited by cost-containment.</p>
<p><i>After noting emails from people saying Mayo Clinic is an example of why government is not needed, Ms. Sawyer asked, “Why get the government involved in something “that is being done already in the private sector and, with the right initiative and impetus, could be done in the private sector without government involvement?”</i></p>	<p>Diane Sawyer, <i>ABC News</i></p>	<p>“And, unfortunately, government, whether you like it or not, is going to already be involved. You know, we pay for Medicare. We pay for Medicaid. There are a whole host of rules both at the state and federal level governing how health care is administered. And so the key is for us to try to figure out, how do we take that involvement, not to completely replace what we have, but to build on what works and stop doing what doesn’t work? And I think that we can do that through a serious health care reform initiative.”</p>	<p>This response, rather than demonstrating a plan to deal directly with the rising costs of Medicare and Medicaid, the impending insolvency of Medicare, and rising insurance premiums as a result of cost-shifting by government onto the privately insured, demonstrates President Obama’s plan to expand federal authority, including authority over treatment decisions, across the entire health care system, including all doctors and all patients.</p>
<p>“But you say we have to figure out how to do that [stop doing what doesn’t work]. Don’t we have to do that first, figure out so people have a good sense that my medical care is going to be sufficient for me?...That’s what people are afraid of...that they’re not going to get...”</p>	<p>Charles Gibson, <i>ABC News</i></p>	<p>“Absolutely, people are afraid of it. People are concerned ---they know that they’re living with the devil, but the devil they know they think may be better than the devil they don’t. And—that’s understandable... “These things are always going to be tough politically. Let me tell you, though, that we actually do know in a lot of instances what works and what doesn’t. What’s lacking is not knowledge. We’ve been debating this stuff for decades. What’s lacking is political will.”</p>	<p>Mr. Obama did not answer the question. Furthermore, he infers that there is universality regarding what treatments work and do not work for all people. He appears ready to standardize care across the country on more than 300 million unique individuals...without their consent. The reason some have been debating this for decades is because Americans have long opposed government take-over of the American health care system, federal interference in the practice of medicine (as is now occurring in Medicare) and loss of freedom over private medical decisions.</p>

<p>“How are you going to assure the American public that medical decisions will still be between the patient and the physician and not some bureaucracy that will make decisions on cost and not really what the patient needs?”</p>	<p>Dr. J. James Rohack, President, American Medical Association</p>	<p>“Doctors are not going to be working for the government. They’re still going to be working for themselves. They’re still going to be focused on patient care. And in terms of how doctors are reimbursed, it’s going to be the same system that we have now, except we can start making some changes so that, for example, we’re rewarding quality of outcomes rather than the number of procedures that are done.</p> <p>“And this is true not just for doctors, it’s also true for hospitals. One of the things that we could say to hospitals is, reduce your readmission rate, which is also often a sign that health outcomes have not been so good. And it turns out that hospitals, when they’re incentivized, actually can find ways to do it that, every study shows, does not have adverse effects on outcomes.”</p>	<p>Mr. Obama contradicts himself in this statement.</p> <p>First he says doctors will not work for the government, but then he says doctors and hospitals will be rewarded (paid) according to government criteria (patient outcomes, which in fact often have little to do with the doctor). Therefore, doctors <u>will</u> be working for government, and according to government directives...or face loss of income.</p> <p>Using squishy language (“often a sign that health outcomes have not been so good”). Mr. Obama admits readmission may have nothing to do with outcomes. However, with payment on the line (hospitals ‘incentivized’), hospital executives may encourage doctors not to readmit patients even when the patient should be readmitted.</p>
<p>“My question to you is, outside the medical criteria for prolonging life for somebody elderly, is there any consideration that can be given for a certain spirit, a certain joy of living, quality of life? Or is it just a medical cutoff at a certain age?”</p>	<p>Jane Sturm, caregiver for her 105-year old mother who got a pacemaker at age 99.</p>	<p>“[T]he first thing for all of us to understand is that we actually have some—some choices to make about how we want to deal with our own end-of-life care... This is something that each of us individually can do, is to draft and sign a living will so that we’re very clear with our doctors about how we want to approach the end of life.</p> <p>“I don’t think that we can make judgments based on peoples’ spirit. That would be a pretty subjective decision to be making. I think we have to have rules that say that we are going to provide good, quality care for all people.”</p>	<p>President Obama makes it clear that government won’t be making ‘subjective’ (individualized, personal) decisions. Instead there will ostensibly be objective, impersonal government rules promising ‘good, quality care for all.’ Yet, in the next section, it’s clear that some people will be encouraged to have less care.</p> <p>The use of the term “we” (four times) is troubling, and points to plans for federal decision-making. It is also not clear how ‘good quality care’ would be defined.</p>

<p>“But the money may not have been there for her pacemaker or for your grandmother’s hip replacement.”</p>	<p>Charles Gibson, <i>ABC News</i></p>	<p>“Well, and – and that’s absolutely true. And end-of-life care is one of the most difficult sets of decisions that we’re going to have to make. I don’t want bureaucracies making those decisions, but understand that those decisions are already being made in one way or another. If they’re not being made under Medicare and Medicaid, they’re being made by private insurers...[W]e’re not going to solve every difficult problem in terms of end-of-life care. A lot of that is going to have to be, we as a culture and as a society starting to make better decisions within our own families and for ourselves.</p> <p>“But what we can do is make sure that at least some of the waste that exists in the system that’s not making anybody’s mom better, that is loading up on additional tests or additional drugs that the evidence shows is not necessarily going to improve care, that at least we can let doctors know and your mom know that, you know what? Maybe this isn’t going to help. Maybe you’re better off not having the surgery, but taking the painkiller.</p>	<p>President Obama agrees that money for medical care may not be available for the elderly. He says he doesn’t want government bureaucracies making end-of-life decisions, but he doesn’t rule it out.</p> <p>The reference to ‘culture and society’ making ‘better decisions’ is concerning, implying a move away from individual decisions. What exactly is a ‘better decision?’</p> <p>Mr. Obama infers that dollars spent on ‘end-of-life care’ (<i>not-defined</i>) may be wasted dollars.</p> <p>What ‘evidence’ would be used to determine that there would be no improvement in care, and how would improvement of care be defined?</p> <p>Who is the ‘we’ that ‘can let doctors know’ that a painkiller for a patient is better than surgery? This statement implies centralized decision-making.</p>
<p>“What I wanted to say was, that the arrhythmia specialist who put the pacemaker in said that it cost Medicare \$30,000 at the time. She had been in the hospital two or three times a month before that, so let’s say 20, 30 times being in the hospital, maybe going to rehab, the cost was so much more. And that’s what would have happened had she not had the pacemaker.”</p>	<p>Jane Sturm, caregiver for her 105-year old mother who got a pacemaker at age 99.</p>	<p>“Well, and that’s a good example of where -- if we’ve got experts who are looking at this, and they are advising doctors across the board that the pacemaker may ultimately save money, then we potentially could have done that faster. I mean, this can cut both ways. The point is, we want to use science, we want doctors and – and medical experts to be making decisions that all too often right now are driven by skewed policies, by out-dated means of reimbursement, or by insurance companies.”</p>	<p>Who are these ‘experts’ that are making decisions and advising doctors from outside of the exam room?</p> <p>Squishy language – use of ‘may ultimately save money’ and ‘potentially.’</p> <p>These ‘experts’ may imply a Federal Health Board that would use their version of ‘science’ to provide doctors with government-issued treatment directives.</p>

<p>“In light of this proposed health care reform and national health care system, I have many concerns. One of them is the big—is the big brother fear. How far is government going to go in reference to my personal life and health care treatments? And then, secondly, how and who will pay for the national health care system?”</p>	<p>Christopher Bean, Allint Tech Systems Human Resources Department</p>	<p>“We’ve been sort of circling around your first question, the whole big brother fear. What kind of insurance, Chris, do you have right now?...So if you’re happy with our plan, as I said, you keep it...[T]here are going to be some areas where we want to regulate the insurers a little more...“What I’ve said is, let’s change the system so that our overall cost curve starts going down, by investing in a range of things, prevention, health I.T., et cetera. We will have some upfront costs, and the estimates, as Charlie has said, have been anywhere from \$1 trillion to \$2 trillion...</p> <p>Now, we’ve put forward some specific ways of paying for...health reform...About two-thirds of the cost would be covered by reallocating dollars that are already in the health care system, taxpayers are already paying for it, but it’s not going to stuff that’s making you healthier...</p> <p>“[This] doesn’t count the savings that <u>may</u> come from prevention, <u>may</u> come from eliminating all of the paperwork and bureaucracy because we have put forward health IT. It doesn’t come from “evidence-based care and changes in reimbursement that I’ve already discussed about. And the reason is, is because the Congressional Budget Office, the CBO, which sort of polices what our various programs cost, they’re not willing to credit us with those savings. They say, that <u>may</u> be nice, that <u>may</u> save a lot of money, but we can’t be certain.</p> <p>So we expect that not only are we going to be able to pay for health care reform in a deficit-neutral way, but that it’s also going to achieve big savings across the system, including in the private sector where the [CBO] never gives us any credit.</p>	<p>Mr. Obama did not answer the ‘big brother’ question.</p> <p>Furthermore, Mr. Obama reiterated the promise that a person will be able to keep their health plan, which news accounts say he had already backed away from.</p> <p>Mr. Obama’s budget director, Mr. Peter Orszag, admitted in 2007 that health I.T. does not save money... unless it is used to monitor patients and analyze physician compliance with government-imposed treatment protocols for the purpose of imposing payment reform (financial penalties).</p> <p>Mr. Obama discusses reallocating health care dollars and claims that current dollars are “not going to stuff that’s making you healthier.” Thus, he implies a plan to centralize decisions over the use of these health care dollars. However, by not defining ‘stuff,’ he does not make it clear what care would no longer be available that is being provided to patients today.</p> <p>Mr. Obama is not sure there will be savings (‘may’), but claims ‘big savings’ anyway. He also plans to use payments to doctors (‘changes in reimbursement’) to secure physician compliance with government-issued treatment protocols, which will likely be labeled as “evidence-based care.” Expect financial penalties for the non-compliant practitioner.</p>
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<p>“I want to go back to how we pay for the expansions. Estimates, as you indicated, probably \$1.5 trillion to cover everyone. You mentioned savings in Medicare and Medicaid, \$500 billion to \$600 billion, from the numbers you’ve provided. Another \$300 billion from additional revenue. That leaves about \$300 billion to \$600 billion more. What do we do in ways that CBO will count so that we can actually get everybody covered?”</p>	<p>Gail Wilensky, Senior Fellow, Project HOPE, former Medicare director under President Bush</p>	<p>“That’s the challenge...This is not an easy problem, and it’s especially not an easy problem when the economy is going through a difficult phase...But the one thing I’m absolutely confident about is that, whenever this country has met a significant challenge to our long-term well-being, that we ultimately rise up and meet it. And this is one of those moments where the stars are aligned...But we have to have the courage and the willingness to cooperate and compromise in order to make this happen.</p>	<p>Mr. Obama’s use of the phrase, ‘willingness to cooperate’ is troubling and has the feel of coercive government power behind it.</p> <p>Since Medicare already poorly reimburses physicians and hospitals, and many doctors are now refusing to take more Medicare patients, and the babyboomers will begin entering Medicare in 2012, how does Mr. Obama expect to save \$500 – 600 billion in Medicare and Medicaid?</p>
<p>“You keep saying, if you have what you like, you can keep it, but if your employer goes over to the government program, maybe you can’t keep what you have.”</p>	<p>Charles Gibson, <i>ABC News</i></p>	<p>“...I think there are some legitimate questions in terms of how the public option is designed. One thing I have to say, though, is, it’s not an entirely bad thing if, as long as they’re reimbursing doctors in a adequate way, and—and—and so not being oppressive on – on health care providers...if the public plan can do it cheaper and provides good quality care, that’s the competition that we talked about.”</p>	<p>Medicare does not currently reimburse doctors in an ‘adequate way.’</p> <p>If most of the privately insured public move into the public option plan as predicted by The Lewin Group (70%), and payment to doctors remains similar or is reduced (Obama’s plan to cut Medicare/Medicaid by \$500 - \$600 billion) the public can expect a growing shortage of physicians and significant limits on patient access to medical treatment.</p> <p>Also, exactly how is ‘good, quality care’ defined, and by whom?</p>

<p>“I am concerned that – of the government taking over health care. And, you know, Social Security isn’t— isn’t doing real well. At least that’s what we’re being told. And how can we know that the government is going to be able to handle the cost of health care? Isn’t that going to tax me? Isn’t it going to be taxing my benefits, those kind of things?”</p>	<p>Pastor David Hattenfield, Cornerstone Baptist Church</p>	<p>“I think it’s a very legitimate question. I guess that the first point I’d make is, if we don’t do anything, costs are going to go out of control... And at the pace at which [Medicare and Medicaid are] going up, if we don’t do some of the things that we’ve talked about tonight, you know, changing how we pay for quality instead of quantity, making sure that we are investing in prevention, all those game-changers that I discussed earlier, if we don’t do those things, Medicare and Medicaid are going to be broke...</p> <p>“Point number two is that a lot of what we’re talking about is reallocating existing health care dollars that are not being spent wisely. And almost everybody agrees that there is a lot of room for use to improve how we’re spending existing healthcare dollars.”</p>	<p>Many studies find that prevention increases costs. In addition, dollars paid for prevention could mean fewer dollars available to care for the ill and injured.</p> <p>What if a patient’s medically necessary or preferred ‘quantity’ of care is no longer considered ‘quality care.’ Who decides, and what happens to patients if the doctor is no longer paid for anything not labeled by government as ‘quality’?</p> <p>The plan to reallocate existing dollar speaks to centralized decision-making over health care dollars, and what is defined as spending ‘wisely.’</p>
<p>“An observation would be, if you’re successful in getting rid of some of that 30 percent of unnecessary care, you’re going to dislocate a lot of people. Now, some of them are criminals committing fraud; they ought to go to jail. But a lot of them are real people with real jobs. Why not right now start talking about retraining these people for primary care jobs, nurse practitioners, physician assistants?”</p>	<p>Tim Johnson, M.D., ABC News</p>	<p>“[I]f you’re going to change the health care system over time, then to be very specific, the amount of person power that goes into billing, administration, all the things that we hate about the health care system, even though those are wonderful people who are doing great work, they’re over time hopefully going to be moving into the actually providing care side of the health care industry as opposed to the bean-counting side of the health care industry...</p> <p>“And the last point I would make is, we’ve got an aging population, so we know that health care is still going to be a growth industry. And that’s not an entirely bad thing. As societies get older, we spend a certain larger portion of our overall income on health care. And that’s OK. We just don’t want to spend it badly and in a way that bankrupts the entire economy. And that’s why we need the changes that I’ve discussed.”</p>	<p>Mr. Obama’s entire plan suggests more centralization, and thus more paperwork and administration, not less. That said, the health care professions typically require a very different personality type than that of an accountant or someone in health plan management (“bean counter”). Even if bureaucracy were reduced, it is not likely that the managers and accountants of today would choose to become the health care professionals of tomorrow.</p> <p>Thus, these assertions of job transition and reduced administration are not realistic.</p> <p>Finally, who defines ‘spend it badly’? This statement speaks to a plan for centralized control over all health care dollars, ostensibly to protect ‘the entire economy.’</p>