The National Healthcare "Debate"

Greed, Fear of Death, and a Vermont Alternative?

Thomas Naylor

Issue no. 32 • Stick Season 2009

Claims that the U.S. healthcare system is broken are by no means exaggerated. The United States has far and away the most expensive healthcare delivery system in the world. Our empire spends more than $2.5 trillion annually on healthcare, averaging more than $8,000 per person. Spiraling increases in the cost of health insurance impose an almost unbearable burden on employers and employees alike, as well as state and local governments. The possibility of the American healthcare system bankrupting the U.S. economy cannot be ruled out.

But contrary to what we have been told by President Barack Obama, Senator Bernie Sanders, and other big-government-spending politicians, there is no national fix to the United States' healthcare problems. First Lady Hillary Clinton inadvertently discovered this the hard way back in 1994 with her abortive attempt to sell Congress on a national healthcare system. She demonstrated conclusively that such a system was not politically feasible. Unfortunately, she did not appreciate the fact that a national healthcare system for 320 million people was beyond the scope of human possibility. Stated alternatively, no one knows how to design such a complex system.

The fundamental problem underlying the United States healthcare system is neither an economic nor a political problem, but rather a philosophical problem. In short, the U.S. healthcare system rests perilously on two principles: fear of death and greed. The demand for healthcare services in the United States is driven by our inordinate fear of death. We neither know when to die nor how to die, and few physicians are very helpful to us in dealing with these questions. The supply of healthcare services, on the other hand, is driven by the greed of providers, hospitals, pharmaceutical companies, and health insurance companies. When human greed exploits the fear of death, there is no limit as to how high healthcare prices can rise. For those who are fortunate enough to have good health insurance, the message is, "You deserve the best medical care money can buy, because you are entitled to live forever." So say physicians and pharmaceutical company television advertisements.

Those with good health insurance have access to a plethora of very expensive, high-tech medical services, including magnetic resonance imaging, ultrasound, nuclear diagnostics, complex multiorgan transplants, coronary-bypass surgery, artificial kidney machines, death-defying prenatal procedures, genetic enhancements, and gene splicing. Antiaging clinics offer everything from yoga, meditation, and mind-body medicine to growth hormones, sex hormones, melatonin, herbs, potions, and elixirs to delay the aging process. But to little avail. Joel Garreau's book, *Radical Evolution*, reports on a new breed of scientists who believe that advances in genetics, robotics, information technology, and nanotechnology will allow us to improve our intelligence, reinvent our bodies, and even become immortal. This new field of medicine is known as "transhumanism."

There are dozens of drugs and high-tech medical devices and procedures claiming to prolong life. We have become accustomed to an endless series of announcements on the evening television news reporting major breakthroughs in the cure of this ailment or that, only to be followed by a retraction six months later warning of risky side effects or questions on the efficacy of the drug or procedure. By widening the boundaries of illness and lowering the threshold for treatment, pharmaceutical companies have created millions of new patients and billions of dollars in profits. By exploiting our

fear of disease and death, pharmaceutical companies have redefined mild problems and common complaints to serious illness and medical conditions requiring drug treatments.

So strong is the fear of death that it's not unusual for the wealthy who are terminally ill to spend their last months either on the Internet or flying from one medical center to another in search of a physician, a medical school, an unproven drug or medical procedure, or a high-tech silver bullet that will forestall the grim reaper for a few more months. The problem is that the number of options available to the terminally ill patient is often completely overwhelming. How does one cope with so many alternatives? Is this any way to live or die? Vermont writer Garret Keizer refers to this phenomenon as "physician-assisted eternal life: the desire of the old to avoid death at any cost, especially if the cost can be passed on to another generation." But at the lower end of the income level, it's quite a different story.

The problem with national health insurance is what I call the "I've got mine, Jack" syndrome. Elderly patients who have paid their monthly premiums feel they are entitled to the best healthcare money can buy. They never think about the effect that a $100,000 hospital stay will have on other people's premiums. It's all about looking out for number one. Indeed, it's not uncommon for a senior citizen to boast after receiving notice of a large hospital bill paid by Medicare, "I'm really getting my money's worth." No wonder Medicare is almost broke.

To promote its cause the Alzheimer's Association recently issued a press release with the provocative headline, "10 Million U.S. Baby Boomers Will Develop Alzheimer's Disease." Virtually all of the attention bestowed on AD by the medical profession, academic researchers, and the National Institutes of Health treats this situation as though it were purely a medical problem: All we need do to cure AD is identify the gene causing the problem and then find a chemical compound to allay the effects of the troublemaking gene. Apparently it has never occurred to anyone that AD may simply be the body's way of protecting those whose lives have become meaningless from the despair associated with prolonged life. AD may, in fact, be a way of taking them out of their misery. Not only may there be no cure for AD, but even if there were a cure, what would be the psychological, social, and moral consequences of administering it?

Notwithstanding the predominance of Christianity in the United States, with its adherence to the belief in life after death, our culture promotes a Darwinian, survival-of-the-fittest attitude with regard to the extremes to which we are prepared to go to prolong our own individual lives. It matters not how much of society's scarce healthcare resources are consumed by prolonging my life for a few more months or years. I am the center of the universe. The rest of the world be damned!

Regardless whether a national healthcare system is publicly financed or privately financed, if it is driven by the confluence of greed and the denial of death it will be unstable and financially unfeasible. Any healthcare system that does not confront the moral, ethical, economic, and political implications of fear of death and greed represents an exercise in utter futility.

Obamacare is no exception to the rule. Not only is it too big, too complex, and too high-tech, but it tries to be all things to all people. Even if the Republicans in Congress do not bring it down, it's only a matter of time before it implodes. In a similar vein is the so-called single-payer healthcare system endorsed by the Vermont legislature—a health care system that will probably never see the light of day. Neither the governor nor the members of the legislature have a clue as to how much it will cost or how it will be financed. It's pure pie in the sky. No one in Montpelier ever mentions fear of death or greed.

For any healthcare system to stand a chance of working it must be highly decentralized so that patients, physicians, clinics, hospitals, and insurance providers are in community with one another. To be quite blunt, if I decide to have a nice $100,000 open-heart surgery performed on me, I must be prepared to face the other citizens in my community, who know I have spent $100,000 of the community's healthcare resources on myself. There must be a feeling of, "We are all in this together." My life may be important to me, but I am a part of a community in which others want to

share in the pool of healthcare resources. Resources are finite and must be rationed by the community.

The Swiss healthcare system, unknown to most Americans, comes very close to achieving this ideal. The Swiss government requires everyone to purchase health insurance with their own money from one of 400 Swiss health insurance funds, some of which are private, others public. If individuals cannot pay for health insurance, then most Swiss cantons transfer funds to them. Ninety-five percent of the population is insured against illness. The delivery of healthcare services is decentralized to the canton or town level. The Swiss healthcare system works, and it works very well, as evidenced by Switzerland's high life expectancy and low infant mortality rates. Swiss healthcare is second to none. What are the lessons to be gleaned from the Swiss healthcare experience?

1. Single-payer health insurance may not be the panacea it is thought to be.
2. Whenever possible, healthcare insurance and the delivery of healthcare services should be decentralized to the community level, where the community might be a town, a country, a village, or a region in a state like Vermont.
3. With healthcare, as with other things, bigger may not be better.

My favorite hospital is the tiny nineteen-bed Grace Cottage Hospital located in Townshend, Vermont. Thanks to a very generous and supportive community, which includes devoted patients, committed volunteers, an amazingly talented, compassionate, and hardworking staff, and wonderful benefactors, Vermont's smallest hospital will soon celebrate six decades of saving lives, caring for the sick, helping those who are dying, and encouraging those who are well to stay that way. It's the Vermont way of living, staying well, and dying.

The United States could learn much from Vermont and Switzerland.