The Debate on HealthCare Policy Reform – an exercise in Pseudo-Journalism

Dateline: June 21, 2009
ChokepointMedicine.blog.com

The American healthcare system is failing all of us in one-way or another. While we spent an average of $7,900 for every person living in the US in 2007, or 16.4% of our total Gross Domestic Product (GDP) on health care, every other developed country spends far less per person, has better outcomes and devotes only 9% to 12% its GDP to healthcare. As an insider in the health care field, I'm all too familiar with the problems in our current system – poor quality, unproductive expense, lack of access, etc. I also know that a wealth of definitive information is just waiting for someone to connect up the dots. This is the only way the public and the policy-makers can understand what makes our current system so dysfunction and why doing more of the same won't fix it.

So far this week I've heard a dozen different speeches and interviews on the pros and cons of national health insurance. According to the political pundits, the next four weeks are critical to the success or failure of the administration's plan for legislative reform. Media coverage is plentiful and includes persons of great influence: no less than President Obama himself, elected officials, popular talk-show hosts, and highly-respected healthcare experts. Unfortunately, this mile-wide coverage is only 1/8th of an inch deep, with the most vital facts are consistently absent from the public discourse. This leaves citizens with no reliable source for factual information of the *quality* necessary to make important personal or political decisions.

"When you don't know where you're going, every road takes you there."

Policy decisions this important should be the subject of hard-hitting investigative journalism. But the corporate structure of newspaper journalism is so tied to advertising revenue that controversial topics are an economic liability. Given the years-long lead-time of the publishing business, books about current events rarely make it into print while their content is still hot. The present crop of books on health care reform was published during the Bush administration. What we need is the quality and quantity of investigative journalism that would allow us to formulate a rational national policy. What we are getting instead is pseudo-journalism -- what looks like public-spirited efforts to inform the electorate is little more than infotainment or dumbed-down journalism – speakers are failing to do their home work or pulling their punches for some reason.

Pseudo-Journalism and the Information Gap

Many people believe they already know all they need to about health insurance reform. Public dissatisfaction is widespread, many businesses can no longer afford to cover their employees and the administration has a voting majority in the Congress that supports incremental reform. People expect these favorable conditions to generate an overwhelming political momentum that will prevail where earlier attempts by Presidents Roosevelt, Truman, Carter and Clinton all failed. But the political and financial matrix of organized medicine, investor-owned corporate medicine, lobbies for big pharma and 1,300 private health insurance companies have hired the same PR firm that produced the Swift Boat ads during the 2004 presidential campaign. They have already started the 2009-version of the "Harry and Louise" media blitz used to kill the Clinton administration's health care bill. None of the usual sources of public discourse, including the administration, have been able (or willing) to provide factually-rich background information on health care policy reform. For ardent supporters, this is not such a problem. But for many others, the gap in understanding will be left to the special interest groups to fill.

This makes fear mongering easy, as so few people have the necessary facts to correct misinformation or disinformation. Confusion is the surest way to sabotage democracy.

A One-Minute Primer on the History of National Health Insurance and Organized Medicine

Five times in the 20th century a plan for universal health insurance has been introduced and five times it has been killed by organized medicine and its economic allies. The current the plan is to use this same wellspring of might and money to stop the 2009 proposal for a non-profit health insurance legislation.

Since 1901, the single most important social and political influence in American health care has been the American Medical Association. The Association has had permanent offices in Chicago since 1905 and in Washington, DC since 1943. By framing the issue of medical practice as too complicated for the 'lay public' to understand and to crucial to be trusted to a democratic process, the AMA was able to convince the public and the Congress in 1910 that it was in the public interest for the medical profession to control the health care system. Functionally-speaking, the AMA represents a third rail of government.

In 2007, the sale of advertisements in the *Journal of the American Medical Association* (JAMA) and ten AMA-owned professional journals topped $289 million, with a net income of $50.3 million and income growth of 99.6%. In addition to ad revenue and subscriptions to professional journals, the AMA also sells malpractice insurance, collects membership fees from its 240,000 MD-members and receives grants money from corporate sponsors. As of 2007, it had a staff of 1,121 full-time employees. As a private corporation, their website describes itself as "one of the biggest and wealthiest lobbies" in the US. With the extensive political and economic resources available to the AMA, its ability to *promote, control or defeat government policy or legislation* is unparalleled.

Given this depth and breadth of resources, it's no surprise that the Association has achieved its insurance-related legislative goals 95% of the time – 1920, 1933, 1948, 1976 and 1993. Equally important, they got a self-serving provision inserted into the only major piece of legislation in the last hundred years to pass in spite its opposition – the 1965 Medicare bill. At the AMA's insistence, a cost plus-fee-for-service reimbursement scheme was added to Medicare, thereby turning a potential defeat into an economic bonanza for the business of medicine.

Due to AMA influence on the Medicare legislation, medical providers retained their unbridled control over all treatment decisions – the number and kinds of tests ordered, drugs prescribed, medical and surgical procedures performed. This gave physicians and hospitals absolutely no reason to use cost-effective practices, since they self-defined the cost of care and billed Medicare for whatever amount they considered 'customary', plus setting professional fees for their services. Cost-plus-fees is a straightforward economic incentive to do more tests and procedures (i.e., billable units), and refer more patients to specialists, who are paid nearly twice as much as primary care providers.

In contemporary time, this costly 1965 Medicare provision has been modified somewhat to reign in its most egregious excesses, but not nearly enough to keep the mounting number of retired baby-boomers from crashing the system. Unless corrected, the inevitable result will be insolvency. Another contemporary example of what happens when health policy and legislation are controlled by corporate medicine and big pharma is the 2003 prescription drug bill. This legislation explicitly prohibits Medicare-Medicaid administrators from negotiating drugs prices –something the US military and Veterans Administration has always done -- even though these purchases are

being paid for by US tax dollars. Not even the Pentagon has this sweet of a deal.

A Study in Contrast: According to the US Bureau of Labor Statistics, General Motors was the country's largest employer in 1960s and1970s. Sometime during the mid-1980s, health care took over as our largest industry. By 1993, the cost of health insurance for GM's employees added $700 to the price of every car and truck. In 2005, GM's yearly spending on health care was $**5.3 billion** for its 1.1 million workers, families and retirees – slightly more than $5,000 for every GM-insured person. This added $1,525 to the price of every vehicle the company builds in the United States. GM's largest competitor, Toyota, spends only $97 on workers' healthcare for vehicles built in Japan. [A Second Opinion; Arnold Relman, MD]

As could be predicted, the healthcare industry is thriving. With a projected 22% increase in its work force over the next decade, health care is one of the few growth industries in the US, along with banking and financial services. Meanwhile, GM was grateful for a government bailout in the fall of 2008 and was forced into bankruptcy by May of 2009.

National Healthcare Policy 2009: If health care policy reform is to prevail in 2009, it must win against these same special interest groups -- organized medicine, investor-owned corporate medicine, big pharma, 1,300 health insurance lobbyists, plus the US Chamber of Commerce. Unless people know the facts, the Obama administration will have a better chance of getting the National Rifle Association to cooperate with banning assault weapons or getting Wall Street bankers to give up usury levels of interest and executive bonuses.

What American should (but don't) know about health care in the US:

Exactly what kind of 'status quo' is this medical dynasty fighting so hard to preserve and protect? Certainly not one that is either cheaper or safer!

The Facts ~ Quality of Care: The US spends **50% more** than any other country in the world, and yet we rank a lowly **19th in preventable mortality.** An estimated 100,000 Americans die prematurely each year due to inadequate or inappropriate care; an additional 100,000 people die from medical errors & hospital-acquired infections, and 20,000 more men, women and children die needlessly because they didn't have health insurance – that's nearly a quarter of a million unnecessary deaths.

On September 11th, 2001, the loss of 3,000 American lives was seen as a tragedy of such magnitude that we went to war to be sure it didn't happen again. However, every year we quietly accept a death toll from a broken health care system that is 73 times greater than the 9-11 disaster. In the eight and half years since, almost 2 million Americans --1,870,000 to be exact -- have died from toxic healthcare system syndrome. One of those fatalities was a highly-trained health professional and close friend of mine for 30 years. My colleague was the victim of a treatable condition that made health insurance *unavailable* to her. Without access to the necessary medical care until it was too late, she died tragically and unnecessarily, one more statistic in the collateral damage of a health care system that is neither healthy nor caring.

The US vs. HC in other developed countries: Compared to Australia, Canada, Germany, New Zealand and the UK, the United States ranks last, or next-to-last, on quality of care, access to care, efficiency, equity, and healthy lives. Measuring 37 different parameters, with a possible 100 points, the **U.S. scored only 65**. Its overall performance *did not improve* from 2006 to 2008. The Commonwealth Fund's *National Scorecard* on health care performance for 2008 found "disturbing" evidence that the health system is performing worse than two years ago in nearly every category measured. Authors of the *National Scorecard* used words such as "squander" to describe an *unconscionable level*

of wasteful care, inefficient systems, failure to treat preventable conditions and unproductive spending, especially on administrative costs. Poor quality included:

- ❖ Avoidable hospitalizations
- ❖ Inappropriate, wasteful, or fragmented care
- ❖ Disproportionately expensive administrative costs
- ❖ Illogical variations in quality and cost of treatments
- ❖ Failure to make appropriate use of new information technology

"Without a new national policy, millions more U.S. residents are on a path to becoming uninsured or under-insured. … Rising costs put families, businesses, and public budgets under stress, **pulling down living standards for middle as well as low-income families**". [National Scorecard – 2008]

They estimated that lowering administrative costs for insurance could **save up to $100 billion a yea**r. According to the *National Scorecard*, if the U.S. health system achieved the benchmark levels of performance identified in other cost-effective systems, it would produce measurable benefits in terms of health, patient experiences, and money saved. For example:

- ❖ **100,000 fewer people would die** from causes that could have been prevented by good care.
- ❖ **Save** an estimated **$102 billion per year** if the US achieved the levels of the best performing countries.
- ❖ **Save $51 billion a year** by lowering administrative costs of health insurances to the level found in Germany which, like the U.S., has a **blended public–private health system**.
- ❖ **Save** at least **$12 billion a year** by reducing readmissions or reducing hospitalizations for preventable conditions for the Medicare patients

Maternity Care for Healthy Women:

The economic impact of maternity care for healthy women with normal pregnancies (70-80% of total childbearing population) accounts for 25% of our national health care budget or 4% of the GDP. Maternity care is the #1 occasion for hospitalization and the largest category of expense for both private insurers and the federal Medicaid programs. Hospital charges for mothers and babies far *exceed any other condition*. [Milbank Report: *Evidence-Based Maternity Care*, 2008] This money mainly pays for the routine use of obstetrical intervention on healthy women. Recent surveys of birth practices in the U.S. identified a 99% medicalization rate, with an average of *seven* medical and surgical interventions per new mother. For seven out of new mothers, childbirth included a major surgical procedure – episiotomy, instrumental delivery or Cesarean section. [Listening to Mothers Survey, 2002, 2006, www.ChildbirthConnection.org] The US is currently spending 3% of its total GDP to unnecessarily medicalize a healthy population, while those with life-threatening medical needs continue to go untreated.

Cesarean surgery is the number one operating room procedure in American hospitals – 1.3 million a year – equal to the number of students that graduate from American colleges every year. Today, the Cesarean surgery rate in the US is 31.4% -- *triple* the evidence-based rate -- with no additional reduction in either maternal or newborn mortality. Because of this or in spite of it, maternal death rates in the U.S. were higher than in 33 other countries in 2005 and have risen the last 3 years in a row. In 1977, the maternal mortality rate (MMR) was 10 deaths per 100,000; in 2007, MMR was 14. Despite the increase in maternal deaths, many in the obstetrical profession are promoting scheduled elective C-sections as the new standard of care for healthy women. Elective Cesarean delivery is associated with a **3.5 fold increase in maternal mortality**. ["*Postpartum Maternal Mortality and Cesarean Delivery*" Catherine Deneux-Tharaux, MD, MPH, *et al*; 2006]

$$$ Healthcare Cost and its Consequence

In 2007 Price-Waterhouse-Coopers estimated that $1.2 trillion dollars of the $2.2 trillion spent on US health care was wasted – that's 55 cents of every dollar. The Commonwealth Fund's *2008 Scorecard on Health Care Performance* warned that: "…. **the U.S. health system is on the wrong track**." Spending more money is not the answer. An important study reported a negative relationship between the amount of money spent on health care and its outcomes – *more money* was associated with higher use of Rx drugs and procedures and *poorer outcomes* as measured by morbidity, mortality and cost-benefit ratio.

Catching-up on half a century: Health care costs in 1950 were about 4 percent of the GDP. In 1966, the year Medicare and Medicaid went into effect, it was about 5.5 percent. By the early 1970s it had risen sharply to 7.2 % ($69 billion) as a result of the cost plus/fee-for-service billing in the 1965 Medicare legislation. This sudden increase in cost was seen as an economic "healthcare crisis" which generated Herculean efforts to hold the line. Despite this, costs continued to increase and by 1980 were 9.4% of GDP ($230 billion). The medical sociologist and author Paul Starr described this explosive growth in health care cost in his 1982 book *The Social Transformation of American Medicine* as something that "… cannot be indefinitely sustained, regardless of the administrations in Washington; other sectors of the economy will not support it".

But apparently the other sectors of the economy were helpless in the face of this run-away freight train. According to the Bureau of Labor Statistics, the fastest growing occupations are concentrated in the health care industry. By 1998 health services became larger in GDP terms than *the entire federal government*. Per capita healthcare spending increased 28-fold between 1960 and 1998 and as of 1998 was 4.3 times the amount spent on *national defense*. By 2007, total HC expenditures in the US were $2.2 trillion, or nearly 17 % of GDP. Spending is expected to reach $4.3 trillion or 20 % of GDP by 2017. By comparison, health care spending accounts for only 10.9 % of GDP in Switzerland, 10.7 % in Germany, 9.7 % in Canada and 9.5 % in France, [National Coalition for Health Care - nchc.org]

A prime example of the irrationality of our system is the way the US regulates and prescribes drugs. According to a paper published in October 2008 in the *Archives of Internal Medicine*: "FDA approval does not require that a drug be compared with alternative treatments; it only has to be safe to use and better than a placebo. Nor ... does a pharmaceutical company have to show that a drug's effectiveness justifies its price." More Bang for the Buck? Randall Stafford, MD PhD, Stanford Prevention Research Center; funded by the Agency for Health Research and Quality; published in the Archive of Internal Medicine 10-27-2008]

Health Insurance: For-profit insurance companies spend **15% to 30% of total premiums** on administrative costs (overhead plus advertising, executive salaries and bonuses), versus just ***3%*** for the Veteran Administration and Medicare. This per capita spending on administrative costs is six times more than economically-similar health care systems in Western Europe. A significant part of the unproductive cost for the 1,300 private insurers is spent cherry-picking healthy adults, while denying coverage to those who have genuine medical needs.

Workplace Disincentives: For employers, the fastest growing business expense is health insurance, which was projected to overtake profits for many businesses by 2008. On average, premiums for employer-sponsored health insurance in the United States have been rising four times faster than workers' earnings since 1999. Average employee contributions to company-provided health insurance have increased more than 120% since the year 2000. In 2008, the employer-paid premium per year for a family of four was $12,700. If administrative costs for private health insurance are figured at the median rate, approximately

$2,600 of that premium was administrative costs. For a government-administered insurance plan or **not-for-profit coverage** co-op group, the cost would be approximately **$377**.

Bankrupting the Insured: Two of every five Americans reported problems paying medical bills, up from 34% just two years ago to 41% in 2007. More than 50% of all bankruptcies in the US are the result of overwhelming medical debt. According to a Harvard University study, 68% of those who declared bankruptcy had health insurance. About 1.5 million families lose their homes to foreclosure every year due to unaffordable medical costs. [www.NCHC.org] Since hospitals routinely bill insured patients at inflated rates ($24 for an aspirin) in order to cover the hospital's losses for uninsured patients who can't pay, medical bankruptcy is a form of double jeopardy. This Alice-in-Wonderland system is sending insured individuals into bankruptcy as a way to subsidize the uninsured.

Double jeopardy for the Uninsured:
Hospitals are still permitted to bill *uninsured* patients at hugely inflated rates in many states. A $9,000 reimbursement for normal birth when billed to an insurance company becomes a $32,000 debt when billed to an uninsured family. This occurs because uninsured patients are not protected by an insurance company's ability to negotiate a cap on payments for a specified form of care. If uninsured patients can't pay, their delinquent account is turned over to a collections agency, putting medically-indigent patients at risk for also having their credit ruined, making it harder to get or keep a job or qualify for rental housing.

Physicians: Physicians are the only health care professionals broadly licensed to perform or order medical, diagnostic and surgical procedures, thus exerting the greatest influence over the allocation of healthcare resources of any entity in the system. Of the 13,621 health care occupations, payments to physicians accounted for 20% of the total healthcare expenditure in 1998. At that time, there were some 427,000 active physicians in the United States; by 2006, the number was 633,000. Based on national population, *the availability of practicing physicians increased* from 190 doctors per 100,000 people in 1980 to 268 doctors in 2000, which is *one doctor per 373 people*. [Ref # 25]

Corporate Medicine: Investor-owned, for-profit hospitals and out-patient clinics prescribe twice as many drugs, do twice as much lab work, order twice as many diagnostic tests (including high-ticket items such as MRIs) and use twice as many medical treatments and surgical procedures on each patient as their not-for-profits counterparts. This also doubles the rate of medical errors and hospital-acquired or drug-resistant infections. However, investor-owned nursing homes and kidney dialysis units (2/3s of all dialysis) are paid by diagnostic code and so improve their profit margin through cost-cutting measures, such as a much smaller and less-educated staff and re-use of materials. This propensity for under- and over-treatment reflects decisions to put profits before patients and contributes to a 20% increase in mortality in investor-owned facilities. [A Second Opinion; Relman, MD].

Deregulation and Privatization: The most corrosive influence on healthcare in the late 20th century was the deregulation and privatization of hospitals in the 1980s and redefining medical care as a for-profit business. This led to the buy-out of small or non-profit hospitals by conglomerates, replacing local control with national hospital chains. By law, the prime directive of the corporate practice of medicine (or anything other business) is its fiduciary responsibility to shareholders and quarterly profits. In pursuit of these goals, investor-owned facilities and service-providers market themselves as a superior provider of safe and effective health care, while making treatment decisions based on *profit-value to the system* rather than *therapeutic value to the patient*. Corporate medicine enjoys the benefit of government regulation when it prevents others from stealing it its assets or engaging in

anything it deems to be 'unfair' competition, while it simultaneously rejects any form of regulation that would protect the vulnerable population it serves (the ill, injured and elderly).

Professionalism vs. commercialism: A recent example of how medical decision-making is influenced by a business agenda – in this case, hospitals and big pharma – revolves around the prescribing of Rx heartburn-indigestion drugs (Prilosec, Nexium, etc). Between 50-70% of all hospital patients, regardless of admission diagnosis and without any history of ulcers (including nearly half the babies in the NICU), are being given these expensive drugs. Unfortunately, patients receiving these drugs suffer an increased rate of pneumonia. Both drug companies and hospitals profit from the drug's administration (hospital patients are billed the each time a drug is dispensed) and profit *again* from the prolonged and more expensive treatment required by patients who contracted pneumonia. [NPR June 2009]

The Marriage of Authority-based Medicine and Investor-owned Corporate Medicine

Authority-based Medicine: The legal and practical configuration of medicine has not changed since medical licensing laws were first passed in the 19th century, which is to say, it is an authority-based profession and the only one to enjoy "unlimited" licensure. Their legal scope of practice includes "all mental and physical conditions". Instead of medical practice being governed through legislature or a national set of scientific principles, all treatment decisions are made by members of the profession. Authority-based medicine rests on the principle that only a medical doctor is qualified to make the decisions involved in providing health-related care. Only those who have satisfactorily completed a standardized medical training can qualify for licensure and only licensed MDs can legally make a diagnosis for a particular patient, determine which tests are appropriate, prescribe drugs, order x-rays, and penetrate or sever human tissue (i.e., surgery). Doctors stand at the top of the chain of command -- they give orders, other carry them out.

Evidence-based Practice: In an age with instant access to scientific data via the Internet, this comes as a surprise to many. It is widely assumed that all aspects of medicine are "evidence-based", that is, every action of every MD represents the "best practice" as defined by the scientific research. Unfortunately, evidence-based medicine is actually much more limited than most people realize. The bulk of medical research is very narrowly focused – a particular cholesterol-lowering drug will be contrasted to one made by a different company or given in a different dose, or a new surgical technique will be contrasted to an older one. This kind of research compares a few similar drugs or treatments against each other, and then provides a scientific opinion as to which of the small number of options is the evidenced-based or 'best' choice.

Mostly this research does not factor in cost-effectiveness. A large number of the original studies in the meta-analysis that constitutes the 'evidence' used for EBM recommendations were actually paid for by drug companies or other special interest groups. This may explain why researchers generally don't pursue studies that compare a particular medical treatment for a specific condition to non-treatment for that condition, or compare conventional medicine to non-allopathic methods of care. There is no money to be made in therapeutic methods that do not directly relate to a conventional product or professional service, so the idea of EBM breaks down when it come to overarching principles of practice.

How to tell the difference between authority-based medicine and evidence-based practice: Evidence-based science informs a physician's choice *between* two different drugs, while authority-based medicine grants him or her the right to decide whether to or not prescribe drugs and once a drug is chosen, how much of it to give and how long it

should be taken.

Physician Preference – the decider of all things medical

Unlimited Licensure: By design the unlimited status of licensure as an MD grants physicians the unmitigated authority to control over every facet of a patient's care in the same way that parental authority grants parents control over their minor children. Based on preference or 'style' of practice, a physician decides whether or not to hospitalize a patient and can order as many tests as he wants, to prescribe drugs and perform procedures. Only another MD can legally judge the 'appropriateness' of a doctor's medical choices and most MDs shy away from "second-guessing" another doctor's medical decisions. On those rare occasions when doctors do criticize a colleague, it is usually for his or her failure to make more extensive use of medical interventions.

In the medical-legal arena, authority-based medicine means that determinations of malpractice -- substandard care, negligence, or incompetence -- are always and only the "expert opinion" of a physician hired as an expert witness. In theory at least, it is assumed that his testimony reflects the collective opinion (i.e. standard of care) of that state's "community of physicians". Nonetheless, standard of care is the numerical 'standard' of what is typically done. It is informed by, but not defined by, medical textbooks and policy statements by medical associations and specialty groups.

A doctor's individual authority also applies to economic-legal opinions relative to workmen's comp, determinations of disability for purposes of insurance or pensions, mental competence to manage one's affairs, insanity, and legal cause of death (natural vs. the crime of homicide). The *only person* in the United States who has the authority (standing in court) to challenge the medical opinion or legal determination of an MD is another MD – no one else, not even a US senator, Supreme Court justice or the President, can trump the legal opinion of a medical doctor. This give rise to that familiar courtroom scene where the attorney for one side belittles the non-physician witness for the other side by snarling "Oh yea, and just where did YOU go to medical school?"

The lack of transparency inherent in authority-based medicine institutionalizes medical decision-making as an encrypted black box to which only MDs have the key or can claim to understand the code. Within the traditional bounds of a specific disease diagnosis or health-related situation (heart attack, diabetes, normal labor, etc), physicians are authorized to do as they see fit, much like an artist decides what colors to use. The impetus for ordering a battery of tests or performing a procedure can be anything from the most trivial personal convenience to a realistic fear of litigation and everything in between, including the highest level of concern for EBM and risk-benefit ratio. It can also reflect written or unwritten rules of an investor-owned facility that have made increased use of profit-making procedures the preferred 'standard' and if not followed, will cause the doctor to be disfavored by the administration or his peers. When the physician is an investor in the facility or the technology, it is to his financial advantage to make sure that all the beds are filled, all technological equipment is in use and each department has lots of work to do. This may be a disturbing thought, but statistics confirm the downside of the 'ownership society' when physicians own a piece of the economic action of a for-profit healthcare system.

It is 19th century authority-based medicine, in combination with 20th century deregulation and privatization of hospitals, that have given rise to our 21st century form of corporate medicine. As the deciders of all things medical, physician preference remains the lynch pin to wealth-producing medical goods and services, with price tags that run from a few dollars for a bedside water pitcher to a $100,000 for a single treatment in a building-sized MRI. All economic activity traces back to the physician's

uncontested authority to dictate the choice of what is done and how many times it is repeated -- lab tests, diagnostic procedures, drugs, medical devices, admission to ICU -- and the oceans of specialized (and inordinately expensive) medical supplies. This includes IV tubing, catheters, suction machines, needles, disposable bedpans and the like. Each product represents a sale to the manufacturer and, after mark-up, a profit to the institution; the more things used or things done, the more the business of medicine thrives.

Business Model of Success: When this scenario is carried out many times a day by a half million MDs, the result is a construction boom -- more hospitals and outpatient facilities are built, more expensive machines are purchased and more people are hired to run them. The Bureau of Labor Statistics estimates a 22% increase in health care employment in the next decade. This expansive commercial model, if judged solely by business criteria, is a success story beyond our widest dreams – that $1.2 trillion identified by Price-Waterhouse-Coopers as wasted every year is pure profit for somebody. However, if the goal is an efficient, effective, affordable, fair and accessible health care system, the distorting effect of authority-based medicine, deregulation, and privatization must be called into question. This double whammy has given us a corporate model of medical practice that rests on the (recently discredited) idea that whatever is good for stockholders is automatically good for all the rest of us, including ill, injured and elderly patients and the taxpayers who pay the bill.

The Art of Medicine – the right place for physician preference: As grim as the above facts are, no one should go away thinking that physician authority is bad or wrong *per se*. These professional qualities and skills are also known as 'clinical judgment' and represent the 'art' of medicine. There are many times and places when the art of medicine is the perfect answer – in particular, places where science has never been or where it has nothing to offer. Sometimes simplicity and common sense make a one-of-a-kind response the right answer for that person at that time. In the late 19th century, the general category of medical practice was collectively known as the "healing arts"; many state medical practice acts still have the words "Healing Arts" in their title. Clinicians often think the art of medicine is the best part of their job. It means having the skill and courage to step outside the box, to be innovative, use intuition, do detective work and by arriving at conclusions that runs counter to conventional wisdom or customary practices, to hitting a home run for the patient. *Viva la difference!*

The ethics of confusing art with science: Physician preference *only* becomes an ethical and economic problem when it is hidden or unacknowledged, when art and science are conflated (no distinction is make between the two) or when the *art* of medicine is substituted for the *science* of medicine. Under those conditions, it is disingenuous at best and often dangerous to the many patients who get under- or over-treated because physician preference is being used as a tool to increase personal or corporate profit, thus turning professionalism into *commercialism.*

Trends in the physician workforce: Between 1970 and 2000, the average number of potential patients available to the medical profession was reduced from 641 people per physician to 373 per physician. This was due to a large increase in new doctors in the decades following the *Health Professions Education Assistance Act of 1963*, which dramatically increased the number of medical schools in the United States. Between 1960 and 1988, the number of first-year students in US medical schools more than doubled. While it was obvious that the number of new graduates would lead to an oversupply of physicians, no medical schools were willing to give up federal dollars by closing or significantly reducing their class sizes. During that period, new physicians entered the workforce at *three times the rate* that older physicians left practice. [Ref #26 -"Physician characteristics and distribution in the *US"; 2000 edition Chicago American Medical Association 2000,* page 352

Defending professional turf: The explosive growth in the supply of physicians during the 1970s and 1980s was not offset by an aging population or greater use of sophisticated medical technology. With such a prolonged oversupply of medical doctors, organized medicine (OM) became even more aggressive in protecting itself against competition from non-physician practitioners and alternative health care professions.

In the last few years, the previous oversupply of MDs has been reversed by the mass retirement of physicians from the baby-boomer generation, leaving a hole that is not matched the number of med students in the pipeline. This disparity in supply and demand is so daunting that many states are wondering how they will be able to provide primary care to vulnerable populations, especially the poor and those living in rural areas or inner cities. More than three-quarters of all new graduates go into the specially practice of medicine, leaving less than 25% of all physicians to provide primary care. Primary care emphasizes first contact care, continuity of care, comprehensive care, and coordinated care.

Non-physician primary care providers a threat to OM: Four years ago the AMA launched an aggressive campaign to further restrict the legal ability of non-physician practitioners to provide primary care. Non-physician practitioners who exercise critical judgment similar to physicians include pharmacists, podiatrists, optometrists, physician assistants, nurse practitioners, nurse anesthetists and professional midwives. However, the AMA's policy opposes anything that "**alters the traditional pattern of practice in which the *physician* directs and supervises the care"**. In particular, the AMA targeted the area of reimbursement, passing policy resolutions to prohibit physician assistants, nurse practitioners and other non-physician primary caregivers from being directly reimbursed by government programs such as Medicare and Medicaid. What that means is that MDs can continue to bill and get reimbursed at MD rates for care provided by the salaried non-physician practitioners in their employ.

The AMA and its role in the Scope of Practice Partnership: In November 2005 the AMA created the Scope of Practice Partnership (SOPP), which is a coalition comprised of itself and the Federation of State Medical Boards, plus six national medical specialty societies and six state medical associations -- the California Medical Association, Colorado Medical Society, Maine Medical Association, Massachusetts Medical Society, New Mexico Medical Society, and Texas Medical Association.

The Scope of Practice Partnership characterizes all non-physician practitioners as 'physician extenders'. The phrase "physician extender" perfectly conveys its MD-centric perspective, one that sees the proper role of other health care professionals as supporting and carrying out the orders of the medical profession, and whose labors are seen as a part of their profit stream. Licensing laws in 28 states already reflect this MD-centric philosophy by legally restricting non-physician practitioners to the subordinate status of a physician-extender, thus prohibiting any form of independent practice or reimbursement.

According to statements published by its Steering Committee, the SOPP intends to use its political, financial and legal resources to turn back the clock and sweep back the ocean – or as they put it, to end the illegal practice of medicine by non-physician practitioners. In the 22 states and District of Columbia that already license non-physician practitioners as independent professionals, SOPP members plan to introduce legislation to repeal these laws. In the 28 states that have restrictive laws on the books already, the SOPP will vigorously fight any effort by nurse practitioners and other non-physician practitioners (NPP) to lift these restrictions. At the national level, SOPP members are working to get federal legislation passed which will permanently block direct

reimbursement of NPP. Last but not least is a strategic plan to elect or appoint physicians sympathetic to SOPP's policies to state medial boards and subsequently force all non-physicians practitioners under the control of the medical board in each state. The SOPP wants to put a stop to the regulation of nurse practitioners, midwives, pharmacists, naturopaths, chiropractors, etc, by their own professional boards. This is based on the notion that other boards are illegally authorizing their licentiates to practice of medicine without a license, thus depriving the medical profession of its legitimate income.

The Numbers ~ Everyday Non-urgent Health Care: Of the 902 million medical appointments every year, approximately 90% are for non-acute healthcare. This category includes "self-limiting conditions" i.e., temporary situations that resolve spontaneously. By definition, self-limiting conditions do not need or benefit from sophisticated medical technology, prescription drugs or surgery. The illustration often used is that a cold, if untreated, will go away in seven days; if treated, it will go away in one week. Ordinary, garden-variety complaints include mild illness or minor injury, psychological states such as anxiety or mild depression, normal biological conditions such as pregnancy, breastfeeding, newborn follow-up, well-woman care (contraception, pap smear), normal aspects of aging, life-style issues (diet, exercise and questions about sexual topics), school and work physicals, vaccinations, testing for STDs, managing a stable chronic disease, etc.

Chokepoint Medicine: In the early 1900s, primary care was provided by a mixture of MDs, non-allopathic physicians (osteopathic, naturopathic and eclectic doctors) and non-physician practitioners (including midwives). Organized medicine chose to do away with the traditional multi-discipline form of health care and replace it with an exclusively medical model that was purposefully configured to have a chokepoint. The decision to get rid of non-allopathic physicians and non-physician practitioners occurred without any prior scientific research and without making any distinction between ambulatory care -- non-urgent care for everyday self-limiting conditions -- and urgent medical intervention for serious and acute problems.

Chokepoint medicine means that every non-urgent patient must first go thru the eye of a needle to see and be seen by a medical doctor before any other aspect of the health care system can be accessed. The big question is whether 9 to 13 years of medical school training in life-threatening medical emergencies and the use of prescription drugs and surgery is actually the most appropriate way to provide safe and cost-effective for every headache, earache, sniffles, sore throat, tummy ache, backache, athletes foot, trouble sleeping, normal pregnancy, healthy child and all the other non-urgent and self-limiting conditions that fill up a physician's waiting room every day? Can this possibly be rewarding way for a highly-trained medical doctor to spend his (or her) time?

Time vs. money: These health concerns are not medically complicated, but can be time consuming and certainly take more than the 6 to 10 minutes allotted for the typical non-urgent medical or OB appointment. What people seeking non-urgent health care want and need is a relationship with an unhurried primary-care practitioner who is able and willing to be empathetically present, to listen, talk, ask questions, sympathize, make suggestions, and spend whatever time it takes to educate the patient (or parents) about how best to manage their health.

Not enough of both to go around: By 2025 the growing US population, which includes children and increased proportion of elderly people, is expected to raise the number of ambulatory care visits by 42 %. The number of patients with chronic diseases – a category who benefit most from the coordination of care and continuity of care -- is also increasing. [Am Coll

Physicians - White Pager 2008]. According to Dr. Atul Grover, the chief lobbyist for the Association of American Medical Colleges (an arm of the AMA), the answer is a 30% increase in medical school enrollments, to produce 5,000 additional new doctors each year.

Institutionalized Mismatch: However, this still misses the point, which is the extreme mismatch between what patients need and want from primary care providers and what graduate doctors need and want from the practice of medicine. From a patient's perspective, it must be nearly impossible to get cost-effective services for routine low-tech care from a physician who is trying to pay off an average of $140,000 in med school loans and simultaneously meet staff payroll, office overhead and malpractice insurance premiums. There is already one MD for every 373 people in the US. The number of doctors who report giving up primary practice because they couldn't make enough money to stay in business is both eye-opening and distressing – primary practice by MDs does not work economically for either doctors or patients.

Unchoking primary care: Time and relationship-intensive non-urgent care is most satisfactorily provided by non-physician primary care practitioners – physician assistants, nurse practitioners, professional midwives, naturopaths. This is where preventative medicine actually starts; it is also how the routine overuse of Rx drugs and procedures is stopped.

A consensus of the scientific literature identifies primary health care by independently practicing non-physician practitioners to be comparatively safe, more cost-effective than MD care and to have a high patient-satisfaction rating. There are about 140,000 non-physician practitioners in the US. In event of a serious or urgent medical situation or request by the patient, non-physician primary care practitioners arranged for referral, consultation or a transfer of care to an MD or emergency facility. Nonetheless, the AMA has maintained an iron grip on its MD-centric system for the last hundred years. The SOPP, which is currently fixated on eliminating alternative forms of health care and the independent practice of non-physician practitioners, is just a more recent expression of 19th century thinking that distorts the entire health care system and prevents self-correction of these problems.

How organized medicine developed its iron grip: The taproot of our "unsafe at any speed" system traces directly back to a historic lack of a scientific foundation for the medicalized system of health care designed by the AMA. In 1904, influential leaders in medical politics knew their plans to close half of all medical schools and make medical care exclusive allopathic were motivated by a political and economical agenda, not science. In the last 1800s, there were two homeopathic physicians for every MD. This glut of medical practitioners had driven down the average income of an MD to little more than the weekly wage of a mechanic. However the AMA, together with the Carnegie Foundation's Bulletin #4 ("Flexner Report"), promoted their plans to close medical schools as a public safety campaign designed to modernize medical education and make medical care "scientific".

Politics masquerading as science: The public and other professionals assumed that the AMA's recommendation were based on a scientific method of evaluation (statistical research and comparative studies) to determine the evidenced-based or 'best practices' model of health care: would it be multi-discipline or exclusively allopathic, MD-only care? Or would it be a cooperative and complementary model of MDs, non-allopathic physicians and non-physician practitioners, with the type of treatment and category of practitioner determined by the kind of care the patient required or requested? As we know only to well, no rational process was used in 1910 to arrive at these restrictive conclusions, nor has one been applied in the 99 intervening years.

The uncritical acceptance of an unscientific premise: Without understanding the long-term implications of an exclusively allopathic, MD-centric model, states began adopting the AMA's recommendations 1910. The most immediate consequence of these policies was to eliminate women and minorities from the mainstream practice of medicine and dismantle and eventually discard the multi-discipline tradition of healthcare. For instance, in 1909 California had a multi-discipline Board of Medical Examiners with 11 members -- 5 MDs and 6 non-allopathic physicians, each one appointed to the Board by the governor at the recommendation of their respective professional associations. In 1911, the Medical Practice Act was amended to eliminate all 6 non-allopaths appointments and replace them with a 12-member all-MD medical board, which is still in place today.

This same MD-centric, authority-based model provided the platform and push-off point for an exploitive form of corporate medicine that has doubled our troubles with the extremes of non-treatment and over-treatment, excessive cost and increased mortality. Too long medical politics has masqueraded as medical science and corporate politics has triumph over fiscal responsibility. As we rightly credit *medical science with saving lives*, so we must discredit *medical politics for costing lives*.

Failed national healthcare policies that have fallen off the public radar

For all the dissatisfaction with our current system, the health care debate in the US has never questioned our MD-centric system or acknowledged the value of a multidiscipline health care system and cost-effective primary care as provided by non-physician practitioners. While we collectively appreciate the excellence of ER physicians and ability of the medical and surgical teams to treat those with life and limb-threatening emergencies, those of us who haven't had a heart attack or car accident must face one of the *most entrenched and pervasive* failures of the current system -- lack of access to health care, including non-urgent primary care, and the ever-escalating costs, medical errors, hospital-acquired infections, and 20,000 preventable deaths annually because insurance is unavailable to 46.6 million Americans.

While choke-point medicine guarantees total control of physician income by organized medicine, it is a failure as a national healthcare policy. Its time to replace this 19th century thinking with a 21st century partnership between medical doctors and non-physician primary care practitioners that puts the needs of society ahead of an out-dated idea of an MD-centric "traditional pattern of practice".

Comparative Effectiveness ~ the lynch pin of an efficient, effective and affordable health care

The biggest missing piece in the health care debate is public discussion on the comparative effectiveness of health care methods, processes and products. As noted, analyzing comparative effectiveness is distinctly different than the current, strictly defined evidence-based medicine -- one is the forest, the other deals with individual trees. Comparative effectiveness takes the biological sciences up to a whole new level by *analyzing the entire spectrum of the "healing arts*", as well as life-style issues, diagnostic technologies, medical devices, treatment regimes, surgical procedures, institutional vs. out-patient or home-based care, etc. Only a science-based analysis that relies on established effectiveness can correct the excesses associated with a century of unbridled, often irrational medicalization and can repair the unnatural split between the art and the science of medicine that occurred in 1910. Its ability to restore marital harmony between the arts and sciences of health care makes comparative effectiveness the lynch pin of an efficient, effective and affordable system for the 21st century.

A Vision for 2020 –
Universal access to affordable healthcare OR the second federal bailout of the 21st century?

The take-home message is simple. Our current system of medicalized health care is unsustainable, unsatisfactory and increasingly unstable. A March 2009 program on the national debt by PBS calculated that current levels of healthcare spending had already outstripped the cost of both foreign the wars (Afghanistan and Iraq) and is projected to be **greater than the entire GDP by 2050**. This level of unbridled spending is stealing money from everything else we hold near and dear, sucking all the economic oxygen out of efforts to prevent global warming, improve our schools, modernize our public transportation system or develop the infrastructure needed to respond to a natural disaster, pandemic or act of bio-terrorism. Were this profoundly dysfunctional and inequitable system forced on us by a foreign government, Americans would rise up in rebellion. We'd be marching in the streets in protest, willing to go to war if necessary to get out from under its unjust and tyrannical grip.

The model of medical care developed by the AMA between 1904 and 1912 simply cannot work -- it lacks the basic element of success and absolutely no amount of money can change that. Leaving healthcare reform to organized medicine and other special interests groups is like depending on Wall Street to fix the financial crisis by allowing banks to issue a new round of credit default swaps. But it's not too late to introduce scientific analysis of comparative effectiveness into health care and in doing so, correct the many problems we see in the current bloated and unresponsive system.

Do or Die: Failure to be politically effective is to risk an economic meltdown in the next decade that can easily trigger the second greatest recession-depression of the 21st century, one that will make the money spent on the toxic asset bailout look like chump change. Should we have a public health emergency of any kind, there will be no funds or reliable system to do what health care is suppose to do – meet public health needs that can't be address any other way.

What Works: Only a rationally-based process can break the ever-escalating cycle of health care spending, defuse the impending baby-boomer-Medicare crisis, and provide on an economically-level playing field that gives American business a fair shot at competing successfully in the global economy. Only by identifying the actual root of these problems can they be successfully addressed and only then will legislative reform free from the control of the AMA and its allies have any chance.

It was a fluke of history that brought us to this juncture -- temporary goals of organized medicine in 1910, doing their best to make sure that medical doctors made a decent living and got the respect they deserved. These policies conflated the general topic of health care with a specific subset of medical treatment, in this case, allopathic medicine. The lobbying efforts that have so dominated the debate over national health insurance and started us on a hundred-year detour around universal coverage were an overly successful expression of the democratic process that we generally approve of. The biggest problem with well-funded organized medicine was unfunded and disorganized push-back. Political power is naturally out-of-balance as long as it is one-side.

It doesn't have to stay this way. The medical politicians who orchestrated these events in 1910 are long dead and that era has passed away. In our lifetime, conventional or "modern" medicine has earned its place as one of the most important, most central pieces of the health care system. However, it is still only of *part* of the whole. It doesn't 'own' our personal health and it doesn't work for it to 'own' our national health care system. Nonetheless, all the players in the health care drama have something valuable to contribute

and there is a place for everyone – private and public, corporate and not-for-profit, allopathic and non-allopathic, physicians and non-physician practitioners.

For policy reform to work, we must design a system that is *equally beneficial* to the insured and the uninsured alike and one that addresses the legitimate concerns of each sector of the health care continuum. One of the most crucial steps is a fair and rational process that includes analyzing the comparative effectiveness of different health care models, medical technology, treatments, devices and procedures. Only then can systemic effectiveness be synthesized with evidence-based medical treatment to give us 'best' practices that balance physician authority, the scientific evidence and facts as generated by comparative analysis. By making health care effective, we also make it affordable. With an affordable system, universal access to money-saving, health-preserving care is not just economically possible, but an *economic imperative*. We can't afford ***not*** to cover everyone!

Comparative effectiveness re-writes the playbook by giving us a new start and a level playing field. Over time, a new perspective will develop in the social, political and economic realm and we will find ourselves with a health care system that is both healthy and caring *and* doesn't break the bank. This win-win solution is as American as apple pie and best of all, it is good for everybody – ordinary people, business, health care providers and our democratic form of government.

This is **the story that needs to be told and retold** until every newspaper, blog, talk-show host, politician and political pundit gets it right.

Additional Topics for next time: Stay tuned for part two, which expands on many of these topics and provides new material on the historical roots of our dysfunctional system.

A. Asking the Carnegie-Melon Foundation to endow a comparative effectiveness analysis of primary-care models – comparing outcomes and costs for multi-discipline and non-physician practitioners providing non-urgent care with the conventional MD-centric model
B. Lobbying for federal legislation like the 1963 Health Professions Education bill that doubled the number of medical schools, only this time to establish educational pathways for non-physician primary care practitioners
C. Making this information go viral -- How to break big blocks of ideas into bite-sized topics; who to write to (ex. Michelle Obama- East Wing of the White House), blogs and posting information on Internet sites; organizing family and friends thru email groups, etc

Medical Board October 5, 1993 Status Report: Health Policy and Resources Task Force

Although California has experienced a dramatic increase in health care professionals, this has not solved or even alleviated the problem of underserved areas. California has more doctors per capita than any other state …. Translate[s] to 1 doctor per 1,000 patients. To put his number in perspective, Orange County HMOs signs up 3,000 patients per 1 primary care physician.

…the hiring of additional allied health care professionals has not really done anything to benefit patients. Although … the concept in principle is that allied health professionals can provide additional access to health care …. **the manner in which they are being hired and used ….. they are really only serving to increase the income of physicians**.

Although physicians are hiring more Physician Assistants and Nurse Practitioners, and often patients never see the physician, the patients are charged the same amount for an office visit. This is income for the physician but there is *no cost-savings to the patient*.

From a speech by Dr. W. A. Evans at the **AMA's annual convention** ~ JAMA., September 16, **1911**

"The thing for the medical profession to do is … to man every important health movement; man health departments, tuberculosis societies, housing societies, child care and infant societies, etc. The future of the profession depends on it. . . **The profession cannot afford to have these places**

occupied by other than medical men."
AMA Vice-President James Sammons, Phil Donahue show, Nov 22, 1982: **"Our reasons for being in political action are exactly the same as the AFL-CIO. Exactly. "**

Wilk vs. AMA Class Action Suit, 1987 - **AMA convicted of violating Sherman Antitrust Act**

Judge Getzendanner's on-the-record remarks about the AMA's campaign against chiropractors: "For over twelve years, and with the full knowledge and support of their executive officers, the AMA paid the salaries and expenses for a team of more than a dozen medical doctors, lawyers, and support staff for the expressed purpose of conspiring (overtly and covertly) with others in medicine to first contain, and eventually, destroy the profession of chiropractic in the United States and elsewhere".

RELEVANT AMA POLICY ~ Scope of Practice Partnership ~ Resolutions

House of Delegate-160.949 – **Practicing Medicine by Non-Physicians:** states that "[o]ur AMA:

(1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and **where such alters the traditional pattern of practice in which the physician directs and supervises the care given;**
(4) continues to encourage state medical societies to **oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician** (MD, DO) training or **appropriate physician (MD, DO) supervision**; and
(5) through legislative and regulatory efforts, **vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.** (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00)."

H-35.973 Scopes of Practice of Physician Extenders

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and **recommended guidelines for physician supervision to ensure quality patient care.** (Res. 213, A-02)

H-35.988 Independent Practice of Medicine by "Nurse Practitioners"

The **AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches.** (Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-35.993 Opposition to Direct Medicare Payments for Physician Extenders

Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician. (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

Bibliography and References:

AMA Timeline; official AMA web site;
AMA Scope of Practice Partnership Resolutions 204, 205, 303, 239, 814, 902
AMA, NMA, and the Flexner Report of 1910; Ololade Olakanmi; Writing Group-History of African Americans and the Medical Profession; [AMA archive]

Amazing Logistics of Flexner's Fieldwork; Mark D. Hiatt, MD, MBA Originally published in the Medical Sentinel 2000;5(5):167-168. Association of American Physicians and Surgeons (AAPS);
Carnegie Bulletin #4 ~ Introduction by President Henry S. Pritchett, April 16th 1910
MEDICAL EDUCATION IN THE US AND CANADA ~ 1910; (also known as the Flexner Report) 386 pages - can be downloaded from Google Books
Wilk vs. AMA Class Action Suit, 1987 - AMA convicted of violating Sherman Antitrust Act

Bureau of Labor Statistics web site, Health Care
Fast Facts on US Hospitals - American Hospital Association; web site Jun 2009
Health Insurance Costs -- National Coalition on Health Care (www.nchc.org) 2009
Medical News Today – Press release by CMS -- Office of the Actuary in the Centers of Medicare and Medicaid Services (CMS); Catherine Paddock, PhD Jun 2009 **More Bang for the Buck?** Randall Stafford, MD PhD, *et al* Stanford Prevention Research Center funded by *Agency for Health Research and Quality*; the Archive of Internal Medicine in Oct 2008
Physician characteristics and distribution in the US - 2000 edition Chicago American Medical Association 2000*,* pg. 352
Policy Statement on Nurse Practitioners in Primary Care; Am College of Physicians, Mar 2009
President Truman's January 7, 1974 Call on Congress -- Healthcare Reform, reprinted NYT;
The Social Transformation of American Medicine, Paul Starr, 1982;
Strategic Management of Healthcare Organizations; Peter M. Ginter, *et al*; 2002, 992 pages
Time Line on Health care crisis ~ PBS.org/healthcare crisis/history.htm Jun 2009
White Pager – Primary Care Crisis; American College of Physicians, 2008
Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008 July 17, 2008 | Volume 97 Authors: The Commonwealth Fund Commission on a High Performance Health System; Contact: cs@cmwf.org

Achievements in Public Health, 1900-1999: Healthier Mothers and Babies - CDC
Birth Environments ~ Emerging Trends and Implications for Design; **The hospital economics obstetrical departments;** Alice Lerman, B.A., J.D., M. Arch; Univ Wisconsin; Sch of Architecture & Urban Planning; Am Institute of Architects & Am Hospital Assoc. Fellowship ISBN0 938744 76 3
Choice in Planning and Experiencing Childbirth
AMA Journal of Ethics ~ Virtual Mentor. September 2004, Volume 6, Number 9. Policy Forum
Elective Cesarean Section: An Acceptable Alternative to Vaginal Delivery? Peter S. Bernstein, MD, MPH; Medscape Ob/Gyn & Women's Health -- Web Site 09/16/2002
Maternal Mortality Rates Are Increasing in California
http://www.cmqcc.org/maternal_mortality;
Maternal death in the 21st century: causes, prevention and relationship to cesarean delivery; Steven I. Clark, MD, et al; American Journal of Obstetrics and Gynecology July 2008
Milbank Report: ***Evidence-Based Maternity Care, Sakala et al*** *2008* ISBN 978-1-887748-70-4 www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf
Listening to Mothers Survey, 2002, 2006, www.ChildbirthConnection.org 2007
Postpartum Maternal Mortality & Cesarean Delivery; C Deneux-Tharaux, MD, MPH, *et al*; 2006
Crisis of Abundance: Rethinking how we pay for health care; Arnold Kling; CATO Institute, Wash. DC 2006

Critical: What we can do about the health-care crisis; Senator Tom Daschle; 2008
Innovator's Prescription: A disruptive solution to health care; by Clayton M. Christensen, Jerome H. Grossman, MD and Jason Hwang, MD; 2009
International Health Care Reform: A Legal, economic and political analysis; Colleen M. Flood, Assistant Professor, Faculty of Law, University of Toronto, Canada 2000
A Second Opinion: Rescuing America's health care – a plan for universal coverage, serving patients over profit; Arnold S. Relman, MD; 2007
SICK: The Untold Story of America's Health Care Crisis – and the people who pay the price; Jonathan Cohn, Senior editor, the New Republic; 2007
The Truth About Health Care: Why reform is not working in American; David Mechanic, Rutgers University Press, 2006