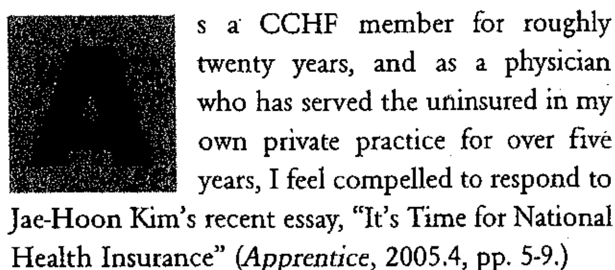
A Grassroots Solution for the Uninsured: A Rebuttal to National Health Insurance

by Robert S. Berry



As a CCHF member for roughly twenty years, and as a physician who has served the uninsured in my own private practice for over five years, I feel compelled to respond to Jae-Hoon Kim's recent essay, "It's Time for National Health Insurance" (*Apprentice*, 2005.4, pp. 5-9.)

I joined CCHF during the mid-eighties while in med school. I was fortunate to spend a clinical rotation in the Mississippi delta with former CCHF Board Chair David Bosscher. Since then I have been inspired by many *Health & Development* articles, which typically feature the experiences and spiritual insights of medical professionals serving the "least of these" in our health-care system. These CCHF members "in the trenches"[1] have demonstrated how laying one's life down for one's neighbors, as Christ did for us, can redeem not only human hearts but human systems as well.

Mr. Kim's article was different. Rather than sharing a personal response to local injustices, Mr. Kim promoted a nationwide political solution. He stated, "I believe that adopting a Single-Payer National Health Insurance (SPNHI) plan would be the best solution to our nation's health-care 'non-system.' "

I share Mr. Kim's frustration with the injustices and waste in American health care, as well as his outrage over the way insurance companies put profits ahead of people. In fact, I joined Physicians for a National Health Plan (PNHP) during my residency because I sympathized with its yearnings for social justice. I understand Mr. Kim's impatience in calling for a "radical change," because (as he says) even the current government awards and grants to faith-based initiatives are not touching the "fundamental problems inherent in our health-care system."

However, I would caution Mr. Kim to be more skeptical of PNHP's political agenda. Before deciding to join them in sweeping out all the devils of our current "non-system," he should consider which devils might be lurking outside to replace them. Mr. Kim's noble ideals notwithstanding, yielding power to the State to finance all of health care would give it free reign to coerce citizens for political purposes, potentially creating more injustices than we already have. Furthermore, even though PNHP members clamor vociferously for covering the uninsured, most don't actually care for them personally. Support for SPNHI is no substitute for practical and personal service to the uninsured. As soon as I realized that PNHP cared more about its own agenda than the well-being of the underserved, I dropped my membership.

A single, faceless payer empowered by the State could pressure medical professionals to compromise their consciences while itself remaining unaccountable. For example, there might be little recourse if Christian physicians or nurses had their compensation withheld or even their licenses revoked for witnessing to patients or for refusing to practice euthanasia or perform abortions. One has only to consider the totalitarian regimes of the last century that promised utopia but produced terror to conclude, as did Lord Acton, that "power tends to

corrupt, and absolute power corrupts absolutely."[2] C. S. Lewis once warned, "Mankind is so fallen that no man can be trusted with unchecked power over his fellows."[3]

State coercion already exists in the U.S. health-care system. For example, under current regulations, physicians (such as I) who start clinics to provide affordable care to the uninsured by avoiding the cost of billing third-party payers are forced into a difficult decision. We either have to discriminate against Medicare beneficiaries willing to pay directly for our services or opt out of Medicare completely for two years.

Beyond the potential for State coercion, we should consider the experiences of other nations that have adopted SPNHI. During a recent lecture promoting SPNHI at a nearby medical school, I asked Larry Churchill (whom Mr. Kim quoted) to name one country where universal health insurance guarantees timely, quality medical care. In response, there was an uncomfortable silence. No country with SPNHI has delivered on its promise of health care for all – at least health care that is of decent quality and administered in a reasonable amount of time.

For example, the average wait across Canada in 2005 between a GP's referral and orthopedic surgery was 40 weeks.[4] The median waits for a CT scan and MRI were 5.5 weeks and 12.3 weeks, respectively.[5] In June 2005, the Supreme Court of Canada struck down Quebec's ban on private health insurance, declaring that "access to a waiting list is not access to health care."[6] It concluded that "the evidence in this case shows that delays in the public health-care system are widespread, and that, in some serious cases, patients die as a result of waiting lists for public health care."[7]

In Britain, the delays are no better than Canada's, even though Brits can contract with doctors privately on a limited basis outside of their National Health Service. Over one million citizens await elective surgery there – such a backlog that the government is subcontracting the work out to other European nations.[8]

In contrast, the Emergency Medical Treatment and Active Labor Act (EMTALA) virtually guarantees that all patients, regardless of insurance status, are treated for emergencies. Having logged roughly 15,000 hours in over ten ER's (one with 100,000 patient visits per year), I never experienced a delay in caring for a critically ill patient because of insurance status. In fact, we never knew their insurance status until after we had stabilized their condition. In addition, it typically has taken less than a month for my uninsured patients to be treated for cancer once they have presented to me with signs and symptoms suggesting a malignancy.

Mr. Kim cites cost savings as a major advantage of SPNHI. However, if U.S. Medicare were such a model of fiscal efficiency, why is it planning to decrease physician reimbursement over 25 percent in the next five years?[9] Expanding Medicare into a SPNHI when it can't even meet its current obligations is not a viable solution.

Perhaps the federal government could increase funding to CCHF-associated ministries, which are, I believe, better stewards and more compassionate caregivers than their public counterparts. However, even if politics were to permit this, there are not enough CCHF members to fundamentally change the system. Besides, CCHF members should be wary of becoming wedded to the politics of one administration lest we find ourselves widows in the next.

Perhaps the best argument against CCHF control over more national resources is that Jesus himself once rejected such an offer.[10] Indeed, God tends to choose the "foolish" and "weak things of the world," not human power, to accomplish his will.[11]

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Perhaps in our day God is using the uninsured, arguably "the least of these" within our health-care system, to fundamentally change health care from the grassroots. God's agenda stems from a "wisdom which none of the rulers of this age has understood; for if they had understood it, they would not have crucified the Lord of glory."[12] Our model is the crucified Christ, not the potentially crucifying State.

As a matter of national policy, I believe the United States should eliminate the tax exemption for health insurance all together. The vast majority of Americans can afford to pay out-of-pocket for everyday medical care, which at my insurance-free clinic costs anywhere from the equivalent of an oil change to a brake job. Direct payment is less expensive than settling claims through a single payer and eliminates bureaucratic intrusions into the doctor-patient relationship. Such a "radical change" in tax policy could fundamentally solve many of the problems within American health care. The uninsured would no longer be forced to suffer the injustice of subsidizing low co-pay, low deductible commercial insurance possessed by most Americans (including, I suspect, many readers of this article) or the indignity of being refused treatment at doctors' offices since everyone would be paying directly.

If CCHF members are genuinely interested in serving the uninsured, I invite them to identify radically with them and consider opening practices like mine. In a little over five years, we have grown to over 6,500 patients with approximately 4,000 uninsured – this despite their option to choose care at four State-subsidized clinics within fifteen miles of my office. Clinics like mine have many advantages for patients, physicians, and the nation at large. Patients at my clinic typically wait less than fifteen minutes to be seen by a physician with experience and board certifications in internal and emergency medicine. In nearby State-supported clinics, they typically wait hours to be seen by a physician extender.

Physicians can avoid the hassles and costs involved in billing third-party payers, as well as the time and expense it requires to apply for government grants and/or set up and raise financial support for a 501(c)3. They don't have to worry that a nonprofit board, whose members and priorities are apt to change over time, will force them out of the practice and relationships they have built. Should you decide to open such a practice, setting your fees is up to you, not a third-party payer. You are free to charge as little above your costs as you would like, which for me in 2004 totaled roughly twenty dollars per patient.

The country as a whole would benefit from this change in tax policy because the costs of delivering routine medical care would be much less, and more resources would be available to care for the truly ill and destitute. The costs per physician at my clinic are approximately one-third those of clinics that bill through insurance. My practice also requires just one full-time employee, three fewer than those that process medical claims. Every employee and asset in primary-care medical practices not deployed in direct patient care unnecessarily adds to the cost of every good and service that this country produces. Eliminating the more than one million jobs involved in settling the small claims from our nation's primary care practices would also help relieve the nursing shortage, which is expected to be over one million by 2012.[13]

Clinics such as mine demonstrate that the United States neither needs nor can afford third-party payment for routine medical care. When asked by the Joint Economic Committee of Congress to describe insurance-free medical practices, I began my testimony as follows:

Our clinic is similar to charity clinics in that it serves patients falling through the cracks of our broken health-care system – except we don't receive any taxpayers' funds either directly as subsidies or indirectly as a tax-exempt 501(c)3 corporation. It is similar to boutique clinics in that it contracts directly with its patients – except that most of our patients don't have insurance.

In January 2001 I left ER medicine to start a clinic primarily for the uninsured of my community as an attempt to flesh out in my own life an answer to the age-old question, "Who is my neighbor?"

As an ER physician, I knew the people the charts classified as "self-pays." In a small community such as ours, I purchase goods and services from many of them. They are all in a real sense my neighbors – too poor for ten dollar co-pay insurance and too rich for Medicaid. Most doctors refuse to see them.[14]

In my community, the uninsured are neither destitute nor derelict. As beauticians, carpenters, plumbers, local retailers, and migrant farm workers, they are able and willing to exchange something of value for my medical services. Local, personal accountability forces me to be fair and honest with my neighbors. Our exchange depends on mutual agreements between them and me, not on a State edict. Canada has mandated that clinics such as mine, which settle accounts outside its SPNHI, are illegal.

Insurance-free clinics are simple to establish and operate. You just need a step of faith to refuse to sign all insurance contracts and then depend on your uninsured neighbors to keep you afloat. Doing this requires not only a tender heart, but a tough mind and thick skin as well! Starting clinics like this will restore your faith in the sanctity of the doctor-patient relationship by liberating you from irrational, wasteful, coercive, and depersonalizing bureaucracies. I have faith you will discover that human weakness crucified in Christ ultimately proves stronger and more compassionate than the State.

Robert S. Berry, M.D., in January, 2001 started PATMOS EmergiClinic, a combination urgent care and internal medicine practice to serve primarily the uninsured of his community. He chose the name "PATMOS" to stand for "Payment At The Moment Of Service," identifying with the political exiles of our healthcare system, the uninsured, who have no other payment option. Revelation 1:9 says that John "was on the island called Patmos because of the word of God and the testimony of Jesus."

Dr. Berry has earned board certifications in Internal Medicine and Emergency Medicine and is a Diplomate of the American Academy of Pain Management. His clinic has appeared on the front page of the Wall Street Journal *and received the King Pharmaceutical "Cup of Kindness" Award for Innovation. His clinic's website is www.emergiclinic.com, and he can be reached at rsberry@xtn.net.*

ENDNOTES

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