The line forms to the left: Waiting for care under health reform

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Will waiting lines at doctors' offices, labs and hospitals get longer if President Barack Obama's vision of health care reform becomes a reality?

And who will decide if a patient is eligible for a treatment or procedure?

It will probably come as no surprise that expert opinion on that is divided — sharply divided — between those who support the president's initiative and those who don't. And there is no way to predict the future with certainty.

But essentially, it is yet another debate over rationing — longer waits for care would be a form of rationing.

It is important to note, as those on both sides of the issue frequently have, that rationing already exists within the current health care system. Most people do some self-rationing — choosing whether to treat themselves for non-life-threatening illnesses or injuries rather than going to the doctor. Insurance companies ration by not paying for every procedure or service people want. There are waiting lines as well, because there is not an unlimited supply of doctors or high-technology equipment.

So the question is: Will the proposed health care reform increase the delays for treatment, procedures or doctor appointments?

Not according to its backers.

Judy Feder, a senior fellow with the liberal-leaning Center for American Progress, is among those who say lines may actually get shorter, because primary care doctors will no longer spend so much time on unnecessary testing, procedures and burdensome paperwork.

Indeed, it sounds like a matter of simple math. If fewer things are being done for individual patients, then doctors can accommodate more patients.

Feder said the legislation will create incentives for "better" medicine, rather than "more" medicine. She said the current fee-for-service model rewards doctors for doing more things, while reform will reward them for "getting it right."

She agrees in part with critics who say that without tort reform — limits on malpractice liability — doctors will be reluctant to stop practicing defensive medicine.

"The importance of protection is understandable," she said, "but I think that will be addressed. Remember

that the AMA (American Medical Association) supports this."

State Rep. Harriett Stanley, D-West Newbury, who chairs the House Committee on Health Care Financing, has been following the national debate over health care reform closely, and agrees with Feder.

"First, we're not talking about government health care," she said. "It is government-funded health care, and we've already got that with Medicare, Medicaid and the Veterans Administration. This would just extend it out.

"We're talking about a return to concept of the family doctor. Young professionals are going to be the ones in charge of saying, 'Let's hold off,' or 'Let's get you in right away.' If you need treatment, you will probably get it every bit as quickly."

But those on the other side bring their own simple math to the table.

Michael Tanner, a senior fellow at the libertarian-leaning Cato Institute in Washington, D.C., said there is nothing in the bill that specifically calls for rationing, "nor is anything likely to cause immediate rationing, but long term, there are some serious red flags regarding costs."

He and other critics say President Obama is promising significantly increased health benefits to 47 million more people, while promising to cut costs at the same time.

"You can't pay for more stuff for more people and cut costs," Tanner said "It's a simple matter of supply and demand."

And he scoffs at the claim that increased efficiencies and taxes on the rich will pay for it.

"I mean, we've supposedly been cutting waste, fraud and abuse since the Reagan administration," he said.

Tanner said the evidence is right in Massachusetts, where in 2006, then-Gov. Mitt Romney signed a "universal" health care bill that took effect the following year.

In a June 9 briefing paper titled "Massachusetts Miracle or Massachusetts Miserable," Tanner noted that overall health care costs in Massachusetts have increased much faster than the national average, insurance premiums have increased 8 to 10 percent a year — nearly double the national average — and a threat of price controls from Gov. Deval Patrick "has prompted some physicians to stop accepting new patients."

So not only has the program failed to cut costs, but "the wait in Massachusetts to see an internist has gone from 33 days to 55 days," he said.

Jeffrey Anderson, a senior fellow at the conservative Pacific Research Institute, sees a similar scenario.

"Saying we need more government involvement to cut costs doesn't pass the smell test," he said. "The only way to cut costs is to ration care and give people longer lines to wait in."

Both describe longer waits as "indirect" rationing. For example, an insurance plan may cover unlimited MRIs, but if there is only one MRI facility available in a region, that service will be rationed by the long line of patients waiting to use it.

Also, the history of government-managed programs suggests it is unlikely that health reform will control costs.

Anderson points to Medicare. In a study for PRI, he found that since 1970, Medicare's cost per patient has increased 35 percent more than the combined per-patient costs of all other health care in the country.

The projections of its total costs were also wildly inaccurate. In 1970, the prediction was that Medicare would cost $12 billion in 1990, with inflation included. Instead, it cost $110 billion.

And while there are a variety of estimates about Medicare's unfunded liability, most of them tend to exceed $40 trillion.

"The lesson is that government programs cost more than anticipated," Anderson said.

But beyond the question of how long the wait for care will be, who will decide who is eligible for treatment?

Feder argues that it will be better than it is now, when insurance companies decide what they will cover, and frequently deny coverage not just for pre-existing conditions, but even after the fact.

"The new rules will prohibit that," she said.

And while she agrees that a government-funded plan can't cover everything, she says that instead of insurers deciding such things, it will be largely left up to doctors and patients.

Anderson is not so optimistic. He agrees that insurers now limit or deny coverage for some things, but says they are motivated to provide more coverage by competition in the marketplace.

With federal control, he predicts, "decisions (on eligible care) will ultimately be made by some federal board. That board will set guidelines that will be implemented by bureaucrats down the line."

And the incentive for doctors, Anderson contends, will not be to do what is best, but what complies with those guidelines.

In short, the best that experts on both sides of the issue can offer are educated guesses.

Those in favor of the proposed reforms argue that this time things will be different — that government involvement will make things better, more efficient and less expensive.

Those opposed are convinced that history will repeat itself.

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