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Supreme Court must consider Affordable Care Act's threat to doctor-patient relationships

By Nora Janjan and Grace-Marie Turner **February 8, 2012**

The upcoming Supreme Court decision about the constitutionality of the Affordable Care Act's individual mandate will have profound implications for government control over the doctor-patient relationship.

Simply put, if the federal government can mandate that all Americans must have health insurance, it is only a short step to strict government mandates about how doctors must practice medicine.

Under the new health law, medical care will transition from what is appropriate for the individual patient to what is appropriate from government's perspective. And the cost of care will be a significant factor, with government, not doctors and patients, ultimately deciding if a treatment is worthwhile.

The groundwork for tighter government control over medical decisions was laid in President Obama's 2009 Stimulus legislation, which charged the Institute of Medicine (IOM) with determining what topics the government should study in its "comparative effectiveness research."

Most of the IOM's 100 priorities relate to Medicare. The top three call for comparing the value of medication vs. surgery; treating hearing loss by teaching sign language rather than relying on cochlear implants; and clinical treatments vs. recommending exercise.

The IOM also included many priority topics in cancer treatment, such as "watchful waiting" compared to actual medical treatment for localized prostate cancer. The IOM report lists many other research targets involving the relative value of drugs, diagnostics, medical treatments, and other interventions.

While comparative effectiveness research can be a valuable tool in helping doctors make good decisions, it also can be a dangerous tool in which government, not doctors, controls the medical care we will receive. Since the government pays for an ever growing share of medical care, it inevitably will place a high priority on finding the lowest-cost treatment.

The Obama Administration already has demonized physicians as largely responsible for the high costs of health care in America. The president, for example, has claimed that surgeons are more likely to do amputations for diabetics because they get paid more for these procedures than for prescribing medication.

But there are other ways the law threatens the quality of patient care. To finance the health overhaul law, Medicare payments will be cut by $500 billion at the same time that a record number of Baby Boomers will be hitting retirement age.

In addition to these cuts, a new Independent Payment Advisory Board (IPAB) was created by the new law with powers to further limit the growth of Medicare spending. Fifteen unelected technocrats will have the authority to cut Medicare spending to stay within set spending targets. Their decisions are not subject to judicial review, and it will be difficult for Congress to overrule IPAB decisions.

By September 1, 2013, the IPAB must submit its first draft proposals to limit Medicare spending. The Secretary of Health and Human Services must act the next year to implement the IPAB proposals unless Congress passes an alternative plan that achieves the required Medicare savings.

If Congress fails, the original IPAB proposal to cut Medicare will take effect. Thus, the IPAB, armed with government CER data, will have the power to limit Medicare spending and thereby ration medical care.

We already see this happening in the programs government controls now. Drugs already are rationed under Medicaid, for example, with many patients facing restricted access to the newest and best drugs. Rationing of care already exists under Medicare with its lifetime limit of 100 days for care in a skilled nursing facility and restrictions on the number of days allowed for a hospital stay, for example.

The transformation of Medicare from an insurance system to a system directing the practice of medicine is defended as necessary to save the program and to standardize what is “appropriate” care for Medicare patients. But it creates a significant conflict of interest when the government is the payer and also determines what constitutes appropriate care.

The autonomy of patients and clinical judgment of physicians will unquestionably be undermined by the health law.

For continued progress in medical innovation and to achieve the personalized care that 21st century medicine will bring, it is vital to move away from Obamacare’s centralized government dominance of the health sector and toward a new system that rewards payers and providers for providing quality medical care. That means putting patients, not government, first.

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