Big Brother with a Black Bag: Four Non-Superficial Flaws of TennCare and the Nationalized Health Care Plan

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On November 19, 1993, the state of Tennessee, not always identified with the vanguard of medical science, made headlines in the Washington Post for its leading role in health care reform. Along with the states of California and Vermont, Tennessee (hereafter TN) is on the leading edge of health care reform even ahead of the national plans recently introduced by the President. As most are aware, health care reform will be one of the larger and most discussed items in 1994, and possibly the most far-reaching if approved. If, as reported, some 37 million Americans are damaged in their health because of legislative negligence then indeed many will support a plan for improved health. However, if that estimate proves dramatically lower,[1] or if non-surface flaws of such health care proposals come to light, then the American people may genuinely desire to avoid the lemming lurch to socialized medicine, even in the face of unrivalled hype about a fabricated "crisis."

It is possible that the estimates are as exaggerated as other recent epidemics,[2] and also that there are clear defects in the plans, which flaws cannot be cured by ever so much adjustment, amendment, or fine-tuning. If the health care proposals before us in the coming year are warmed over socialisms of the 60's, or more of the type of plans attempted but even now being jettisoned in Sweden, or if they are fundamentally, philosophically, and irrevocably flawed, then they could realistically violate the first part of the Hippocratic Oath: First do no harm. If such plans are more harmful than helpful, then indeed we can argue that we would be better off doing nothing, rather than creating more harm, be it ever so well-intentioned.

It may even be that we would be far better simply leaving health care alone, since it has worked quite well when arranged between nongovernmental parties, instead of creating a new super-bureaucracy to manage our health. It might be better to identify and subsidize the truly needy (likely about 5 million) and provide them a Cadillac policy for $5,000 a year. According to such a direct approach at remediating a single issue, a mere $25 billion expenditure would suffice, helping to cure our national debt, since health care expense is purportedly the real barrier to budget balancing. Such $25 billion annual expenditure would cost less than 10% of the Defense budget, or we could cancel some foreign grants, or eliminate a few outdated expenditures, allowing us to then care for the disadvantaged, as well as be on the way to curing the deficit, if those were all we really wanted to accomplish. Yet, as such simple solutions are eschewed, it becomes apparent that larger political goals are the real driving forces behind present health care reform, not the actual amelioration of those in need; for all the while, numerous other economical and sensible plans to genuinely remedy the uninsured are rejected.

Tennessee has become one of the leaders in health care reform, winning modified approval from Health and Human Services (HHS) to begin TennCare in January of 1994 to replace its state medicare. This plan is in all probability a pioneer for the version of nationalized health care that eventually will be put forth for legislation. One of the difficulties in analyzing the national plan, supposedly clear in the minds of the 500-plus secret planners, is that no clear plan is ever presented long enough to weather criticism. As soon as a plan is announced it is criticized and the administration denies that the plan is really the health care plan it will present. It is indeed difficult to assess or tarnish phantom plans, which factor, of course, some crafty administration would exploit.

In an effort to assist some who wish to go beyond phantom-cum-incorrigible plans, emotion, horror stories, scare tactics, or crises by exaggeration, I would like to put forward a critique of TennCare, in that it is one of the few plans which is now a matter of public record, and also in that it is likely a portent of things to come, a pilot program, if you will, of what can be expected on the national level. I will first describe briefly the TennCare proposal and then highlight some flaws.

As with most of the present plans, the goal of TennCare is to provide universal coverage at the highest possible level of benefit. These present plans - with regional rates, regardless of health or lifestyle[3] - will employ regional collectives (euphemistically called "regional health alliances," but collectives nonetheless) supervised by either regional health boards, or in the case of the Clinton plan, a National Health Board - consisting of seven Clinton appointees (otherwise known as apparatchiks). These mammoth bureaucracies will then promise universal care to all members of the state's party, purportedly for a lower aggregate sum than at present. Euphemisms aside, this will result in rationing with the state (through its politburo) controlling the centralized plan.

Furthermore, physicians will be required4 (upon threat of criminal penalty) to provide services through Managed Care Organizations (MCO's), and will be reimbursed at per capita rates. Supposedly, the benefit package to recipients will be comparable to or better than present plans, and will include abortion services and most psychological services (although recently the Clinton plan has reduced those out of economic necessity). In sum, the populace has been told that it will receive better care at lower cost, and without the possibility of future revocation. In light of such promises, one can see why so many people are clamoring for such promises. If only they were true.

As a prime example of the utopian promises, consider the stated Goals of TennCare, as proposed by the Governor of Tennessee in April of 1993.5

- Comprehensive health insurance for virtually every Tennessean:
- Resolves the "Medicaid problem
- Eliminates the Hospital Services Tax (March 31, 1994);
- No other new tax or tax increase is required;
- Eliminates most "cost shifting" from the uninsured to the paying patient and the business community;
- Encourages the market to limit total health care spending in Tennessee which would save, if limited to the growth of our economy, an estimated $6.5 billion by the year 2000;
- Creates a competitive environment by encouraging the creation of competitive provider networks at the community level;
- Encourages welfare independence by eliminating the link between welfare and health benefits by providing health benefits to the working poor;
- No health care reductions;
- Maintains the current Mental Health System;
- Maintains the current Public Health System;
- Preserves and enhances the Children's Plan'
- Nursing Home Services and services to the Mentally Retarded are maintained under the traditional Medicaid program.

Thus, in sum, TennCare will, according to its own inventors, care for children, welfare recipients, mental health recipients, all other public health needs, "virtually every Tennessean," while at the same time resolving the "Medicaid problem," and saving both the state and federal government over 8 billion by the end of the decade. It also is supposed to eliminate some taxes, and create "No other new tax or tax increase" and all with "No health care reductions"!! Smoke and mirrors take over health care.

The impossibilities are manifold. Even if we admit some enthusiastic hyperbole and admire the benefits of competition in reducing health care costs, there is no possible way that all of the above can be provided at a cost of less than the present. The math is spurious and the economics impossible. Yet, the TennCare plan reasons as follows:

According to the original TennCare proposal, we are in a "crisis" that demands we take action in a short time. Our choices, if we do not reform health care are to "have a major tax increase or make major reductions in health care for almost one million Tennesseans who are

covered by the Medicaid program."[6] It is presently estimated that Tennessee expends approximately the national average on health care, 13.65% of the gross domestic product (GDP). It is noted that this is "more than double the share of the GDP which health care consumed in 1965."[7] But watch this: the TennCare plan assumes a constant percentage of increase in medical costs, a large and unsubstantiated assumption, and projects that if there is no health care reform, citizens will spend ca. 18% of GDP on health care by 2000. Further, it assumes that total state costs will double from $13 billion to $27 billion by the year 2000. This extrapolation at a 1965-1993 constant rate is without warrant, especially when it is noted that the trend line for health care increase in costs has actually declined the last several years.

Moreover, the TennCare proposal has the lack of insight to base its model on state government employee's plan (similar to that chosen by Congress for their own families), which in fiscal year 1992 expended an average of only $1463 per person. But two things must be noted. First, that the per capita price was as low as it is because of genuine market forces (these state employee plans, similar to the Fedeal Employee Benefit Health Plan, being among the most competitive and efficient), and secondly, for a family of four or more, that annual cost is still nearly $6000 ($5852 for four). So, even for the best of plans and on the most efficient of assumptions, such cost basis is not a real reduction at all, yet it is represented to potentially save nearly half of the $13 billion cost, supposedly able to reduce costs from $13 billion to $7.2 billion if used by all citizens.

The goal of TennCare is to cover all medicaid recipients and uninsured citizens (estimated at 1,000,000) and still care for a net increase of 14 -16%[8] of population with no explained financial revenue. The only winners appear to be hospitals and a few of the larger insurance agencies. In order to gain their support, hospitals were promised that the Hospital tax would be eliminated in the first year.[9] A few insurance agencies will have the inside track on MCO's.

Of course, as in the nationalized schemes, all health care providers will be coerced to participate. Yet the chronic categories such as the mentally ill, children in state custody, nursing homes, and public health costs will still have to be covered by Medicare, indicating that Medicare will not be entirely phased out. These categories are perhaps the most severely under-funded on a per capita basis. Those remaining massive costs must be funded somehow, too. In addition, the single largest hypothesized source of revenue for TennCare will be "Charity Care" ($595 million) amounting to nearly half of the proposed budget.[10] That proportion may be as unintentional as accurate, as indeed it would likely require half of all medical practice to be chalked up on a charitable basis to make this program economically feasible. Health care providers may be charitable, but it strains the credulity of such plans for budgets to anticipate that nearly half of their revenue will come from "charity care," an amount of philanthropy by physicians that is 12 times that of revenue expected from local government funds according to the TennCare proposal.[11]

Consider the fact that few physicians or hospitals have a very substantial source of income outside of their practice. Therefore, true charity from physicians and hospitals can mean only one of two things: (1) that they will accept much less profit, or, (2) that they will cost-shift to their paying patients. If TennCare is effective in stopping cost-shifting it is assuming an unrealistic notion of the degree of profit in health care and the willingness of providers to see it drop. Would the state planners propose to fund public education through the teachers?

The challenge is for the state of Tennessee to come up with a plan that covers those who pay little or nothing, at a cost of nearly $6,000 per year for a family of four, based on one of the lowest and most competitive (perhaps even privileged) rates per capita. In order for this rosy scenario to come about the rest of Tennesseans will have to fund about $1.5 billion per year, at the lowest present rates. Few have found a way to effect that without a recurrence of the original dilemma, either a huge tax increase (even if hidden), or a vast reduction of services for all citizens. The other four million Tennesseans will each have to bear a real economic burden of $1.5 billion in addition to their own

$6,000 per family of four per year. That shared portion will amount to nearly 400 extra dollars per person per year, or about $1,500 per year for a family of four. This is socialism alright, but hardly an approach to commend even when compared to the present crisis.

Although the plan insists that there will be no new taxes, Commissioner David Manning refuses to rule out a tax on physicians, and may at a later date reduce payments to providers of health care.[12] In addition, to provide a glimpse into big Brother Medicine (or medicine according to the Veterinarian model as opposed to the human model), this plan will impose "monitoring standards" for appointment scheduling and waiting room times: "Appointment scheduling targets are three weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting room times should not exceed 45 minutes."[13] This Big-Brotherization of medicine will certainly appeal to those who complain about long lines to see physicians, but will assuredly create whole new levels of regulatory bureaucracy to maintain compliance.

Under such, one Chief of Staff of a TN hospital said that if TennCare is enforced it will mean the immediate reduction of the- nursing force by at least 15%. This hardly inspires confidence that health care will improve as economic strictures are put in place. Hospitals are governed by laws of economics, even if politicians hope not to be. Further, hospitals and physicians will assuredly take measures to stay in business, even if it means rationed treatment or diminished staff.

Despite the promises of no long waits, the lines in Canada for certain procedures are probably predictive for Tennesseans. Tennesseans will not like waiting six months (as in Ontario) for a CT scan, or up to a year for eye or orthopedic surgery, or four months for an MRI, or two years for lithotripsy on a kidney stone.[14] Before signing on to TennCare, Tennesseans will first want to be informed that "In Canada today, the average wait is 10 weeks for a mammogram and five months for a Pap smear. Canadian heart surgeons estimate that the statistical risk of dying on the waiting list for heart surgery now exceeds the risk of dying on the operating table "[15]

While these opiate promises appeal to frustrated patients, to be sure, and to the envy among people who think physicians are little more than travelling witch-doctors, sly and only in search of profit, there -are real and profound flaws in this plan. Those who examine it either in light of the teachings of Scripture or prudence will find it wanting. In what follows, four non-trivial flaws at the deepest levels will be discussed. Regardless of superficial changes in some of the details of TennCare, or any of these present- socialist plans, these areas will still present fundamental challenge to the schemes proposed: (1) the nature of man qua consumer, (2) basic economics, (3) the proper role of the state, (4) the object of dependence, and (5) faith in and dependence on the state.

1. Expectations of Altruism

The TennCare plan might work in utopia, or could be conceived as workable in an idealistic compound like a high-school Governor's Honor program. Then again, perhaps its authors have a greater sensitivity to the presence of a millennium than I do. However, in any level above Economics 101, this model simply cannot be financed. The only possible premise upon which this could be financed would be if citizens dramatically and immediately changed their health care consumption and became health care minimalists, which of course the TennCare plan denies to be the intent or effect.

The only possible way to prevent bankruptcy (I'm told by some physicians that this could occur within 6 months, based on the economic assumptions versus the economic realities) is if consumers covered by the plan cut their health care consumption by at least half. Now that might be a worthwhile objective. We might even want to state that as a prudent goal. However, how do we get citizens to do that? Or, if they are guaranteed health care; is there any empirical basis to expect that they will voluntarily reduce their own family's health care by 50% apart from economic necessity?

Our government planners may cling to a wish that humanity were that altruistic, but there is no reason to assume that to be man's normal character. To the contrary, it is proven that apart from either external constraints (law) or internal gain (profit) there is no

reason to expect citizens to do the right thing automatically, consistently, and altruistically . In addition (see below), there are several documentations that when total care is subsidized people do not restrict themselves from consumption. Such abuse lies at the heart of the inflation in health care costs. These costs will only decline when that behavior is changed, as may be the case now in the process of correction under our present partly-free market forces.

Theologians call this propensity "depravity," or the expectation that even the best of human beings will not act righteously apart from some mechanisms of constraint. If human beings are indeed self-interested, then these plans will not encourage them to limit their choices. On the contrary, citizens can be counted on to "Get what's coming to them," and to use the system to its fullest.

Yes, Virginia, there is a human nature.

Creators of health care plans should factor in that users will avail themselves and their families to the ceiling of health care, not voluntarily opt for floor-level health care. The only people who will consistently opt for floor-level health care are those who have other external incentives (again largely dependent on self-interest) to do so. That is why plans such as those by Stuart Butler at the Heritage Foundation, or the plans conceived by Phil Gramm, Don Nickles, or Richard Armey, combine economic savvy with realism about human nature. The TennCare plan (and others) fail to admit the reality about human nature, that we are indeed selfish and self-centered. We will routinely take all that we can, and give as little as we can. This behavior will lead to bankruptcy in these related plans. The failure to admit this human nature is a non-superficial flaw of this plan which will not be cured by superficial adjustments.

As Ronald Nash comments, "No economic or political system that assumes the essential goodness of human nature or holds out the dream of a perfect earthly society can possibly be consistent with the Biblical world view."[16] Realism about depravity must be included in any succeessful health care reform. In addition, with a Fallen universe as a constant in our formulations, resulting health care reform will be delimited from seeking either utopian or totalitarian means and ends.

The various socialist experiments of the twentieth century have demonstrated this depravity write large. It should be part of the body of social truisms by now that if some other agency will automatically make a provision for individuals, invariably the individuals will rely on that agency to provide for it continually. That is to say, if the state guarantees welfare, unemployment, disaster insurance, agricultural subsidies, or health care, then citizens will allow it to, and abuse the guarantees in the meantime. Such is the effect of depravity applied to public policy. Informed public policy will take this anthropological given into account.

Such abuses of provision will not take a long time to be felt in effect. The reason lies in the very nature of man (theological or philosophical anthropology). Not only is this the case theoretically, i.e., that sinful people look for their own advantage, and not altruistically to the concerns of fairness or justice, but it is also abundantly demonstrable from the last generation of social experimentation.

It is now as well-proven as it is lamentable that when a society subsidizes immorality, the recipients of that MCO will take the government up on immorality or non-efficiency. As the illegitimacy rates have risen dramatically and steadily since the creation of the "Great Society," who, other than partisan ideologues, can dispute the deleterious effect on the rate of illegitimacy of welfare payments to mothers of out-of-wedlock children? Health care reform plans like TennCare share this non-superficial deficiency on the level of principle.

When one asks whether all this expenditure-oriented approach has helped, it can be noted that in 1965 there were less than a quarter of a million illegitimate births to blacks and yet after some 20 years of social engineering (a generation to those bearing children) it was reported that "In 1980 48% of live births among blacks were to single women compared to 17% in 1950."[17] Further escalating, by 1988 "63.5% of all black babies were born out of wedlock."[18]

Steven Moore has noted that, "Welfare rolls have skyrocketed from two million families in 1970 to 3.5 million in 1980 to 4.6 million in 1990. The child of a parent on welfare is three times more likely to be on welfare as an adult."[19] It is still more shocking to note that, "Despite a great society effort now well into its third decade - the cost of more than 2.5 trillion dollars -the life of many inner city residents has never been worse, for blacks especially. Today blacks comprise almost half of the prison population. The homicide rate for black males age 15-24 has increased by 40% since the mid-1980's, and is now the leading cause of death for that age group. Forty percent of those murdered in the U.S. are black men killed by other black men. Sixty-five percent of all black babies are born to unwed mothers; the number is as high as 80% in many inner cities."[20]

The centralized planners of the coming health care reforms could learn the anthropological lesson from a cousin to medical care, welfare. If human beings have responded to welfare provision as they have, then what reason is there to believe that they will respond any differently to health provision? Based on the nature of man, there is no reason.

The same kinds of graphs will no doubt be forthcoming (although it will not take 30 years to show) for pandemic health care abuse. Because of our self-interestedness, if an insured is guaranteed health care, without restriction, in the present philosophical soil he will overuse and wrongfully use the syustem which is without cost to him. Not only that, but also those who abuse themselves with immoral lifestyles will continue to reap health repercussions which will also be as fully treatable (not to mention, subsidized) as those who live healthy lifestyles. In the present proposals there is an ignorance of this basic anthropology, and such ignorance cannot give a good reason for "Why be healthy, if unhealth is equally subsidized?" While in the past we could depend on moral or religious codes to persuade in favor of health, in our present climate about all we have to convince a self-interested population is economics. It is precisely those economic disincentives which, having been stripped from present proposals, will no longer help limit self-interest in the consumption of health provision.

Consequently, if access and guarantees are given apart from economics, the true costs will soon skyrocket and continue to increase exponentially as welfare payments have over the past 30 years. The flaw is the same in both attempts: no one ever calculated that recipients are truly sinful, and even in the best of scenarios they take from the system more than they give. They are in it for themselves, and until precautions are taken to limit that, no system will endure.

2. Economics

Many people show an abysmal lack of grasp on economic consequence. Economic ideas do have consequences. TennCare is faulty on the economic front in several regards.

(a) The Budget projections are unrealistic. From the outset, it may not be the case that health care costs rise at a constant rate. Nowhere is it considered that perhaps we've seen the most inflationary period of health care costs in western history. It has not been proven that the costs of health care will continue at the same exponential upward trend as the past decade. To the contrary, in 1992, health care costs only increased 5.7%, the lowest rate since 1973,21 and also the basic inflation rate is significantly lower than this time 10 years ago (ca. 13% then, as opposed to 4% now). The decline in rate of increase is from: 9.6% in 1990 to 7.9% in 1991 to 5.7% in 1992 to 5.4% in 1993 to 4.4% in the second half of 1993.

Neither is it certain that the projections of revenue from the federal government, nor from "Charity Care" will actually materialize, leaving contracted providers responsible to care indefinitely for a bankrupt system out of the goodness of their hearts (even if they had no objections to socialized medicine), or else leaving genuinely sick people out in the cold. Do any dare imagine that a state (or national plan) would actually recognize a problem of economic short-fall and care for its citizens?

Of course, it has not been definitely proven that health care costs will either decline or that the rate of annual

increase will fall. But the market force correction begun in the past few years should encourage us at least to wait before making such drastic attempts.

Yet, perhaps the chief error in extrapolation is the fabricated number of Americans without health care. It would be a titanic challenge actually to locate 37 million Americans without health insurance, as even the Urban Institute admits that 70% of these are only without insurance for nine months or less,[22] likely only between jobs - which may be a legitimate concern, remedied by other means. Matthew Glavin has even more conservatively estimated that of the purported 37 million without health insurance "half are without insurance for four months or less, and only 15% are uninsured for more than two years."[23] Burkett and others have also demonstrated how the purchase of health insurance is a choice, in that over 16% of those supposedly without insurance could certainly afford it, having incomes in excess of $40,000 annually, and that nearly "half of the uninsured had incomes greater than $20,000."[24]

Another matter of economics altogether, which is seldom mentioned is the reported fact that perhaps as much as 40% of people will pay more under the Clinton plan (even with its rosy suppositions), and that as many as 7 - 18 millions of jobs could be lost by this plan, according to the National Federation for Independent Business.[25]

(b) The capitation rate is spuriously low. The annual capitation rate (the amount of money the state will allow a provider to collect; thus indicating how much can be spent on health care) for TennCare as announced by the state on September 3, 1993, to be effective on January 1, 1994, is:

-$179.28 for ages 1-13 (Presently that would not cover a case of ear infection and strep throat per year, much less any serious illness.)
- $685.68 for males 14-44 (an amount less than a single inpatient surgical procedure);
- $1505.52 for ages 45-64 per year;
- $378.36 for 65 and over (This figure certainly does not plan to spend much on senior citizens, in their most expensive health care years, or else severely limits the number of services to this sector.)[26]

If the capitation rate is the amount of revenue for a medical business to continue, it will not be able to provide the superior care promised by the benefits above for these rates, which include severe overstatements of charity care. It may well cover inexpensive care, such as immunizations, a lot of "two aspirins," and pharmaceutical prescriptions. However, it will not cover major medical procedures.

(c) Cadiliac plan for Chevrolet costs? Another economic aspect of TennCare that is dubious is the claim that costs can be lowered, while simultaneously providing a universal and comprehensive range of medical benefits. According to TennCare, the deductible would be only $200 per individual, capped at $500 per family. Superior corporate plans presently have higher deductibles on the average. TennCare would pay 90% of medical costs (most corporate plans are 80%, with only the very best co-paying at 90%), with an out of pocket maximum per family at $2,000 per year in an MCO. Mental illness costs are reimbursed at 90% for hospitalization, with 75% of first 15 outpatient sessions (which can include any kind of counseling) covered. Even substance abuse is covered up to 90%, with full psychiatric costs (up to 45 days per year). There is no limit to TennCare's benefit for outpatient service (present Medicaid limits to 30 visits per year), physician serivces whether inpatient or outpatient (presently limited to 20 and 24 visits per year respectively), psychiatric inpatient care, lab and X-ray procedures (presently limited to 30 occasions per year), hospice (presently limited to 210 days, although admittedly this is terminal care), pharmacy (presently limited to 7 prescriptions per month), medical supplies and ambulance services.[27] The only things not fully covered are dental work (non-surgical) and eye care.

This is a Cadillac plan that would cost many Tennesseans more than the present $6,000 per year per family of four. If services are not reduced somewhere, it is simple economics to admit that costs and revenues must increase. Yet, TennCare and other, national, plans deny this fundamental economic truism.

(d) No worst case scenario. None of the above plans calculate any reserve of the magnitude necessary to stay afloat is there is any downturn, or economic depression. Furthermore, until late January, the plan stated that physicians would not be reimbursed should funds be depleted. They would, however, be compelled to continue to provide treatment.

All in all, it never reckons with the fact that users will take more than they give, unless there are economic disincentives to the contrary. Related to the anthropology above, no system of economics can truly provide a fiscally sound basis for the above TennCare plan. These and other economic uncertainties caused even HHS to issue a conditional approval (although that has not been publicized in the major media, even within the state) for the TennCare plan on November 18, 1993, with the state required to meet 35 additional waivers within 30 days to gain final approval. These 35 waivers not only reveal the economic inadequacy of the plan, but further show how intrusive the governmental medical approach really is.

Since these waivers have not been widely publicized, one might be interested in a few of them. Among the waivers which help effect even more of Big Brother's encroachment into medicine are the following: In order to qualify for federal funds, the state must have all MCO contracts approved at the federal level by the Health Care Financing Administration (HCFA).[28] Furthermore, the state must develop extensive auditing procedures and, "Within 45 days of awareness, the State must submit a workplan to the HCFA project officer that includes detailed criteria for monitoring the financial stability and quality assurance controls of each plan."[29] Imagine the novel levels of bureaucracy that will be needed to accomplish this. Out the door goes privacy and the right of individuals to secure their own health care. Nor should it be overlooked that no later than "30 days after the end of each quarter, the State must submit the Form HCFA-64 quarterly Medicaid expenditure report, showing actual Medicaid and matchable TennCare expenditures made in the quarter just ended."[30] These waivers grant broad review powers to the federal level, while requiring virtual surrender of determination from the serfs below.

To further insure exact inspection (and to make sure that no one shines the light on failures until administrative rationalizations have been well-secured), "The HCFA project officer shall be notified prior to formal presentation of any report of statistical or analytical material based on information obtained through this project. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the HCFA project officer before formal dissemination to the general public."[31] Freedom of information, academic inquiry, nonpartisan analysis, and unhindered scientific research will also have to be subordinated to the whim of the state, through its project officer. We could end up having a lot of big brothers.

Moreover, "At any phase of the project, including the project s conclusion, the awardee, if so requested by the project officer, must submit to HCFA analytic data files, with appropriate documentation, representing the date developed/used in the end-product analyses generated under the award [including] primary data collected, acquired, or generated under the award and/or data furnished by HCFA."[32]

The morality of TennCare is thinly veiled as it contains this prerequisite for funding: "Within 60 days of the date of approval, the State must submit a written plan that describes how family planning services will be made available to TennCare enrollees ... The plan must delineate how the confidentiality of enrollees (particularly adolescents) who receive family planning services through such health plans will be maintained."[33] Hence special care is taken to provide for groups like Planned Parenthood and other condom-distributors, while requiring secretiveness and impunity for immoral lifestyles. These and only these moral options will gain approved funding. It is clear that abstinence-based medical programs will not satisfy Big Sister.

What is to be gained from all this surrender of personal liberty? The answer to that question helps explain the economics. As argued above, the income is at best half

of what is needed to finance such a program. The state of TN must magically secure a large revenue source, or depend on unprecedented and uneconomical levels of charity. However, tucked away in waiver #12 is the solution: The federal government, as much as admitting that the plan cannot balance its own books, in order to prop up such demonstration will allow taxpayers from the whole nation to help finance its socialist experimentation. According to waiver #12 HCFA will match funds to pay for "the actual cash capitation payments ... made by the State to MCOs for each TennCare enrollee."[34] In addition, this clause explicitly commits the federal government to match expenditures for "unreimbursed TennCare costs (including medical education costs) borne by participating TennCare providers," "services provided to TennCare enrollee and eligibles in private hospitals in Knox and Davidson counties," "services to a TennCare enrollee residing in an institution for Mental Diseases," and "actual ongoing non-TennCare costs ... of the Medicaid program."[35] Thus, TennCare will not really pay for itself, nor will Medicaid truly be phased out. We will merely have national taxpayers cover those bills. But, the costs must be paid for by someone. The laws of economics cannot be ignored.

Under this plan, Big Brother will gain a lot of turf, health care will not be improved, and the costs for services will not truly be reduced at all. The true costs will simply be hidden, elusively passed on to the next level of central government, and the people misled. Yet, someday, these bills will come home to roost, while in the meantime we are capable of irreparably destroying an adequate medical delivery system. One legitimately wonders also how the federal government will try to pass on its cost when it seeks approval for its medical plan?

3. Distorted view of the role of the state.

There is absolutely no rational or empirical basis to support the idea that the state should or can do a better or more efficient job of managing health care than individuals and private groups. Nor is there any constitutional basis for government agencies to assume this role.

Individuals and families are responsible for health care. It cannot be delegated to some other agency, and the particular agency of the modern state is one of the least likely to succeed, if charged with individual responsibility. It is a misplaced faith to rely on the state to take care of individual needs. It cannot, nor will it, although it may enhance its own goals in the process, leading to more dependency. The state has no warrant to move into this realm. This fact has led columnist William Rusher to query if the next liberal cause may be to propose a "right to eat."

"Do you realize that 40 million Americans go to bed hungry every night? ... Can the world's wealthiest society allow this disgrace to continue? So, down the road some smiling demagogue will wave a small card in the face of a joint session of Congress and tell the applauding lawmakers that this piece of plastic will guarantee every American a basic diet of three square meals a day (duly modified for variations in ages, size, and gender) from cradle to grave."[36]

It is also the case that thousands of individuals in the USA will die in the next year. Can the state step in and stop, or take over, that area, too? Can the state provide Managed Care Longevity? It is not a deus ex machina even if its citizens click their heels together, close their eyes with ever so much concentration, and wish it to be. It is high time to realize that the state is limited in its warrant and ability. Only individuals can do certain things, and we must be healed of the modern delusion that all problems find their cures in state intervention. They certainly do not, and some things can only be executed by individuals. After all, the state is invisible if stripped from its individuals. It is the sum total of individuals writ large.

The state can produce nothing. It can only raise money from its taxes, thus paying for health care (or any plan), only with our money. Already that is what happens. We are already the payers, and should wisely seek to find out if we're getting a better deal for our money. Health care will always be funded from our own money - either directly by individuals, or indirectly and less efficiently by the state. It is still our money; the state has none of its own.

Then again, the state is all too prone to be expansive and take over by default whole areas which truly belong to individuals. Others have warned us against the creation of totalitarian states, along with their correlative tendencies. Helmut Thielicke warned against the totalitarian state because it "necessarily seeks to penetrate every sphere of life and hence to take over the care of children, the chronically ill, the sick, and the aged ..." and cautioned, "The totalitarian state plays the role of the 'universal father;' attending men with its claims and services from the cradle to the grave, it forces on them the same kind of dependence as is evident in all spheres of life."[37] This totalitarian or maximal state, "is always a threat to the very foundation of the doctrine of the two kingdoms. The state as universal father, the state which intervenes in all things, exploiting even the inner powers of man ... and registering everything and laying claim to everything, transgresses its allotted sphere ... and - whether latently or deliberately - assumes the role of a pseudo church."[38]

According to Thielicke, this has institutional ill effects. Even though other systems may not be free from error, the error or the maximalist state in Thielicke's analysis is more severe than the others. Of the inhibition which can be foisted on health care by the maximalist stare, Thielicke comments, "It is conceivable that the modern threat to human society, to put it bluntly, arises less from chaos than from an overabundance of state order, a political super-organization which acts as an institutional buffer to isolate men from one another, depersonalize them, ... and turn love of neighbor into a welfare machine."[39]

Later Thielicke argues, "once the state establishes a monopoly in [a field], once it is forced to render 'complete care for its citizens in body and soul,' it not only reduces individual initiative but also kindles suspicion of other groups."[40] One of the ill effects is the turning over to the maximal state the arena of health care. Thielicke diagnoses the two-step process as: "The first phase is the development of the state monopoly. The second is the exclusion of all independent outside actions which seem to dissipate the centrally directed effort and introduce ideologies of their own."[41]

Moreover, "How far all this can get from any direct person-to-person care of a fellow human being finally becomes clear in the fact that the burden of the material requirements ... must be borne by general taxation." It is most amazing to note that these things were written much earlier, about truths which we now see played out.

His recommendation toward the end of this section should be heard in full.

"In thus warning against the utopia of a humanly inaugurated perfect state of affairs at the end of history, Christianity has to draw attention to three points. The first is that external perfection unaccompanied by the buttressing of inner substance gives rise to new forms of sickness in society. The second is that if the state would be true to itself, avoid totalitarian perversion, and remain in the kingdom of the left hand, it cannot create these inner equivalents. And, the third is that for this reason the state cannot claim a monopoly in [health care], but so far as possible must delegate the tasks ... to agencies which have a message and can devote themselves to more than merely external welfare. At any rate, the state must in principle not exclude but allow for such institutions ..."[42]

Thus in a properly related posture, the minimalist state embraces private responsibility, "always standing ready to give up tasks as other non-state agents become available Negatively, this means that the state should oppose the trend toward a total and direct assumption of all tasks, and recognize that in this area, too, it ought ideally to be a minimal state. Obviously, this ideal arrangement has to be fought for, and the church ought to take the lead in fighting for it."[43]

In conclusion, Thielicke stresses, that the principle of the minimal state derives ultimately from the theological character of the state as an emergency order. This concept contains within itself the postulate that we should commit to the state, not everything we can, but only what we must. It is in keeping with the provisional and interim character of the state that its claims are possible only with the caveat of an ultimate 'Nevertheless.' Where this caveat is omitted, there

arises the totalitarian tendency which we have discussed in detail. ... This tendency is accompanied by a similar tendency to level down all distinction, to ignore personal maturity and dignity and to degrade persons to the position of mere objects, and to establish the dominion of the perfected machinery. It was up against this background that we insisted that the state should give up as many tasks as possible and commit them to other agencies.

This means that the movement towards totalitarianism will be stemmed only to the degree that non-state agencies actively assume responsibility. The movement will be arrested not by the insight - even the theological insight - of responsible men and groups in government but only by the power of these non-state interceptors, only by men who are prepared to act."[44]

It is indeed scary to hear that the requirements for TennCare eligibility depends on "primary care physicians [to serve] as gate-keepers for all health care services provided to enrollees as the case managers for all cases warranting intensive case management."[45] One analysis of the Blue Cross Blue Shield contract for TennCare[46] points Out that physicians will be required "to allow on-site inspections and audits, including copying at no charge, of all TennCare related records." This is excessive state domination.

The state neither has these roles by natural law, by constitutional authority, nor by common interest. It is unwise at best to delegate to the state such roles. It would even be preferable to simply preserve the present "crisis." As Cal Thomas observes, the only drive to move to such a socialist system is if "a flawed philosophy about humanity and government - that it is and should be our redeemer - permeates all of their policies and rules their proposed health care reform package. When the trade is made, there will be no stopping government from self-deification, especially in matters involving life and death. .. ."[47] He further cites a recent British assessment from The Economist: "Not since Franklin Roosevelt's War Production Board has it been suggested that so large a part of the American economy should suddenly be brought under government control."[48]

Moreover, what should give one confidence in a governmental approach when the President's health care proposal is 1,342 pages in length after federal spending on Medicare is up 526% in past 14 years. Larry Burkett has reminded us that in 1965 when Medicaid was invented its budget was 1 billion dollars, while in 1992 it actually cost $72 billion. And "in 1965 the government estimated that by 1990 Medicare would cost $12 billion in inflation-adjusted dollars. The actual cost was $107 billion."[49]

However, many - even thoughtful Christians who should know better - do not critically assess these alternatives. Due to the fact that many have forgotten the proper role for the state, people are willing to surrender the world's best
medical care (even though not perfect) for one which is characterized by governmental control, regional surrogates, the abolition of private health insurance, a one-size-fits-all approach through employee mandates, price controls, MCOs for all, fewer specialists and new research, and rationed waiting lists. To exchange such, it would seem that some state would necessarily have proven its competency in these areas beyond a shadow of doubt. Or else, citizens may be looking for the state to do something that is entirely impractical, and not even within its properly defined jurisdiction.

If citizens wish to have sound health care, they'd best get their view of the state right, before it takes over important parts of their life. It is utopian and unfounded to look to the state for health care. It is wrong for the state to expand its role outside of its jurisdiction as well. TennCare and other plans all assume an inflated and ill-conceived role for the state, which becomes Big Brother with a black bag.

4. Faith in & Dependence on the State

Implicitly, those who look to the state to care for our health are violating the first commandment, and worshipping another god. To do so is to attempt to create a deified state which provides health. The state simply cannot do this, and we do wrong to search for it from the state. Only God can truly provide for our health. Sure we can take some preventative steps and

should. But even the best of those only yield slight improvement on any scale.

Dependence for health must be truly provide. These various health care proposals are cases of misplaced providence, the attempt to find suitable provision from a source which cannot deliver.

As a people, we have come dangerously close to deifying the state. We look to the state for cradle to the grave employment, education, welfare, subsidies, and now health. These commodities -work, wisdom, relief, income, health, and even safety - were once the domain of providence. It seems that we now have produced a generation (or three) who rely on the secular state to provide these things. Our faith and dependence may have been gradually and unwittingly transferred to a non-deity. It may be the case that we actually have come to trust the governmental agencies instead of God to provide for our most basic needs. Such substitution surely leaves us impoverished and unhealthy.

The health that we do worship may, in the end, only be guaranteed by God. It is likely that the plethora of health plans - knowingly or not - are but imitating the provisions that only God can bring. Substitution of a lesser agency - the state - will only result in frustration of those goals, if they can never be furnished by any other than our Creator. In the meantime to depend on some other is to perpetuate a non-superficial and substantive error.

There are other flaws in this plan, and will be in every plan. I have barely mentioned the inconvenience that more than 37 million will feel as they wait like our Canadian friends for long periods before certain procedures. We have not even addressed the loss of personal relationship with a caring physician in the transition to the newer Veterinary model. Nor have we begun to calculate the burden placed on physicians,[50] the vast majority of whom are very caring, ethical, professional, and no more greedy than any other class of workers.

Still one of the most fundamental flaws in these plans is the concession that human beings have rights to medical care. Philosophically that contention is as questionable as it is novel. Neither the history of philosophy nor ethics supports the expansive rights claims today.[51] According to William Willimon, "The notion of 'rights' is not a biblical idea. It is a legacy of the European Enlightenment. The notion of rights has been helpful in forming liberal societies, that is, societies formed without reference to God. No one need feel grateful or to say 'thank you' in a society of rights.'[52]

Commenting on the "dialect of rights as being uniquely American Mary Ann Glendon decries the fact that we are so consistently silent about our duties and obligations, while always shrill about our rights. She-says, "The American rights dialect is distinguished not only by what we say and how we say it, but also by what we leave unsaid. Each day's newspapers, radio broadcasts, and television programs attest to our tendency to speak of whatever is most important to us in terms of rights, and to our predilection for overstating the absoluteness of the rights we claim.'[53] Later, in "Refining the Rhetoric of Rights" Glendon says, "The strident rights rhetoric that currently dominates
American political discourse poorly serves the strong tradition of protection for individual freedom for which the United States is justly renowned. Our stark simple rights dialect puts a damper on the processes of public justification, communication, and deliberation upon which the continuing vitality of the democratic regime depends. It contributes to the erosion of the habits, practices, and attitudes of respect for others that are the ultimate and surest guarantors of human rights. It impedes long-range thinking about our most pressing social problems. Our rights-laden discourse easily accomodates the economic, the immediate, and the personal dimensions of a problem while it regularly neglects the moral, the long-term, and the social implications.'[54]

Perhaps our post WWII invention of rights shares the perspective of the U.N. In the1948 U.N. Universal Declaration of Human Rights one may be amazed to be informed of rights never before imagined. Article 22 postulates that "everyone, as a member of society, has the right to social security." Even more utopian in scope, Article 25 of the same charter alleges that everyone has

a right "to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing."[55] Another encyclopedia lists the following supposed "rights:" right to confidentiality, right to die, right to fertility control, right to food, right to health, right to health care, right to information, right to life, right to privacy,[56] and others.

The same refrain is now being heard in one of the latest variations on this central theme, health care reform. Our population is repeatedly informed that over 37 million Americans do not have health care insurance (not health care, mind you), and that moreover, they have a right to health care, despite the fact that millions of these who have been deprived of the right to health care do spend their income on TVs, food, cigarettes, cars, entertainment, and other products. In short, they have purchasing power, and wilfully choose to purchase certain products, leaving the government to provide health care, and then plead that their rights have been stultified, in that they have not received health care.

To base health care reform (or any other reform) on such a tenuous foundation is most unwise. We could only wish for those who will be affected to enter into such radical change with their eyes open. It is hard to justify another socialist experiment after the twentieth century, even if those in leadership insist. The people may just say no.

Recently historian Paul Johnson commented with clarity:

"The question future historians will ask is not why politicians and public opinion turned against the welfare state, but why it took them so long. Indeed, if ever a theory has been tested and disproved, it is that of the all-powerful, all-benevolent state - a theory that has led in practice to wars, to the death of millions of people, and to the scorching of entire economies and environments. Never before has mankind created such an allconsuming monster. In both its totalitarian and social-democratic versions, it has proved efficient in nothing except a capacity to squander resources and lives."[57]

Socialized medicine, if it is imposed, won't be the end of the world, although it will surely create a lot more problems than it will solve. It can easily do harm, and once created will leave its participants pining for these days when they had real health care. But, it won't be the end of the world. It would just be highly stupid. These and other non-superficial flaws may lead us to simply oppose on grounds of principle. We may just say, "No" to socialized medicine, and not even be required to offer alternatives, so manifestly flawed are thse present plans. If one person proposes an action that is manifestly imprudent (say mass jumping off the Golden Gate Bridge without bungee cords), another person is justified in simply refusing to participate, rather than first proposing an alternative prior to rejection of such an imprudent idea.

The same may be true if we adopt plans like TennCare. If TennCare is an aberration from the forthcoming nationalized schemes of health care, then this has been a mere exercise in critiquing one flawed plan. If that is the case, then we could even see a disjointed patchwork of flawed plans' underscoring the need for citizens to be involved in their own states, not only being fixated on the federal level, as if Washington could genuinely heal an illness. However, if TennCare is a sibling of the other plans now being considered, if it is organically related to the Clinton plan, then these non-superficial criticisms will apply to that plan as well, even before the administration puts something forward in writing and sticks to it. Any one of these could sink such a plan, even independently of one another, much less in concert as is the case with the present prescription. To ever persuade, all four of these must be healed.

Matthew Glavin may have it right: "Health care reform is one of the most complex public policy issues to face this nation since the creation of the social welfare programs of the 1960's. And, like the welfare programs of the sixties, the decisions currently being discussed in Washington will affect not only health care for millions of individual Americans, but the very foundations upon which our free society was built."[58]

Endnotes

1. Say, as much as 80% lower, as in the recent study by the Cato Institute which estimates only S million truly without

adequate health care.

2. For example, when homelessness was - without evidence - estimated at 3 million, while it was only about 10% of that, or Lord Kinsey's estimate of homosexuality at 10%, again being subsequently proven to be too high by a factor of ten.

3. In a recent experiment in the state of New York, as this regional averaging was imposed, actual costs increased 170% in the first year.

4. The proposal by President Clinton, being the most extreme in this aspect, will even abolish nonparticipating private insurers, and make it illegal to purchase medical procedures or care outside of the system. Even the more socialistic single-payer plan proposed by Rep. James McDermott (D-WA) allows for purchase of non-covered procedures.

5. Taken from, TennCare: A Proposal for Health Care Reform by Governor Ned McWherter. Emphasis added.

6. Ibid., p. 1.

7. Ibid..

8. Note that one million actually exceeds 20% of TN's slightly less than 5 million population, thereby skewing projections based on this by about 30%.

9. Yet, by Dec. 3, 1993, Commissioner Manning admitted that in order to satisfy HHS waivers, this promise could be annulled. The Oak Ridger, Dec. 3, 1993, p.2.

10. TennCare: A Proposal, Ibid., p.4.

11. Ibid.

12. "HCFA Provides TMA with TennCare Assessment," The Oak Ridger, Nov. 29, 1993, p. 1.

13. Ibid.

14. Goodman, John, "Lessons from Abroad" in National Review, Dec. 13, 1993, Health Care Supplement, p.4.

15. Ibid., p. 11.

16. Nash, Ronald, Poverty and Wealth, Westchester, IL: Crossway, 1986, p. 62.

17. Doner, Colonel, The Samaritan Strategy, Westchester, IL: Crossway, 1988, p. 142.

18. Rubenstein, Ed., National Review, May 11, 1992, p. .35.

19. Moore, Steven, Reform Afoot, National Review, May 11, 1992, p. 36.

20. Ibid.

21. Larry Burkett, Money Matters, Nov. 15, 1993, p. 5., As further confirmation of this inchoate trend, participation in HMO's increased nearly 10% in 1993, further deescalating health care costs. With more participants in HMO's double-digit increases were fading. According to the Group Health Association of America, "the increase in HMO premiums moderated for the fifth year in a row. Premiums rose 8.1% in 1993, compared with a 10.6% increase in 1992. They will rise an estimated 5.6% in 1994, the report said." (Source: Wall Street Journal, 12/10/93, p.B5) With a trend line like this, and a 5.6% increase (only slightly above inflation), the crises may be solved already.

22. Ibid., p. 2.

23. Glavin, Matthew J. Health Care and a Free Society, Imprimis, Nov, 1993, Vol. 22, No. 11, p. 3.

24. Burkett, op cit.

25. Ibid.

26. Memo to MMC Physicians from Becky Lew, 9/10/93. It is worth noting that these rates, when compared to the present rates, allow for as little repayment as 30 cents on the dollar, with capitation rates respectively of 179.28 (compared to present 607.20), 685.68 (compared to present 113.60), 1505.51 (compared to 1933.44), and 378.36 (less than half the present 806.28).

27. See TennCare: A Proposal, Attachment E-3.

28. "Health Care Financing Administration Special Terms and Conditions" for Tennessee TermCare Demonstration, #1 1-C-99638/4-03, (Nov. 18, 1993), p. 1.

29. Ibid., p. 3.

30. Ibid., p.4.

31. lbid., p. 8.

32. Ibid., p. 8.

33. Ibid., p. 2.

34. Ibid., p. 3.

35. Ibid., pp. 3-4.

36. Rusher, William A., Next Liberal Cause: The Right to Eat, Newspaper Enteprise Association, Nov. 11,1993.

37. Theological Ethics: Politics, Vol. 2, Grand Rapids, Eerdmans, 1979, p. 289.

38. Ibid., p. 290.

39. Ibid., pp. 291-292.

40. Ibid., p. 302.

41. Ibid., p. 303.

42. Ibid., p.311.

43. Ibid., p. 312.

44. Ibid., p. 316.

45. See TennCare: A Proposal, op cit., p. 7, Attachment D.

46. Issued by the Tennessee Medical Association, 9/13/93, p.7.

47. Thomas, Cal, Clintoncare: A Question of Trust, Los Angeles Times Syndicate, Nov. 4, 1993.

48. Ibid.

49. National Review, Dec. 13, 1993, p. 8.

50. In one analysis of the contract with Blue Cross Blue Shield of TN as provider under TennCare, the following were noted as unfairly burdensome: (1) the requirement of on-site audits at physician expense and with no prior notice, (2) withholding of up to 20% by MCOs until revenues are sufficient, (3) a "cram-down" provision by which a physician is presumed to be participating and contractually obligated, unless he withdraws from the BCBS Tennessee Provider Network, and (4) a clause in the contract which guarantees reimbursement only upon condition of state solvency, to wit, "To the extent and only to the extent that BCBST is provided with funds by the State for the payment of TennCare claims, BCBST shall make payments to PHYSICIAN for Medical Services rendered to TennCare Enrollees pursuant to the provisions set forth in this Amendment and the TennCare Schedule of Payments." (p. 3).

51. Cf. the author's Too Many Rights Make Wrong, Journal of Biblical Ethics in Medicine, Spring, 1993, Vol. 7, No. 1

52. Willimon, William H., The Effusiveness of Christian Charity, Theology Today, April, 1992, pp. 79-80.

53. Glendon, Mary Ann, Rights Talk: The Impoverishment of Political Discourse, New York: The Free Press, 1991, p. 76

54. Ibid., p. 171.

55. The Encyclopedia of Philosophy, Vol. 7, New York: Macmillan, p. 195.

56. The Encyclopedia of Bioethics, Vol. 4, New York: Macmillan, p. 1498.

57. Johnson, Paul, Whatever Happened to Socialism, Reader's Digest, Oct., 1991, p. 112.

58. Imprimis, op cit. p.1. 2.