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MATTERS OF CONSCIENCE©

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IN THIS ISSUE

We examine the problems caused by health care (or lack of it) in early twenty-first century America. This is a topic that is riven with errors, ideology, inconsistencies and deceit.

While we may not be able to produce an instant solution, we hope to be able to throw light into enough dark corners to reveal its true shape. As its many parts and broad economic and emotional impact do not lend themselves to easy or brief analysis, we will continue our coverage in our January issue.

IN OUR NEXT ISSUE

We will revise our format to be able to treat more subjects, albeit somewhat more briefly.

In our first four years we have examined issues that we deem as absolutely critical to the future of our nation and society. These have included the environment, immigration, child abuse, fiscal responsibility, our national sovereignty and security, constitutional integrity, the war in Iraq, foreign policy, population and others.

We will continue to cover these topics but from a more current, rather than historical, perspective. This is a result of the unrelenting acceleration imposed by technology on our policies, communications and actions, including, of course, human error.

HEALTH CARE, USA

The problems involved in providing good, inexpensive medical diagnosis and treatment to all levels of our society are generally referred to as "the health care issue". Actually, what is most at issue is money – lots of it – and with it the exercise of power.

Health care is an issue we approach with considerable trepidation because of the fierceness and complexity of the dynamic between the major parties involved.

It is not an "either/or" issue that permits our elected representatives to consult a poll, take a stand and have enough political cover to deflect any serious confrontation.

Nor is it a "community issue" that plays out in the local high school or town hall auditorium. Quite to the contrary, the major players are doctors, lawyers and corporate executives. The first two groups, and many members of the third, have both college and postgraduate degrees and are determined to use their considerable skills and education to protect what they see as in their interest.

We do not have expertise in any of the professional disciplines involved and are highly

unlikely to break through the long-standing argument that passes for policy. Our best contribution would be to provide insight into realities usually drowned out by the sounds of institutional battle.

* * *

ACCEPTANCE

Because the health care controversy is so bitter, it tends to obscure factual evidence or recognition. The fact that is recognized in policies today can be altered, eliminated or ignored tomorrow with the position based on it thereby weakened.

Accordingly, the best structural framework we can offer for dealing with healthcare does not cite facts, but rather what we have termed "acceptances".

"Acceptance" is a word with multiple meanings, all relevant to health care. It has a financial use (bankers acceptances), a medical meaning (the ability of the organism to tolerate treatment or medication), a legal denotation (as in the acceptance of evidence in a court of law) and a moral/ethical assertion of what we individually or collectively allow.

In the matter of health care there are some acceptances we cannot avoid. These are not rules, regulations or commandments. They are not given with the divine authority of the tablets on Mt. Sinai, The Quran or the Christian parables. They are not offered as proof like the mathematician's equation; nor are they fixed in the vise of bureaucratic inertia.

They can be seen very differently by different interests at different times, and yet they are real, and we think they have to be kept in mind to come to any understanding of our health care problem:

1) "We have the best health care system in the world". We don't

2) There's quite enough money involved to provide for everyone, but not in the present form.

3) The health care argument is the mother of all special interest battles.

4) Annual losses due to fraud amount to many billions of dollars.

5) Political ideology is a thinly disguised, but ever present and sometimes dominating factor.

The "acceptances" we have listed are those that seem most important to us. There are others. Take your pick; there's no limit. They can also be seen and felt as contradictions, and sometimes as both. Health care is not an orderly world built around clear and consistent definitions. Its sight lines are often not straight. Perspectives vary and any view ahead is one of shifting clarity.

Nevertheless, we offer these "acceptances" as a guide, in the hope that, if you hold on to them firmly, you may make your trip to the center of the maze and return without losing your way or your sanity.

They are what we view as the elements of our national health care system that cry out for public understanding and legislative attention.

* * *

Health care in America is a vast enterprise that attempts to serve the nation's diagnostic, treatment and rehabilitation needs. In doing so, it employs and/or supports an ever widening mix of people and services — doctors, nurses, anesthesiologists, hospitals, laboratories, pharmacies, clinics, caregivers, rehab centers, manufacturers, publications, real estate developers, con artists, authors, media and consultants in both general and specialized fields of medicine.

With millions of people contracting more forms of illness, and sometimes multiple forms, these activities interact commercially at many levels of our health care structure. And even those in good health make their contribution through regular check-ups, preventive medications, diets and regimens.

> "conflict, not just competition,
> has become the normal
> state of this market. "

The result is an enormous and rich market from which all its participants expect to extract their fair (if not more) share of rewards. "Fair" being a subjective word, here and in many of its other uses, it is easy to see how conflict, not just competition, has become the normal state of this market.

The largest players are doctors (i.e. the American Medical Association, or AMA), the insurance industry and the large drug manufacturers ("Big Pharma"). With all this firepower available, it's easy to see how trial lawyers are drawn to the mix after which ignition is almost certain.

Considering the billions of dollars that are spent on health care, we might expect that there would be sufficient rewards for everyone, and that agreement could be reached to provide a simple, generous and efficient system that could provide for all.

That has not happened. The participants are lined up facing each other on opposite sides of the trough. Every movement is suspect; every sound, an alarm.

But those who come to this "party" bring more than just a voracious appetite for money. Most, either alone or in combination with others, have formed political constituencies. As a result, the knives that are used to slice this immense pie have double cutting edges that leave their marks on the state and national legislation that defines our health care.

As this is not the way it should be, not the way we want it, we must ask "Why?". Our politicians claim we have the best health care system in the world, but this is not true.

We have been very good at producing high technology medical equipment ranging from small, portable kits to large, ultra-sound, CAT scan, MRI, or X-ray machines that are truly wonders of medical science.

But away from the high-tech, million dollar machines we seem to have lost our way with the result that many in our wealthy society have no insurance, and others find that decisions as to their care and costs are made by an insurance company rather than their doctors.

It is easy to boast that we have "the best health care system in the world". But what does that mean? There is a major discrepancy between, for instance, the quality of our system's technology and its delivery as evidenced by the estimated forty-seven million uninsured people that it excludes.[1]

As there are many forces involved in health care, so there are many ways to measure them. The OECD[2] last year compared our system to those of Canada, France, Australia and Britain in four different categories, as shown below. The results are most revealing:

	SPENDING PER PERSON	GOVERNMENT SHARE OF TOTAL SPENDING	LIFE EXPECTANCY IN YEARS	INFANT MORTALITY PER 1000 BIRTHS
United States	$6,102	45%	77.5	6.9
Canada	$2,165	70%	79.9	5.3
France	$3,159	78%	80.3	3.9
Australia	$3,120	68%	80.6	4.7
Britain	$2,508	86%	78.5	5.1

Unfortunately we are statistically high where we would prefer to be low, and vice-versa.

> ". . . home-grown, macho, "we're #1" political rhetoric."

There can be many reasons for these variations and in health, as in life, one size does not fit all. But whatever the sources of these differences (and we will explore some later) the claim that we have "the best health care system in the world" comes off as nothing more than home-grown, macho, "we're #1" political rhetoric.

* * *

". . . ENOUGH MONEY . . . FOR EVERYONE"

Our present system sustains a high greed level which we accept because over the past century and a half we have allowed it to be enshrined in our view, legislation and growth of free market American capitalism. To be honest, we should recognize that, more often than we might like to admit, this homage has proved self-defeating to capitalism and caused it to trip over itself.

We like to think of our capitalism as a highly efficient machine powered by the smooth humming of engines of competition. That's a bit of fluff, really; it is just not true, as a look at our health care system makes clear.

You would think that a bloated and inefficient bureaucracy would not be the end result of a system formed by many profit-seeking entities engaged in seeking their "fair" share of the health care pie. And yet, that is what has happened.

Quite simply, the greed factor has fostered a winner-take-all mentality which creates its own disorder in the market and has made competing in it more expensive and difficult for all.

* * *

A HALF-CENTURY OF CONTRAST

Fifty years ago a doctor's office for a small, active practice consisted of a secretary to manage billing, appointments and correspondence, the doctor who had initiated the practice and a junior

medical assistant who might have been a nurse or a young doctor just commencing his career. And doctors made house calls then.

Today the same three person office has a very different form. The doctor and the paper work employee remain, although the latter may also serve as a medical assistant. Another person has been added whose sole function is to manage the flow of information to and from insurance companies, maintain these records and be able to provide documentation, when necessary, to the patient, the employers, the insurer and the government.

This is a difficult and demanding job and subject to human error. The doctor must be able to rely upon his insurance manager and must pay a salary commensurate with the position's value and responsibility.

Today's doctor does not make house calls and has far less time than his predecessor to study the increasingly complex science that he must know and administer.

Another difference is that today's doctor is faced with the very substantial cost of malpractice insurance which can amount to thousands, or even hundreds of thousands, of dollars per year.

Fifty years ago the cost of malpractice insurance was modest and litigation of malpractice claims was rare. Today any error or unexpected outcome can find its way to a court of law regardless of whether neglect, serious damage or faulty intent are established. This basic shift penalizes doctors and rewards lawyers.

Our recent rush to install litigation as a determining mechanism for settling our society's differences could not have been accomplished without the active sponsorship of our legal profession, especially the trial lawyers for whom medical malpractice suits hold a strong appeal.

While the doctor is the primary target, trial lawyers regularly reach behind him/her to lay claim to the far greater resources of the doctor's insurer. This is important because the plaintiffs' attorneys' fees are often based on the amount of any award.

The courtroom is the battlefield where opposing high-priced attorneys wage their war of words. The result is decided by the jury which, unfortunately, is the weakest link in the whole process. its members frequently lack both the mental capacity to absorb the scientific and financial testimony presented and the personal assurance needed to fairly distinguish between the emotional and persuasive arguments of competing attorneys.

There are enormous sums of money up for grabs by many health care participants — hospitals, insurers, drug manufacturers, doctors, etc. — with a ready supply of lawyers for all.

The practice and delivery of medicine in America has been drastically changed to the point where it seems to be more difficult, more costly, and more demanding of everyone involved.

Is this what we want?

"THE MOTHER OF ALL SPECIAL INTEREST BATTLES"

In its simplest form, which long ago ceased to be simple, our health care program is dominated by Medicare, a government program that was originally designed to make payments for hospital care and doctors visits and has recently had prescribed medication added to it. Its funding, administration and payments are a mix of federal and state participation that challenges efficiency.

Employee wages are taxed a fixed percentage up to a maximum level of compensation and employers also contribute. This was the heart of our Medicare program and was intended to enable the government to pay for the nation's health expenses, which it was able to do in its early years.

Such a system requires a sustained equilibrium to keep its original promise, but with the passage of time two key factors emerged that would cause first the disruption, and then the destruction, of the necessary balance.

As our postwar economy and population expanded, the labor force moved its workers towards retirement. this imbalance in favor of retirees meant that the shrinking number of workers were not able to provide for the growing expenses, both in numbers and dollars, of the Medicare beneficiaries.

The second factor was a continuing escalation in medical costs far greater than for the economy in general. These price increases showed themselves throughout the system — in the charges for diagnosis, care, medication, hospitalization, etc.

> " . . . how to be assured equal,
> if not greater, profits
> under an altered system."

It was this predictable shattering of the system's equilibrium that brought forth the first cries that "the system is broken". But repair would

require change and change would create uncertainty, and therein lay a threat to all the parties (i.e., special interests) involved — how to be assured equal, if not greater, profits under an altered system.

We refer to our health care system in an encapsulated form — just three words to describe a system so massive, complex and subject to variations of human or natural origin that it is almost impossible to imagine, let alone comprehend, in its entirety.

The forces that either are joined or oppose each other at one time or another include employees, employers, Big Pharma, doctors and lawyers and their professional organizations, hospitals, HMOs (Health Maintenance Organizations), insurers and our state and federal governments. These are for starters; there are others.

Not only do these groups very fiercely pursue their interests, but they also have created political constituencies from them and have identified and enlisted multiple sources of state and national political support.

This fight over our health care system is huge! Its many and varied participants don't care to lose and are not likely to give up.

The big danger from this concentration of opposed power is that it will not be able to make the adjustments necessary to take our health care system to the next form that our economics and demographics are demanding.

Failure by prolonged inaction to transform the system to the degree necessary, due to individual "turf" or profit motives, could serve a death sentence on systemic change. This, in turn, could impose serious, if not irreparable damage on our economic and social structures.

* * *

"FRAUD — THE EVER PRESENT AND EVER SO SUCCESSFUL PARTNER"

The possibility and, sometimes, the reality of fraud exist at every level, every moment and every transaction within our health care system. It can move silently and swiftly from one place to another, and then can disappear without a trace except the appearance of new wealth. The complex multi-party structure of our health care system is a made-to-order opportunity for those who work outside the law.

The small, local strip mall has become an icon of our economic development and can be found throughout the country. It usually consists of group of retail outlets that serve a small area and can include a laundry/dry cleaner, deli/restaurant, food market, card store, real estate agency, etc.

These bear no relation to the glamorous mega-malls at the peak of the retail economic scale. By comparison, they are plain and insignificant. What they mostly offer is convenience, parking space and anonymity.

There is one not far from us where, earlier this year, a medical services operation working out of a very plain store-front was raided and closed down by federal agents for multiple violations of Medicare fraud laws.

Press reports stated that it had existed in that location for somewhat less than two years in which time it had been able to illegally extract an estimated sixty million dollars from Medicare by the use of false identities, prescriptions and services.

> " . . . the true scale of
> Medicare fraud begins to take shape."

Now, take one non-descript south Florida store front's sixty million dollars in fraudulent charges and extrapolate them to a national figure, based on either population or geography, and the true scale of Medicare fraud begins to take shape.

A canny fraud operation can work one area for a few years and then close down with enough money for a lifetime. Or, after closing, can move to another state and reinvent itself with new identification and methods. The variations are many. The hours are not long. And the pay, as we have seen, is good.

We may as well face that there is no way to obtain a precise figure for Medicare fraud. We can only know that it is immense, running to billions of dollars annually, thrives on the system's present structure and will not be easily extinguished.

There are many ways to "scam" the system and no shortage of volunteers.

Any new system should have as one of its foremost priorities the ability to contain and diminish fraud through better means of detection and enforcement. That would seem to be only a fair "shake" for the American taxpayer who pays the bill.

* * *

"THE POLITICAL CONSTANT – IDEOLOGY"

In today's America ideology rules and health care is no exception. Just as in the 1930s objectors to Social Security described it as "socialism", so thirty years later those who feared and opposed Medicare instantly raised the cry of "socialized medicine" in their attempts to portray it as a fate worse than any other.

"Socialized medicine" has become a mantra of our time and, regardless of how many blue-ribbon panels are presidentially appointed, or who serves on them or what they recommend, they will be accused of transforming our system into a socialist model.

As we have seen both from the magnitude of our system and the public's acceptance of Medicare, it would be impossible to devise any successful system in which government would not have a role.

> " . . . ready with garlic,
> cross and wooden stake to save us."

But conservative ideologies view all extensions of government into our lives as a type of political evil just waiting to ensnare us and drain our blood. Fortunately for us, in their view, they are ready with garlic, cross and wooden stake to save us.

The key element that evokes the playing of the socialized medicine card is any proposal, or even suggestion, of a system built around a single payer, usually government. And yet, because of the size and structure involved, there would seem to be no possibility of any other entity assuming this role.

One look at our present system's high cost, high fraud and less than desired results argues that we should be open to any and all ways for its improvement. And this should even include a willingness to question whether a system, which holds as its highest value competition for profit by its operating parts, can provide the quality and efficiency of care that we claim to want.

Efficiency is an important concept here. Much of the "socialized medicine" criticism that is leveled at any system involving government, and especially at a single payer system, sees government's presence as a violation of our free market economic system to which we, as a nation, are philosophically committed because of its superior profitability and efficiency.

The fraud factor of our current system offers evidence to the contrary. The profits from fraud are sucked out of the system to reward criminal activity on a national scale, and the loss of these funds greatly reduces the financial and operational efficiency that might otherwise have been applied to other parts of the system.

Consider, for instance, how the figures in the first two columns of our chart on page 3 might be altered by the elimination of billions of dollars of fraud losses.

It is also difficult to join in a free-market celebration of our health system's efficiency when almost fifty million people are excluded. There is some truth that our demographics, geography and immigration policy complicate our health care problem in ways that other countries do not face, but we have chosen to provide health care on a national basis, and excluding such a large segment of our population seems inconsistent with this goal.

There is another level of inefficiency at work in our present circumstance. Those who are denied health care through our national plan end up obtaining their care via emergency room services. This is not only more expensive than preventive care, but seriously diminishes the ability to provide care to those taxpayers who are paying into the system, and ultimately raises the costs for all.

And then there are those efficiencies that serve not the system itself, but rather the various parts competing for its dollars.

Lawyers have been extremely efficient in extracting large jury awards, which severely impact insurers and raise the cost of doctors' liability insurance.

On the doctor's side, advantage can be taken of the Medicare billing structure to include charges and receive payment for minor, or vague, services which are combined with the primary charge, thereby compensating for the generally less than adequate Medicare reimbursement rate.

This discrepancy between what doctors charge for their treatment and the amount that Medicare reimburses is especially notable in more affluent areas where doctors' overhead and other costs are high.

Another creative efficiency favoring government was revealed in the Part D Prescription medicine program in which all coverage was eliminated once a specified dollar level of cumulative reimbursement had been reached, and then resumed later at a higher and less frequently attained level.

The missing coverage came to be known as the donut hole. Its imposition was arbitrary and it fostered a bureaucratic near meltdown that caused

hardship for patients and pharmacies alike. But it served the government's purpose of making life more pleasant and profitable for the insurance industry, as we suspect the donut hole was the "fat" area where the volume and size of claims produced maximum payments.

> " There are too many interests,
> and they are all special,
> very special!"

Our system is complex and designed to serve a variety of masters. Unfortunately, the individual public citizen/patient is not one of them. The ongoing financial crisis caused by our current workplace and population demographics has revealed many systemic faults and failures, but great amounts of money are at stake and the room for the kind of political maneuvering necessary to bring about change is just not there. There are too many interests, and they are all special, very special!

* * *

A QUESTION OF PRICE

We recently had a curious experience when we went to pick up a prescription. The person behind the counter located the medicine, did some necessary paperwork and said "That will be $150."

As the price for the past eight years had been $26.00, we questioned the amount and was then told that the first price was an error, "that it was a price for someone else". We asked "who" and received an evasive answer.

This pharmacy is a family owned and operated outlet, and we repeated our question to a senior family member from whom the same evasive response was offered.

We are left with our unresolved curiosity. Who pays $150 for a prescription priced to us at $26?

If there are no buyers at $150, what is the purpose of the manufacturer listing it at that price? To discount it by 30% and sell it at $105? Or by 50% to sell at $75?

> ". . . a meaningful profit . . .
> from a meaningless price."

Whatever the answer, it seems there's a level of deception here as high as the price level, and that somewhere along the line someone will obtain a meaningful profit from what we were assured was a meaningless price.

* * *

Many pages and volumes of analysis and comment have been written about our health care system. Contradictions are many and, from the patient's view at least, it would be impossible to attempt to evaluate our system as "the best in the world".

Quite frankly, it seems more "mess" than "best". The cost is high and restrictions on delivery and participation create barriers that frustrate human and medical expectations.

Were we honest, as a society, in our evaluation, we would admit that a system composed of competing parts and different goals is unlikely to run smoothly and, thereby, create "the best" result. And at these points where the various parts come together it would be logical to hope that they could do so in a way that would further the system's goal of quality care at low, or at least reasonable, cost. Instead, these interactions seem to be seen and managed as profit center opportunities.

In its present form the complexity of the system and its insistence on serving the commercial needs of its participants seem to preclude the realization of our public health care goals.

For instance, the exclusionary intent of determining pre-existing conditions has been part of our system since its inception. Its presence has everything to do with profits and no concern for the patient's health, and yet in the halls of government and the private sector it is viewed as scriptural authority.

If we look at most other major economy systems, we will find no mention of "pre-existing conditions" or "payment denied". Admittedly, these are mostly single payer systems without a "socialized medicine" watchdog mechanism to protect them from political peril.

It is also true that leftist politics, ranging from left of center to communist parties, have played a larger role in some countries since WWII than here.

However, health care need not be held hostage to politics. It is basically an apolitical matter, but

we have let the political genie out of the bottle, and it will take an enormous effort to put him back. But put him back we must, if our system is not to be destroyed by the rapid cost and population increases that we now face.

* * *

THE SINGLE PAYER

In the argument over health care that has taken place over the last half century, and especially in our country, those on the left of the political center have castigated the ways and means of the major insurance and drug marketers.

On the political right these major members of corporate America are never mentioned and constant criticism is directed to the government's presence. The high emotion and persistence of this attack, in which the government's role is invariably defined as "socialized medicine", came to stigmatize government involvement to the extent that overt mention of government was dropped, and the phrase "single payer" adopted instead.

In truth, it would be impossible to undertake the development of a national health care system for a major economy/population without the use of government resources, policy and structure.

The single payer can be a department within government, such as Health & Human Services, a unit or trust specifically created for health care with its obligations guaranteed, much like Social Security, a newly designed federal/state entity or some other new agency.

* * *

Beneath the surface of the health care argument there lies a basic contradiction that engenders strong opposition. This contradiction has proved to be pervasive and derives from the different values that drive the system's participants.

> ". . . an essential aspect of life in a wealthy society . . . "

On the one hand is the primary value of providing care and treatment and relieving, to the extent possible by a mass program, the pain and/or misery of illness. This is a humane approach that its adherents deem an essential aspect of life in a wealthy society such as ours.

On the other hand, the primary value of any corporate participant is the profit motive. Corporations are formed and operated to pursue and deliver profits to their shareholders. Lacking success in this effort, we are told, they would, in time, cease to exist.

In our health care system doctors, nurses, clinics, home care givers and rehabilitation specialists inhabit one world. The drug companies and insurance companies have their own world, and, somewhere in between, the hospitals, including some major multiple unit chains, have to function and survive in both worlds.

We think this confrontation of purposes has been at the heart of much of the bitterness and failure that has marked our national health care discussion over the last fifty years, and, conversely, that we will not be able to develop a successful alternative without resolving it.

* * *

We believe that both the care and financial aspects of our system would be improved by changing to a single payer. In the matter of care, it seems that a national system must attempt to include as many citizens as possible, including those at the lower end of our socioeconomic scale whose care needs surpass their means.

In our present system, because these last tend to have higher illness levels and, therefore, cost more to cover, insurers have been successful in excluding them. With the adoption of a single payer system they could be brought back into coverage.

This would raise the charge that the cost would be too high, but the many substantial opportunities for savings and economy under a single payer would far outweigh the price of universal coverage.

Again, we should bear in mind the first two columns of our chart on page 3, the key one being the high dollar amount we spend per person. If this can be substantially reduced, we could certainly tolerate a higher percentage of government expenditure as long as we maintained a net dollar benefit by reducing expenses.

Robert H. Frank, an economist at Cornell University, supports this approach in citing that administrative expenses for our system run about 31% of total costs whereas Canada's single payer program with universal coverage amounts to less than 17%.[3]

This reduction, he continues, in our system with yearly expenses in excess of $2 trillion could bring about an annual saving of about $300 billion!

It would seem that rewards are there to be had just from better administrative practices.

* * *

"WHEN IN ROME . . . " OR PARIS, OR ELSEWHERE

A college classmate reporting on a trip to Italy has written:

> "Helen slipped on the 1,000 year old cobblestones and suffered a severe fracture of her right femur. The next ten days were in a fine teaching hospital in Perugia – four and a half hours of surgery by the Chief of Orthopedics; ambulance to Rome and special air arrangements back to Phoenix; . . . what would have been a huge bill in the U.S. was ZERO in Italy, courtesy of Italian National Health which covers tourists."[4]

A rather inspiring tale, and yet there's more. Another friend wrote recently of becoming ill and requiring surgery in Paris. He was in the hospital for a week followed by several more days of recuperation at his hotel. No one ever mentioned payment and on his departure to return to the U.S., when he inquired about the bill, he was told it would be sent to him.

Time passed, but no bill arrived. Concerned that any reimbursement process would require documentation, he wrote the French hospital and requested a bill. He then received a phone call in which the caller apologized for his having to write about such a minor matter and said a bill would be forthcoming soon.

My friend was somewhat puzzled by this casual attitude, but saw no other course of action could be pursued until he had the necessary information. Within a week a bill arrived for slightly more than twenty-three dollars with the notation that it was sent at his request and that he could pay whatever part of it he thought appropriate.

In both of these cases excellent emergency care was provided promptly and at basically no cost through a system that covered not only its own nationals, but also foreign visitors.

Nor should we ignore the growing popularity of elective surgery in foreign countries, notably India and Thailand, at great savings. In a recent case, an American facing heart surgery with an estimated cost of $200,000 chose instead a three-week trip with two operations in New Delhi for less than $10,600, travel included.[5] Economic globalists, please note.

If we admit that the primary goal of any national health system is to deliver low cost, quality care on demand, then we have to also admit that these systems which we tend to lump together and demonize as "socialized medicine" are doing many things right, and even better than we can.

* * *

"COMPARISONS ARE ODIOUS", BUT CAN BE INFORMATIVE

It is clear that there are two enormous disconnects here. The first is between how we describe our system and what it delivers. And the second is between our degree of commitment to health care and our tolerance of economic, political and ideological constituencies intent on turning it to their own advantage.

As it stands our system is an expensive and unwieldy mix of politics (state and federal), the corporate sector (insurers and Big Pharma), treatment centers (hospitals, clinics, rehab and outpatient services), medical care givers (doctors, nurses, specialists), representative groups (AMA, labor unions), and lawyers.

This mix is in constant motion seeking to locate, identify, protect, expand and control economic opportunities and to simultaneously establish and extend their political power bases.

The methods used are many and varied and include fraud, greed (institutional and individual), cost cutting, frivolous/phony lawsuits, deceptive billing procedures, denial of care or claims and the list goes on.

There is not a moment in the health care industry when this competitive war is not being waged on many fronts. As with other wars there are

casualties. Lives and/or livelihoods are lost and the fault always lies elsewhere.

It is a source of national shame that our government cannot see and solve this problem in a way that will produce the health care results that other smaller and less wealthy countries expect and have in place.

> "Health care in America . . .
> comes down to a matter of will."

The sticking point, of course, is politics. We might find a president willing to risk his political career by embracing a form of health care no longer burdened by the profit and power lines that increasingly control our current model. But the Congress gives little hope that a majority might form that would be willing to stake their careers on a bitter fight against extremely powerful interests. Health care in America, with all its contradictions and competition, comes down to a matter of will.

* * *

Central to the evaluation of any health program that, like ours, does not offer universal coverage is the matter of affordability, that is where on our society's economic scale is the line of exclusion/inclusion to be drawn. This is not a fixed line and its placement is affected, for example, by medical costs that have increased at the rate of 7% annually in the past five years while our GDP growth has been at the 3% level.[6]

Of all the candidates for nomination for the presidency, only one, Dennis Kucinich (D-OH) has favored a single payer system which he views as the only way to break the grip of insurers and pharmaceutical companies on our health care system.

This may sound extreme at first reading, but it is not. We need only recall the most recent health care legislation in which Medicare was specifically forbidden to negotiate with drug manufacturers to obtain lower price levels for its high volume purchases.

Here, at the urging of the pharmaceutical companies and their representatives, government took upon itself to suppress competition and set prices in a move that seems far closer to socialized medicine than free market capitalism.

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SUPER DUPERS

Dupe – v.t., to deceive, delude, trick.
Duper – n., one who dupes
– Webster's New Universal Unabridged Dictionary, 1996

The U.S. pharmaceutical industry has undergone great change in the past half century. It emerged from WWII with new techniques and technology for both treatment and research. And this technology explosion was coupled with a global population increase that, because of poverty conditions and greater movements of people, was accompanied by major increases in many forms of disease.

Pharmaceutical success is initiated by research which is capital intensive. Over the last fifty years expenses for research have been pushed ever higher by the increased cost of the personnel, instrumentation and testing procedures which it requires. The research function consumes time and money without producing any significant return. It is the first step on the path towards the high volume consumer sales that produce the pharmaceutical companies' enviable profits.

The active ingredient that transforms research from expense into profit is marketing, and nowhere has the change in recent years been more notable than in the marketing of prescription drugs, especially in the last decade.

We have witnessed and been part of a marketing revolution. As recently as the 1950s, almost all medical products, although sold by pharmacies, were advertised to doctors through low circulation "trade" publications with mostly technical editorial content.

In recent years pharmaceutical companies have extended their reach and, without abandoning their traditional promotion to doctors, made direct contact with consumers.

Key to this process was our parallel media explosion of radio, TV and four color newspaper advertising. Such is background for what follows.

Parade is a four-color, weekly supplement distributed mostly to small and medium size

newspapers that cannot afford a Sunday supplement of their own. In the postwar print media hey-day it was an editorial and advertising success. Today both areas are considerably diminished.

Its July 8 issue[7] carried a five-page advertisement by AstraZeneca Pharmaceuticals for Seroquel, a drug for the treatment of bipolar disorder.

Three pages of this ad are in two colors and are devoted to its marketing message. The remaining two pages are in small type, black and white and contain the mandatory information regarding dosage, side effects, precautions, administration, etc.

Any campaign that runs five-page ads in national publications becomes expensive. And then, there's television where the cost and frequency is far greater and where the ads with their "Ask your Doctor" message are endlessly repetitive, as are their attention to the medical conditions and drugs that treat them.

The truth is that the pharmaceutical industry spends billions of dollars every year to promote not only the new drugs that it develops, but also the illnesses for which they can claim to provide effective treatment.

The advertising for prescription drugs that was mostly confined to medical journals and other 'trade' publications, now appears in any and all consumer media and deals with a mix of conditions that includes nutrition, appearance, sex, obesity, age, etc.

There seems to be no shortage of medical conditions that require attention and no shortage of drugs with which to treat them. How has this come about in a span of only fifty years?The first two answers are easy. This period has been one of exceptional population expansion and concurrent media growth fueled by technology.

"Big Pharma has big money!"

And the pharmaceutical industry is one of the most profitable manufacturing groups in the country with some of its members reporting after tax profits of over twenty per cent. Big Pharma has big money!

But now the questions get tougher. In a period of spectacular advances in medical technology and treatment why are we faced with advertising for more illnesses and drugs with which to treat them?

And, most important, are these conditions truly "illnesses", or are they part of the natural physiological transformation that marks our life process and that we have historically understood to result from the passage of time?

A recent, and in our opinion frivolous, example of this effort to portray naturally occurring processes as illness can be seen, again, in the June 10 issue of Parade[8] in which an article by Dr. Isadore Rosenfeld (no background information provided) describes Restless Legs Syndrome. He lists some symptoms and a few statistics, but no sources, offers some home remedies and then gets to the point and mentions two FDA approved drugs.

Two months later the August 12 issue carries an almost two page ad by Glaxo Smith Kline for its Requip, one of the drugs specified by Dr. Rosenfeld. A few quotations from this ad are:

> Subheadline – "Requip helped me make peace with my legs"
>
> Main text – "Restless Legs Syndrome (RLS) is a recognized medical condition." "Requip is the first FDA approved treatment for RLS." "Ask your doctor if Requip Is right for you." [9]

If you come away with the feeling that a high cost hoax is being perpetrated by this kind of marketing, you are probably getting close to the truth, and it's likely to be worse than you suspect.

* * *

Today, the American public is under constant assault in every marketing medium by a barrage of advertising from the pharmaceutical industry. These ads claim to provide relief from the symptoms of a wide variety of "illnesses" and/or "conditions", including depression, erectile dysfunction, osteoporosis, macular degeneration, high cholesterol, menopause, high blood pressure, female sexual dysfunction and many others.

There is money, lots of it, at stake. Lipitor is the world's largest selling prescription drug with more than $10 billion annual sales[10], and there are many more that follow in its wake. Their advertising budgets are what the marketing media dream about, but are easily affordable for their manufacturers given the hundreds of billions of dollars in revenues they produce.

But these revenues could not have been achieved without a fundamental change of marketing strategy on the part of Big Pharma and its

unsuspecting acceptance by the public.

Quite simply, the pharmaceutical industry transformed its message from selling medicine to selling illness. Its logic is that once people are convinced that they are ill (or suffer from a medical condition), they will create a lemming-like mass market that will demand the advertised products from doctors. And, because this advertising convinces people they are ill, they become long-term, repeat customers. The power of these messages, if you read them carefully, can be based on persuasion or fear. For the unknowing, unsophisticated or unsuspecting reader there is no defense.

* * *

"ASK YOUR DOCTOR IF (BRAND X) IS RIGHT FOR YOU"

Unfortunately this transformation of medical marketing could not have taken place without the participation of the doctors who write the necessary prescriptions.

For the most part they are distinguished by their humanity, dedication and industry and lead lives not dominated by commercialism. But there is that minority who are only too willing to mix money and medicine and who make easy prey for Big Pharma's lures.

There are many ways this can be done. Doctors receive frequent visits from the pharmaceutical companies' "detail" (i.e., sales) men who provide free drug samples and literature, meals, events tickets and invitations to conferences where all travel, entertainment, lodging, meals, golf, lectures, etc are free.

This is a more or less passive form of commercialism in which a great many doctors join. Depending upon degree, it may cross the line and foster a closer relationship with the pharmaceutical companies than an objective observer might consider ideal.

There is a smaller group, however, that takes a far more aggressive role and engages in third party marketing and PR functions that can manipulate consumers and alter the regulations that govern medical product development and sales.

In Selling Sickness[11] authors Ray Moynihan and Alan Cassells provide detailed descriptions of how sales campaigns have been built on false or misleading information that effectively and increasingly establishes in the consumer a perception of illness and the need for medication.

Sadly, this perception is in far too many cases based on incomplete information, questionable marketing practices, invalid statistics and lacks objective scientific support.

As all cases are not the same and techniques can vary, we have assembled a composite example for Brand X, a medication developed by the National Drug Co (NDC).

1) Throughout their careers doctors find it beneficial to periodically attend medical education refresher courses and to take advantage of convenient sources of scientific research. About half of the cost of providing these services is paid by the pharmaceutical industry.[12] And early in their careers young doctors, considered by their detail men to show promise in assisting in product promotion, are assigned speaking opportunities to present their drugs to local audiences. If effective, these initial efforts can be expanded to national or international scale with correspondingly greater compensation.

   Taken together, these practices provide the means over time for pharmaceutical companies to form a "varsity" team that can prove invaluable in moving their products from the research lab to the public marketplace.

2) Awareness Raising — From time to time small advertisements appear in local media that ask questions about physical symptoms that "growing numbers of people may be experiencing more frequently". The ad further suggests that, if the reader shares these symptoms, he/she may want to join a research group to explore ways to provide relief. A phone number or PO Box for reply is also listed.

   After responding, the reader is contacted and invited to a discussion group to be addressed by a local doctor. These initial meetings are generally enthusiastic and successful, as those attending share a common curiosity and condition. They receive a report of the meeting that normally includes mention that a leading drug company has done important research in the area of interest, and that they will be contacted again.

   These meetings, and the advertisements that preceded them, are part of a national effort directed at many different demographically selected localities. The drumbeat has begun.

3) Patient Advocacy – Next, the discussion

group participant receives a letter from NDC thanking him/her for taking part and enclosing a questionnaire asking general information about the recipient's history and nature of symptoms and emphasizing that such information would provide valuable input for its research program.

NDC now has a large number of replies from around the country which it can tabulate and translate into the language of consumer research. This can substantiate and give voice to a patient advocacy group. It can also be employed to make contact with local media via Letters to the Editor and occasional editorial coverage, as the drum beat gains in strength, but is still not notable to the general public.

4) Gaining Legitimacy – The pace quickens and movement switches back to NDC. It provides the doctors on its "varsity" advisory staff with copies of its statistical documentation and its product research with the suggestions that they use it in writing media articles or giving papers to their regional or national medical groups who would benefit from recognizing such a new and large advocacy group.

5) The Critical Factor – In order for the seed planted by NDC to germinate, it must now have the support of the medical community, most of whose members have a genuine interest in new science, products, treatment, etc. as an essential aspect of their chosen career of healing.

6) Peer Pressure – In medicine, as in most professions, there are a variety of opportunities for the enterprising. There are deals to be made and money for those involved. In the medical middle ground between practicing doctors and producing pharmaceutical companies there are doctors who work both ends and do so profitably and without apparent conflict. They are small in number, but very important to the drug manufacturers as they are able to influence decisions that can widen the application, the market and the profits for new or existing drugs.

These doctors serve as paid advisors to pharmaceutical companies who provide them with the information derived from the awareness raising and patient advocacy activities. In contact with other doctors, regional/nutritional medical associations and consumer/trade publications the paid advisors make the point that a growing number of people suffer from the same symptoms and that Brand X has shown real promise as a course of treatment.

The drumbeat increases as more publicity mechanisms are set in motion. We should note that here and at other stages throughout this process all the normally available PR tools such as celebrity appearances, talk shows and artificial reports are put to productive use.

7) Official Recognition – This is the final stage in which the advisory group doctors are essential. They seek formal action by their professional organizations in transforming the data obtained by the awareness raising and patient advocacy groups into the formal rules, and definitions that regulate medical marketing and provide product approval to drug manufacturers.

Much of the work undertaken by the doctors/advisors involves semantic differences, definitions, and considerable language as to dosage, side-effects, administration and many other details of usage that must be disclosed by federal law.

> "Money is quietly being moved from one group to another."

We tend to visualize editors in green eye shades poring over too small type while proof reading endless pages of copy. Well perhaps, but something else is taking place. Money is quietly being moved from one group to another.

For instance, "according to the official U.S. National Institutes of Health cholesterol guidelines from the 1990s, thirteen million Americans might have warranted treatment with statins. In 2001 a new panel of experts rewrote those guidelines and effectively raised the number to thirty-six million.[13] This constituted a very significant increase in the size of market for Pfizer's Lipitor.

We cannot escape the evidence that, "over time, the boundaries that define medical conditions are slowly widened and the pools of patients steadily expanded".[14]

And what finally emerges from a new application for listing is an authoritative statement that presents the known medical history and defines it as an official illness or a condition that meets professional standards for diagnosis and treatment. It is this classification process that opens the flood gates of consumer advertising, with the endless appeals to "ask your doctor . . . ", and which joins the manufacturers' research and marketing functions into an enormously profitable whole.

In viewing the role of the paid advisor/doctor we start with the fundamental assumption that anyone legally and ethically engaged in a licensed profession is entitled to compensation therefrom. But legal and ethical judgments can vary significantly.

Many businesses use "independent" third party referrals or sources to promote their products that are, in reality, not "independent", but receive payment.

Medicine is different. It is about life and death and, when we choose a doctor, we are often assigning that power to him/her. That's a heavy choice and, because it is, we think it requires full disclosure by all parties.

To this end we think professional ethics should necessitate that any statement by a doctor regarding any product, treatment or medication should contain disclosure of compensation.

It's not the compensation, itself, that creates the problem. The fault lies in providing expert opinion that appears to be independent and objective when, in fact, its source has received compensation. A brief and simple one-line disclosure is all that is needed as correction.

* * *

Today we drown in a multi-media sea of advertising, an increasing amount of which promotes medical equipment, drugs and treatments. We are exposed to warnings, "slice of life" messages, special effects, humor, audio and visual excess, scare tactics and many other ways by which it is hoped that we will "get the message".

But what is the message? A careful analysis of current medical advertising, whether print or broadcast, reveals that we are continuing targets for two different messages.

The first, and most obvious, is the product which the ad promotes and urges us to use and buy. This is a traditional message with a history of many years of success.

Then there is a more recent and subtle message with a broader reach and target. It attempts to change our view of our bodies, to convince us that illness is a natural and continuing state from which we can gain relief by the frequent and extended use of prescription medication, even though the latter may cause unwanted side-effects.

Invariably the benefits of new or existing drugs are emphasized while their potential drawbacks are not noted.

Some years ago Wyeth Laboratories developed a drug called Premarin, designed to combat the symptoms of menopause. Its ads presented naturally occurring menopause as a condition called "estrogen loss" and promoted a regimen of hormone replacement therapy (HRT) with the use of Premarin. Many millions of women were persuaded by Wyeth's advertising, and HRT became an accepted therapy during the decade of the 1990s.

> " . . . outweighed by increased risks of heart attack, stroke, blood clots and breast cancer".

But there were troubling and serious side-effects to which little attention was paid until in 2002 the Journal of the American Medical Association published findings that, while HRT had somewhat "reduced the risk of fractures and colon cancer, (this) was outweighed by increased risks of heart attack, stroke, blood clots and breast cancer".[15] Not exactly a good trade.

The process of aging brings about body changes for all – hair loss, shortness of breath, eyesight/hearing deterioration, lack of balance, muscle weakness, etc. In the past these, and others, have been regarded as natural events but are now transformed into "conditions" and marketing opportunities.

It seems surpassingly silly to think of restless leg syndrome, erectile dysfunction and pathological gambling as illnesses to be medicated at the taxpayers' expense. And yet that is their status. Addictive gambling, for instance, was classified as an illness in 1980 when it first appeared in the Diagnostic and Statistic Manual which is used by doctors to describe disorders and by insurance companies to determine reimbursement.

* * *

There is one other element we should note as being part of America's health problem, although not a part of its health care system.

This is the close, and often dominating, relationship between Big Pharma and the Food and Drug Administration (FDA) which is charged with the responsibility for testing and approving new drugs.

Ideally, given this function, the FDA should be an independent body, but it is not. It is often put to political use and the influence of the pharmaceutical industry is readily found in its personnel, budgetary and policy choices.

As an example, the drug testing programs it conducts are paid for by the drug's manufacturer. The closeness of such a shared role is never completely free from conflicts of interest that can compromise both the FDA's results and the nation's health.

* * *

CONCLUSION

Our present health care system suffers from having to serve too many powerful interests. It must serve two professions (law and medicine), corporate America, a rich and efficient criminal fraud element and at the same time provide quality health care and impose a political litmus test ("socialized medicine") on its design and structure.

Many "blue ribbon" panels have been appointed to study it and report back to whichever president appointed them. But study and report is all that usually results, and the opportunities to reform the system, the ones that require real change ("the road not taken")[16] are lost in fading interest and the passage of time.

We believe that the bloat, corruption and manipulation of our present system is so advanced and entrenched that only drastic reform has a chance to succeed.

And we also believe that, once we accept the possibility of drastic reform, we begin the process of liberating ourselves from many of the constraints that in the past have reduced our efforts to repair the system to minor tweaking at its edges.

The most drastic reform would be to switch to a single payer system. There are models currently operating in France, Australia, Sweden, Italy and elsewhere. Some are similar; others are markedly different. We should be able to look at how they operate and then design a system that will work for us.

It is easy to dismiss a few, or all, of the parts of these programs with phrases like "we can't do that" or "that wouldn't work here" or "we've never done that before", but one thing that these other countries' programs have in common is that they are able to produce good care at for what is to us not just an acceptable, but an enviable, cost.

Single payer, itself, could take several forms. It might entail direct payment by the government or the creation of a trust such as Social Security funded by a combination of government, corporate and public sources. We should approach this with a "Why not?" and "Don't take no for an answer" attitude.

As a nation we should be able to do this in order to solve the problem of providing good care at reasonable cost. We have vast, but not unlimited, economic and intellectual resources. Is it beyond our capability to create for us what other countries have been able to provide for their people?

Of course, we will face the usual congressional resistance and insistences that every political, philosophical and economic constituency be preserved in its present state of funding. Perhaps we could borrow a feature from the military base closing act and devise a new and somewhat different legislative procedure as follows:

1) President appoints special advisory panel. Its selection should not be politically dominated, but should include members from academia and medical and financial experts.

   As the primary purpose of the new system would be to provide universal care at reasonable cost, not profits, the corporate sector should not be included. Its voice can always be heard in Congress.

   This panel should be instructed to design a system that would meet presently lacking coverage and cost goals, and that would have as another prime objective the elimination/ reduction of fraud and excess administrative expenses. It is absolutely essential that this group include forensic accounting and both electronic and paper document security expertise in order to eliminate as much as possible the effect of fraud upon the new system's structure and function. The latter should include prosecution under the RICOH statute and the immediate deportation of any convicted non-citizen. It should be told to be innovative, not to depend upon prior practices and models and to consider the possibility of a single payer structure.

   It should also include two former state governors with Medicare experience at the state level. They, with the security oriented members, could provide a much needed force to simplify

structure, reduce fraud and administrative costs and to resolve the differences between state and federal roles.

This is no small task, but, if approached with imagination and independence, could lead the way to remaking the present system.

Time being a factor, this group should be asked to submit its report in six to twelve months. Were it to consist of retired experts from the appropriate fields of interest who could give their full attention, this schedule could be met.

2) Advisory panel submits its report/ recommendations in outline, not legislative form, to the Congress. This is important! At this point it should provide a structure, not a body of law. So far, political input, both presidential and congressional, has not had a chance to enter the process.

3) Report is delivered to Congress with the proviso that it must be accepted for further review or completely rejected. If accepted, it can be returned to its authors with a specified number (we'll use 40 as an example) of requests for changes, additions or deletions.

4) Upon the return with recommendations, the advisory panel will study the congressional requests and reject half of them, refine the other half and return the revised plan to Congress. Again, Congress may reject or proceed.

This elimination process will have the effect of doing away with much of the favor/ vote trading by lobbyists and members that would normally accompany such an important piece of legislation, as neither group would want to spend necessary political capital on elements that may not "make the cut". Indeed, this procedure, because much of it is beyond congressional reach, could protect the Congress from lobbyists, voters and even themselves, and in the process capture public interest.

Also, as Congress will submit requests of which at the most half will be retained, it should attempt to propose those changes that have the broadest appeal and best chance to survive.

5) Panel's new version, including the twenty alterations, is received by Congress with instruction to review the revised plan and return it with ten additional suggestions for the panel's consideration; or to reject it.

6) Advisory group reviews ten proposed alterations and makes its final recommendations. It can accept none, all or any part of the ten congressional submissions. Final outline of plan is again sent to Congress for acceptance or rejection without modification.

If accepted, there begins the process of turning the language of the plan into legislation. While intense lobbying and voting pressure will now enter the process, it will be subject to having to conform to the detailed outline provided by the advisory panel with no additions, deletions or substantive alterations permitted. The final congressional legislation version will then be returned to advisors for their review and approval.

To work best, the panel must be able to engage its responsibility and perform its work free of presidential, congressional, corporate or professional interference.

This elimination procedure assumes that the Congress, at those points where it is given the opportunity to accept or reject, will find that outright rejection would create an unacceptably high level of political risk, as it will be dealing with an issue of great national importance and controversy that should not be dismissed out of hand.

Timing is crucial to maintain interest and produce results. Accordingly, each congressional review period should be limited to sixty days. We suspect that the panel's deliberations could be accomplished more quickly, perhaps in thirty days or less. Should this prove accurate, the whole process from the identification of the advisory group through final congressional and presidential approval could be completed in from twelve to eighteen months.

* * *

The most critical element in this mix is the creation of the advisory panel. It will have to serve as a guide to Congress and persuade it to part company with some of its more parochial and less productive methods. Congress may be reluctant to tolerate such a lesser role, but, on the other hand, if the prize is the delivery of a new and improved health care system, it may be able to pull itself together. If not, the next question is "what is the alternative?"

Fortunately, we have a moment of opportunity. Can we now identify something between the excessive governmental involvement of European systems and our present economic and care failures to contrive a uniquely successful and American model?

And here, rather unexpectedly, idealism again presents itself as a way forward. The circumstances of our national health care are similar to the problems that faced our founders.

There are many difficult interests and differences to be resolved and, if we are to remain captive to defending or trading the benefits of the old system, we can only assure the defeat of the new.

Idealism, informed and defined by the improved quality, cost and availability of health care, is the only force that can bridge the extensive differences in our current system and free us from the errors of the past. It is very rare and fortunate when idealism and practicality can be merged to resolve such a difficult problem.

We are at that point now. Do we have the will?

END NOTES

[1] NY Times 12/31/06. Section 3, page 3. Health Care Problem? Check the American Psyche by Anna Bernasek. This figure has been recently updated from the article cited. It is accepted by most commercial and government participants and has been widely used by candidates of both political parties in their campaign speeches.
[2] Ibid. Source: Organization for Economic Cooperation and Development.
[3] Ibid 2/15/07 p. C-3
[4] Yale Alumni Magazine March/April 2007 '49 notes.
[5] AARP Bulletin 9/07
[6] The News Hour PBS 8/28/07
[7] Parade, 7/8/07
[8] Ibid 6/10/07
[9] Ibid 8/12/07
[10] Selling Sickness by Ray Moynihan and Alan Cassells. Nation Books, NYC, NY July 2005 ISBN 1-56025-697-4
[11] Ibid
[12] Ibid
[13] Ibid
[14] Ibid
[15] Ibid
[16] Robert Frost – The Road Not Taken - 1916

POST SCRIPTS TO OUR LAST ISSUE

BUSH LEAGUES

As time passes, and only a year remains until our next presidential election, a case can be made that in the seven years of his two terms President Bush has dealt broad and deep damage to many of our governmental institutions. These include, but are not limited to, the White House, CIA, Departments of Defense, Justice, Homeland Security and Interior, armed services, etc.

The two Bushes are usually distinguished from each other by being referred to as Bush I and Bush II or Bush 41 and Bush 43. Given the record above, a more appropriate reference might be Bush the First and Bush the Worst.

* * *

POLITICAL PROCESS FLOW

We had a couple of responses from readers who thought our comments about the Congress overly harsh and who opined that most members of Congress were "good and honorable" holders of their offices.

This we see as a subjective generalization that misses the two most important issues. For whatever else our elected representatives may be "good" at, they have not proved to be good creators and administrators of government.

As for honor, we think they have largely failed to honor the Constitution which by their oath of office they are committed to serve, protect and defend.

This failure is part of the integrity/cynicism issue. We feel that the intellectual integrity necessary to understand and defend the Constitution is a congressional rarity, and that the problem lies in the current perspective of our elected representatives.

The first American dream was that of an open, accountable and fair government based on the rule of law. Those we elected to political office were to be the implements by which the promises of the Constitution would be delivered through succeeding generations.

Although their salaries are paid by the