The Center for Medical Missions' *e-Pistle* October 2009

Welcome to this month's e-Pistle. Dave has omitted his usual 'management' article in order to bring you up to date on America's health care reform issue. We hope you will appreciate having a current CMDA view of this issue. You are welcome to send comments to Dr. Stevens via Susan Carter at susan.carter@cmda.org

Here is the complete list of content in this month's e-Pistle:

I hope you enjoy this month's e-Pistle. As you are praying this month, please remember the Center for Medical Mission as we go through a strategic planning process. We have been tasked with planning for the next few years and would really like to follow where the Lord takes us. If you have any thoughts on ways we can better serve you, please let me know, Susan.

Health Care Reform

By Dr. David Stevens

I debated this month whether to write about this topic but then I remembered how acutely I wanted to stay in touch with what was happening in the US when I was overseas. Healthcare reform, as proposed, will profoundly affect you as a physician, so you need to know what is going on.

One effect you might appreciate. A recent Investor Business Daily poll revealed that US doctors opposed the proposed bills two to one. Forty-five percent said they would consider retiring early or leaving medicine if they passed! A survey of faith based healthcare professionals we commissioned revealed that 95% would quit medicine before violating their conscience. There is no healthcare right of conscience protection in these bills and they fall outside the protections that exist.

So if healthcare reform as proposed goes through, you could have all your personnel problems on the field solved! Doctors could flock to the mission field.

Before you start praying for the bills' success, let's dig into them a little deeper. A few things are obvious:

- The five bills are complicated – they are over 1,000 pages each.
- Hard to understand
- Give enormous powers to the Sec. of Health and Human Service. The person essentially becomes the Health Dictator who dictates what is medically necessary and what is not.

First of all though, let me say I am for reform. Health costs are going through the roof! We are spending over 16% of the GDP so that one-in-six dollars spent goes to cover medical expenses. Annual healthcare inflation is up to five times the general inflation rate. We spend 50% more than the next industrialized country spends per capita and are not overall healthier. Bottom line, cost has to be controlled. We can't sustain the present course. This is the most important issue in health care reform.

The battle cry in this war is the uninsured, but this is not the main issue that we should focus on. There are only about 13 million people in the US who are not illegal aliens and who do not have insurance for a whole year. The 40-50 million you hear bantered around includes illegal aliens and all those that do not have insurance for any part of a year. What's more, any person can go to an emergency room to get healthcare in the US and they cannot be turned away for lack of payment. Not ideal and not cost effective but very few Americans die because they can't get healthcare intervention. Access is important but it is not the most critical concern.

Affordability and access are the first two legs of the health care "stool." The third is "quality." Overall, we have a medical education system that is the envy of the world, the most research (90% of new drugs), the best hospitals, the latest diagnostic equipment and highly trained doctors. A lot of what you hear negative about US outcomes is based on two factors. One is comparing apples and oranges. For example, our perinatal outcomes lag behind some countries. Doesn't sound good until you realize they don't count many premature babies in their statistics. They only count babies born after arbitrary weeks of gestation. We count all live births. Secondly, because of our affluence we have much bigger issues with heart disease, diabetes, strokes, hypertension and other diseases related to obesity. Ironically, the economic group with the highest rate of obesity and related disease are the poor. Prevention is a big issue that needs to be addressed.

Our curative capabilities outstrip other countries. For example, for all cancers, the cure rate in the US is 66% for men and 64% for women while in Europe it is 47% and 55% respectively. About 99% of men with prostate cancer in the US survive 5 years compared to 77% in Europe. Screening for disease, we do a much better job in obtaining pap smears, PSA's and colonoscopies than other countries.

It is easy to have two legs of the healthcare stool but very difficult to have all three. Universal healthcare in Canada and the UK means better primary care but limited access or long delays for specialists as well as expensive diagnostic or treatment options. For example, the US has thirty-four CT scans per million people. Canada has twelve per million and the UK only eight.

Yes, we need reform, especially to lower cost, but we don't need to transform a system and lose the quality we have.

There are seven "rulers" that I hold up to healthcare proposals. You might find them useful as well.

1. **Will healthcare be affordable?** We have an inefficient healthcare bureaucracy. Estimates show that up to 20% of every healthcare dollar goes to bureaucracy ($500 billion a year). When I was young, the local doctor had a receptionist at the front desk and a nurse or two in the back office. Now there are a half dozen people getting preauthorizations, filing a myriad of government and private insurance forms and negotiating reimbursement. The doctor spends too much time arguing with insurance companies that won't authorize reimbursement. Solo practices have difficulty bargaining reasonable reimbursements for their small patient panels. I know a wonderful family practice doctor who created a Christian practice with four or five other doctors. They were driven out of practice, not by low numbers of patients per doctor, but because they could not get as high reimbursement rates as larger groups.

   We must decrease bureaucracy. Unfortunately, all the plans proposed increase bureaucracy at the federal level. Significant money has been put in the stimulus and reform package to standardize and computerize medical records across the country, which will have some benefit. That is a two-sided coin though. The downside is that as proposed, everyone's medical records and names will be in the government's hands raising huge privacy issues.

   Malpractice is the elephant ignored in the room of healthcare reform. Used to, only bad doctors got sued. Now those that have not been sued are the exception. More than high malpractice premiums ($300,000 for an OBYN in Miami) and multimillion-dollar settlements is the cost of doctors practicing defensive medicine. You know, you are 99.9% sure that knock on the head didn't result in a subdural hematoma but "just in case" you order a CT scan. Eighty-nine percent of malpractice cases result in no compensation. Eighty percent of those going to trial are settled in the doctor's favor. Experts estimate that more than 10% is added to overall healthcare cost in this area alone. I believe those that are seriously injured should be compensated but it would best be done by an unbiased expert compensation panel not in a cumbersome, time consuming jury system where lawyers get half of any compensation given.

   Unfortunately, none of the reform proposals include malpractice reform. In large part because the trial lawyers have given 91% of their multimillion dollar political contributions to the Democratic party that has opposed malpractice reform over the last 20 years. (Top 10 political donor list – 3 groups with fairly balanced donations between two parties, other seven - 90% plus to Democratic Party = five unions, the National Educational Association and the trial lawyers)

   Other factors contribute to excess cost. Due to government regulations, it costs on average $500 billion dollars to bring a new drug to market. Only 1 in 100 compounds that

hold promise actually make it. This creates a lottery mentality for drug companies that charge outrageous costs for new drugs, many of which have minimal advantages over older ones.

Some reform proposals attack drug companies and try to regulate drug prices. This puts the cart before the horse. Reasonable regulations by the FDA would go far in solving the issue by lowering the cost of bringing new drugs to market. Limiting direct to consumer advertising and better distribution of cost efficacy data would also be a better path to control costs.

Better collaboration between doctors is needed. Tests are often repeated (one of my staff had three EKG's in one week by three different doctors who wouldn't accept the report from another office) and there are many financial incentives to do unnecessary procedures. Doctors are not without guilt in the mess we face.

We are over specialized and have two few primary care doctors to coordinate care. The financial incentives for specialization are high – higher pay, fewer work hours, narrower focus in medical knowledge to keep up with. Specialization is also driven by the fact that greater than 50% of medical school graduates are females who often want fewer work hours a week to have more time with their families. Add to that are the facts we will be short 150,000 doctors by 2025 with present trends and an aging population. Without better collaboration and more primary care, we will just increase costs.

Lastly, we need to assure people access at the appropriate point of care. There are 82 ER visits per 100 Medicaid patients per year but only 21 per 100 private insurance patients. One out of six people going to emergency rooms has no insurance. Many of these illnesses could be handled at a much lesser cost in a primary care practice that has a added bonus of providing continuity of care.

The proposals on the table in Washington, project close to $1 trillion in more costs over the next 10 years, but even that is deceptive. Estimates escalate each year so that 20% of the cost occurs in the last year and increases dramatically after that. Many of the costs of reform are being underestimated and others are not included. For example, Congress just passed a $250 billion Medicare package, much of which should have been in healthcare reform's final bill but it was pulled out to make the bottom line look better.

The government is going to tax high value insurance policies (pay back time - unions will be exempt), tax insurance companies, etc, to pay for adding millions of more people to the insurance rolls. At the same time, they are requiring insurance companies to include applicants with preexisting conditions, do away with yearly or life time caps and have a benefit package defined by the government. All of these things push cost up and will be passed on to those that have to pay the bills.

What is happening is cost shifting, not cost savings.

Are you depressed yet? If not, let me share two more things.

The only way under the present proposals the government can control cost is to ration health care.

- Sec. of Health and Human Services with the non-binding advice of the creation of the "Federal Council on Comparative Effectiveness Research" will decide what will be paid for in healthcare. Essentially, one person will control one-sixth of the economy. One of the members of that council is Dr. Ezekiel Emanuel, the brother of the President's Chief of Staff. He is a Senior Health-Policy Adviser at the Office of Management and Budget. The Wall Street Journal calls him "Rationer in Chief." He blames the Hippocratic Oath for the "overuse" of medical care because doctors see the phrase "use my power to help the sick to the best of my ability and judgment" as an imperative to do everything for the patient regardless of cost or effect on others. Medical students, according to Dr. Emanuel, should be trained "to provide socially sustainable, cost effective care" instead.

  He advocates a system where "When implemented, the complete lives system (his invention) produces a priority curve on individuals roughly 15-40 years of age, to get the most substantial chance (i.e. health care), whereas the youngest and oldest people get changes that are 'attenuated.'' He goes on, "Adolescents have received substantial education and parental care, investments that will be wasted with a complete life. Infants in contrast, have not received these investments." He advocates establishing the Orwellian sounding, National Institute for Healthcare and Clinical Excellence (NICE), to slow the adoption of new medications and set limits on how much will be paid to lengthen life.

  A screwball opinion? Yes and no. Yes, he advocates a cold hard utilitarianism. No, the article advocating this was printed in the New England Journal of Medicine and he has the power to make it happen.

- The Baucus Bill in the Senate has another twist. It makes doctors rather than bureaucrats do the dirty work. It requires the doctors that spend the top 10% of Medicare funds to refund 5% of it to the government retroactively. There is no allowance for your patient demographics, your type of practice or patient outcomes. There is no way to monitor how you are "doing" during the year. It turns doctors into rationers in chief.

Add to this that the President and Congressional leaders are saying one thing and doing another. They want a "public plan" to "compete" with private insurance companies to lower cost. For those that don't speak politicalize, "public plan" means government run healthcare.

The President said only about 5% of the US would be part of the public plan and you would be able to keep your private employment based insurance if you wanted. Sounds good, right?

First of all, the group that makes the rules can't fairly compete in an open market but it is more sinister than that when you read the bills. If you change jobs or lose your employee insurance for

any reason, you must go on the public plan. Hang on, it gets worst. If your employer decides to ditch your insurance benefit, they must pay an 8% penalty for each employee to the government.

Let's apply those facts to an actual situation. CMDA pays $10,800 for a family plan for each employee. One of my staff members would have to make over $135,000 a year (none of them do) before it would be more expensive for me to pay the penalty rather than to put them on the public plan. I have personnel that make under $30,000 a year that work as secretaries, cleaning staff, etc. It costs me over 30% above their salary to provide just health insurance and the premiums go up each year.

This creates a huge financial incentive for employers to dump their employees into the public plan and a sure fire way for the government to control almost all healthcare in this country.

How do we change the unsustainable cost curve?

- Malpractice reform and focusing on bureaucracy could lower costs dramatically
- Making insurance companies compete across state lines would definitely lower cost. Many states don't have enough competition. California has only five insurance companies operating in the state.
- Letting individual and small businesses join larger pools would bring down costs. CMDA has 100 employees and is rated on those employee's claims the previous year. If we have two or three major illnesses or hire new employees with chronic illnesses, our premiums skyrocket the next year.
- Healthcare savings accounts – more on that in the future
- Better prevention and coordinated care.
- Less incentive to do tests and procedures that may not be necessary.

Don't let me leave you looking for the Prozac. God is still in control. Yes, we need to speak out but our hope is not built on the US healthcare system. It is built on Christ alone. In the midst of unprecedented changes in our country, we have one of our best opportunities to witness with our lives through radiating the peace that passes all understanding to our friends and colleagues.

Next month I will cover most of the other principles. Stay tuned.

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Cura Animarum

By Rev. Stan Key

The American Heritage Dictionary of the English Language has suddenly become a great source to help us better understand the Gospel.

> ***Passion*** *(pash en) n. 1. Any powerful emotion or appetite, such as love, joy, hatred, anger of greed. 2. Ardent adoring love. 3. Boundless enthusiasm. 4. An abandoned display of emotion… 5. Passivity. 6. Martyrdom. 7. The*

sufferings of Christ in the period following the Last Supper and including the crucifixion.

How can one word carry so many meanings? The best way to answer that question is to look long and hard at the most passionate event in human history. I am, of course, talking about the self-giving act of God in sending His only Son to die for the sins of the whole world.

Mel Gibson did not invent the word "passion" to describe the crucifixion of Jesus. This honor goes to the New Testament itself! In Acts 1:3 (KJV), the Bible refers to Jesus' death as "His passion" *(Greek, pascho)*.

Jesus' death on the cross was an act of passion. He did not just suffer for you. He was (and is!) passionate about you!

But here is the rub. People who love like this are taking a great risk. They can be hurt, deeply hurt. To lay down one's life for others is to take the risk of getting nailed (literally). People who love passionately often get hurt deeply. But suffering love is the key to the redemption of sinners like Peter and John… and Caiaphas and Pilate… and you and me!

The world had never encountered such passionate devotion as was displayed on Calvary. Here for all to see was suffering love: pouring out His life for others, longing for fellowship, absorbing in Himself the sin of the world, forgiveness, new birth, redemption. Passionate love always means that death is working in one person so that life is working in someone else (II Corinthians 4:10-12).

But here is the amazing thing. Jesus calls us to live a life like His. He wants us to live with passion. *Christ **suffered** (pascho) for you, leaving you an example that you should follow in His steps (I Peter 2:21)*. He sends us into the world with a mandate to lay down our lives for others. He calls us to passionate, self-giving love.

People of God, let His passion ignite yours!

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Announcements

Free Bible Software

E-sword provides basic software for the King James Version including a Strong's Concordance. Many other Bible versions, commentaries, dictionaries, graphics and extras are downloadable for free or at a reasonable price. You can find them at http://www.e-sword.net/downloads.html

Gray's Anatomy Arthritis Posters

The company has 5000 of the above name posters they are happy to give away. They show arthritis of the hands and feet mainly. The posters are approximately 22" x 28" in size and are individually rolled inside of a cardboard tube. I will ask for as many as you want. If interested, please tell me the number and to whom I may send them. You can send me the informaiton at susan.carter@cmda.org.

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Loneliness

By Ron Koteskey

Lately you have been feeling "invisible." It seems like everyone else has friends, but you are just "in" the crowd - not "of" the crowd. You feel empty, disconnected, and alienated from those around you—socially inadequate, socially unskilled. You are anxious and sad but feel like no one else knows how miserable and isolated you are. You feel empty and hollow, like you are separated from the rest of the world.

People around you are friendly and greet you with a smile. However, you find it difficult, seemingly impossible, to have any really meaningful interaction with others. Feeling unloved and unwanted, you are lonely. But how could you be lonely when there are people all around you? Isn't God always with you so that you will not be lonely? Can missionaries be lonely? What can you do?

How can I be lonely?

You are certainly not alone if you live in a city of millions of people. However, loneliness has nothing to do with being alone; it has to do with relationships. If you live in a village of a hundred people, you are much less likely to be lonely than if you live in a city of a million people. You are likely to know the names of everyone you meet in that village, but you may never meet anyone you know in that city.

Many people choose to be alone, to experience solitude, and they find it a positive, pleasurable, enriching time. Loneliness is essentially unwilling solitude, wanting to be in relationship with others but not experiencing it. "Forced solitude," solitary confinement, is one of the most terrible punishments used on people in prison.

You may be relatively new to the culture in which you live so that you find it difficult to have meaningful relationships with the nationals. You have not yet internalized enough of the culture to feel at ease with close relationships in it.

Can God's people be lonely?

You may think, "Isn't God with me everywhere? I'm part of the family of God so how can I be lonely?" God is with you everywhere, but you need human relationships as well. You are part

God's family, but you may still not have the deep friendships you desire with other members of his family. You can still be lonely. Here are some examples.

- Adam - Even before sin entered humanity, God noted that it was not good for Adam to be alone, so God created Eve as a companion with whom Adam could be in relationship (Genesis 2).
- David - In the Psalms David said, *"My friends and companions avoid me…my neighbors stay far away" (31:11),* and *"look to my right and see; no one is concerned for me" (142:4).*
- Elijah - While deeply discouraged just after a great spiritual victory, Elijah said, *"I am the only one left, and now they are trying to kill me too" (1 Kings 19:10, 14).*

Do other missionaries feel this way?

Everyone feels lonely at times, and missionaries are no exception. Living in a strange culture away from family and friends, most people feel lonely.

Near the end of his second letter to Timothy, Paul (a veteran missionary) wrote about several things that made him feel lonely.

- *Demas, because he loved this world, has deserted me (2 Timothy 4:10).*
- *At my first defense, no one came to my support, but everyone deserted me (2 Timothy 4:16).*

Paul was so lonely that he even asked Timothy to bring Mark, a man who had deserted Paul and Barnabas years before. Paul had held this desertion against Mark many years and would not even let Mark go with him on his second term of missionary service. Lonely now, Paul said:

- *"Get Mark and bring him with you, because he is helpful to me in my ministry (2 Timothy 4:11)."*

What causes loneliness?

Loneliness is common because it has so many causes. These causes may be found in your situation or within you. Here are some possible causes.

- Your moving - Part of being a missionary is moving from one place to another, either reentering your passport culture repeatedly or moving from one culture to another.
- Friends moving - If you do not move, other people from your agency are likely to. Expatriates are constantly on the move.
- Away from family and friends - Part of working cross-culturally is living in a place far from acquaintances in your past.
- Expectations not met - Perhaps you had heard how friendly people were in your host culture, but you find them quite distant.
- Rejected - You may not be accepted by the people you came to serve and feel rejected even by people serving in your agency.

- Discriminated against - You came to serve, but you find that political or social forces in your host country discriminate against you because of your passport country, your race, or your religion.
- Lack of social skills - You do not understand how to interact well in your host culture—or maybe your passport one.
- Self-conscious or shy - Having low self-esteem or lack of self-confidence. You find it difficult to get close to anyone in any culture.
- Fear of rejection - You had some intimate friends, but they turned on you so that you now fear it will happen again.

What can I do to get over loneliness?

The good news about loneliness is that you CAN take steps yourself to get over it. It is the only "disorder" that can be cured by adding two or more cases together! However, the more lonely you feel, the harder it is to take the steps needed, so remember that it takes time, effort, and commitment.

Basically what you want to do is to find the cause (perhaps from the ones listed above) and then do things to counteract that cause. You may have to make changes in your situation or changes in yourself. Do not wait for your feelings of loneliness to go away - act first, and the change in feelings will come later. Here are some suggestions.

- Look for ways to get involved with people around you, such as eating with them, sitting near them, exercising with them.
- Put yourself in situations where you will meet new people, such as joining a club, attending a new church and doing volunteer work with others.
- Develop your social skills, practice getting to know others, and become vulnerable enough to let people know you.
- Do not assume new relationships will be the same as old ones. Look at each new person from a new perspective.
- Respond to others and their interests, but do not pretend to be interested in something you are not. People will sense that
- Go do things you like to do even if you have to go alone. Attending a concert or film, even taking a walk you may meet someone with similar interests.
- Being a friend or helping someone may result in a deeper relationship.
- Ask people about themselves because people usually want to share with someone who is interested in them.

For a more complete treatment of this topic as well as other topics please visit www.missionarycare.com. Also please let your non-medical colleagues know about these free resources.

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