Reflections on Health Care and its Reform

Paul H. Elovitz—Ramapo College

In response to our work on the subject, a Psychohistory Forum colleague challenged David Lotto and me to examine "the psychological roots of…[our] own beliefs" concerning health care reform, suggesting we were "unconsciously…cherry-pick[ing] arguments to fit with underlying ideological or psychological motivations."

I readily accepted his challenge. My position is clear-cut: The expensive human and economic costs of our current system are irrational for society as a whole, although it works well for the short-term benefit of significant segments of our population. The U.S. system creates enormous amounts of anxiety and uncertainty for many members of the middle and working classes. It is hard enough to be hurt, sick, or dying, without having to also navigate our crazy quilt system of health care that results in huge numbers of needless deaths, disabilities, and personal bankruptcies. Group justice is also an important element. In most cases it is the poor—black, Hispanic, and white—who are inadequately served by our system. For them there is not enough preventative health care and far too much reliance on using the extremely expensive, impersonal, and inappropriate emergency room as their primary health care agency.

The economic cost of the current system is utterly astounding given the poor showing of American health care regarding infant mortality rates, longevity, healthy life expectancy after age 60, recovery rates, and the psychological cost of dealing with bureaucracies that are often more obstructive than they are facilitative. It should be a national embarrass-

ment that Cuba, with a mostly failed economy and a per capita income of about $4,000, scores almost as well or even higher on health care results in some categories while devoting only half of what the U.S. does for the medical care of its citizenry (Reid, *Healing of America*, 2009, p. 149).

My motivation is not ideological, since I distrust all ideologies. I vote, for example, across party lines, as well as write in candidates when I find the choices offered to be unacceptable. I am repulsed by the human and economic waste of the American health care approach because it is hurting a U.S. economy already in comparative decline. On the basis of my own life experience, I know what it is like to worry about not having medical care due to a lack of money and insurance—I feel for the suffering of those who do not obtain proper care or who worry terribly about how they will pay the doctor, pharmacy, or hospital. My identification is with the frustration of millions dealing with big insurance companies. My dominant emotion regarding the U.S. medical care is anger. The failure of our national debate to look realistically to the experience of other developed countries adds to my frustration. It is important to keep in mind that I was trained as a psychoanalyst to use my countertransference feelings without becoming a captive of them. This fits in with the Eriksonian methodology of "disciplined subjectivity" that is so important to our work as participant observers in the great issues of our day. Thus I work hard to not let my anger, frustration, and hope for better health care cloud my judgment when I am examining arguments or deciding among competing statistics. This is not an easy process.

It is disappointing and enraging that health care in wealthy America should be so far behind the rest of the developed, and even some of the undeveloped, world. In 1912, the Progressive Party (Bull Moose) Platform called for health care for all Americans, yet almost a century later we have not made this a reality. On the basis of the five Congressional

committee bills that are now being reconciled prior to being voted upon, it does not appear that, even if successful, the final legislation being pushed by the 44th president will achieve universal care, though it should improve the health care situation. Despite a determined effort to contain costs, success seems unlikely in this regard, partly because of the legislative process, the complexity of the problem, and the health needs of an aging, increasingly obese, and physically unfit population.

Our colleague's charge of cherry-picking arguments and statistics, given the complexity of the health care system, is easy to assert, and there is insufficient space here to definitively refute it. However, the notably lower infant mortality rates and significantly lower health care costs in other developed countries, along with longer life expectancies and ease of use, does not represent cherry-picking. Higher U.S. breast cancer survival rates are admirable, but they do not negate these more basic indicators.

Two articles in this issue provide examples of some of the advantages of the German and Italian universal health care systems over that of the current one in the United States. They are provided in Angela Davies' moving article about her own health care in the U.S. system and that of her brother in Germany and reinforced by Peter Petschauer's four cases of end-of-life care of his loved ones in Germany and Italy. Davies, a woman who has been categorized as having fourth-stage cancer since 2001, astounds her friends, associates, and family with her uncomplaining courage and determination to survive the cancer that continues to ravage her body. Time and time again she comes back from appearing only steps away from death's door. It is a shame that she has to worry about issues of insurance coverage rather than have the empathetic ease of care her brother receives as an American long-term resident in Germany. The U.S. can and should do better.

Peter Petschauer brings up important points seen from the perspective of a compassionate human being, family member, and historian. He feels for those whose families cannot be with them physically or emotionally at the end of life because of distance, cost, and struggles with health care providers. However, healthcare, eldercare, and end-of-life care are not just a function of the financial resources devoted to them and the physical closeness of the family, as one might gather from a quick reading of Petschauer's conclusion. With typical humility, Peter ignores the role of his warm personality on the health care workers resulting in better care for his loved ones. Beyond that, I suspect that just the notion of the Petschauers' crossing the ocean repeatedly to be with those under their care helped inspire the staff to give the extra effort to those he visited. Their care contradicts his idea that it is the distance of their families that results in poorer end-of-life care. Also, no matter how good the quality of the health care system may be, for their own psychological reasons some people will fight with the system or each other. Anger can serve as an outlet for their enormous anxiety in confronting serious illness and death. Old intra-familial rivalries also surface at such times, especially because of the role reversals associated with the decline of parents. Consequently, healthcare workers sometimes have to ask the family to leave the bedside of the loved one.

The health issues of people closer to the beginning, rather than the end of life, also contribute to the health care conundrum. The obesity so common in a younger generation raised on super-sizing everything but exercise, has made for an epidemic of asthma and diabetes. The costs of these diseases are enormous in terms of medical personal, money, and suffering. Lifestyle changes are essential for the health of Americans, yet many self-destructively ignore them, and they are often overlooked in the current health care discussion, as pointed out by Sander Breiner. The importance of a healthy

lifestyle was brought home to me yesterday as I observed a 67-year-old seldom-seen neighbor full of vim and vigor. I commented to him that he looked so much better than he did a decade or so ago without mentioning that at that time I feared for his life because of his obesity, diabetes, and a heart condition. He proudly declared that a regiment of dieting, drugs, exercising, walking, and weight loss had led his doctor to declare he is now a recovered diabetic and does not have a heart condition. Further discussion revealed that his situation was more complicated. After making lifestyle changes a decade ago, a half dozen years ago he had relapsed to the point that his obesity and inactivity left him on the verge of a heart attack. He then had gastro/intestinal surgery resulting in a loss of over 100 pounds and a return to a healthy lifestyle.

Why is dieting so difficult for so many people? Psychotherapists know the reasons: Food represents our mother's love. We eat to live, but also to comfort ourselves, compensating for our disappointments and failures. Individuals who demonstrate great will power in stopping smoking or drug abuse often fail at dieting because it is not an either-or situation; one must ultimately eat. Many, like my neighbor, do a wonderful job of healthy eating only to relapse into dangerous habits. They then feel the need to compensate for their reduced self-esteem by eating even more. An exercise routine can be a great help because it restores self-confidence, breaking the cycle of overeating.

Lifestyle changes and athletics are excellent, although I must add a note of caution. A number of the athletic instructors/directors at my college have been easy to identify by their limping around campus as a result of overdoing their sports. Conversations with my students about their athletic activities often focuses on the medical problems that have followed from injuries, to say nothing of my observations of

once impressive muscles turned to flab on a large scale among many former athletes.

In viewing health care around the world, some common patterns that emerged are that there is so much anxiety about health and its care that providers and patients complain about it no matter how good the system may be. The latter is true even in France, which is often rated as having the best health care system in the world, and where there have been major reforms in 1996, 1997, 2000, and 2004. Laura Nicolas, a 25-year-old French scholar on a Fulbright teaching assistantship at Ramapo College, enlarged my knowledge of French health care, including some of its problems. Controls on the system were tightened up recently as a result of concerns about overuse. For example, an elderly woman using her medical insurance some 900 times in a single year! The health care system for students is slightly different than for the rest of the country. Competition between the two insurers was so intense that last year both were temporarily banned from a university.

Yulia Ivanova, a Ramapo exchange scholar from Russia, explained some of the ins and outs of the system in her country. Unlike most young professionals who spend little time thinking about health insurance, the costs of treating a broken leg led her to come to terms with the issue. The costs of medical care for her leg cost about a month's salary in Russia's somewhat haphazard health care system. She said her university provided a level of care for their employees, as do some other institutions in the country. The universal health care system of Russia, which advocates of Soviet communism used to brag about, was nothing to boast about, but it did provide minimal levels of health service which are now mostly lost. This is reflected by the life expectancy of Russian men dropping about eight years after the collapse of the Soviet system (http://www.accessmylibrary.com/coms2/summary_0286-390308_ITM). This decline was partly a

consequence of an extraordinary increase of alcoholism, continued high rates of smoking, and the personal demoralization in this period of societal dislocation, rather than simply a question of their collapsed health care system.

While I support a system of universal health care and think that the current reforms are a step in the right direction, I do not see them as a cure-all. Improving American health care through reform will not in itself make America a healthy country, although properly done it will save lives and money. The aging, fattening, and sedentary lifestyles of Americans will contribute to increases in our health expenditures. Baby Boomers (77 million were born between 1946-64) will soon be on Medicare, straining the system and greatly increasing health expenditures. Below are some of the questionable assumptions commonly found among those in favor of health care reform, followed by explanations as to why they are questionable.

- A onetime reform is all that is necessary, as asserted by President Obama in a speech promoting reform. (The reality is that given the incredible complication of the American system, many reforms will be necessary to maximize health benefits and control costs.)
- Health care reform will satisfy both doctors and the general public. (American economist Tsung-Mei-Cheng, has formulated the "Universal Laws of Health Care Systems." These are that people complain about all health care systems no matter how good, doctors and hospitals invariably insist—no matter how much money is provided to them—that they are not getting enough, and "the last reform always failed" [Reid, *Healing of American*, p. 27])
- Health reform can be achieved without raising taxes or reducing services, as planned and promised by President Obama. (A number of factors mitigate against this being

possible, three of which are Obama's limited control over the legislative process which involves placating conflicting interests, the aging of America resulting in more of our population being in the cohort requiring more care, and the enormous thirst of the American public for new and expensive treatments.)

- A governmental single payer insurance system available to all will inevitably drive out private health insurance companies, as David Lotto believes. (In Germany, France, Japan, and other countries, the health insurers, and the providers, are private. However, they are regulated carefully by the government and profit is not their primary motivation.)
- America will continue to be the world leader in the development of new life saving medicines and technologies even after reform, as is anticipated by our citizens. (Controlling drug and technology costs may lessen the economic incentives for these developments.)
- There is no need to deal with the legal issues faced by doctors. (Current legislation does nothing to lessen the cost of malpractice insurance for physicians and their subsequent inclination to practice expensive defensive medicine. Although this is not a major percentage of the costs, it is still a factor.)

It is important to remember that these questionable assumptions about health care by advocates are only a part of the picture. In communicating with colleagues in our psychohistorical community, they have provided me with many insights that did not take the form of articles in this issue. Below I will share a few thoughts of Marilyn Charles, Goeffrey Cocks, Tom Ferraro, and Nancy Unger.

Marilyn Charles, who wrote so movingly about trauma and its intergenerational transmission in our "Death and Dying" issue a year ago, brought up the question of the treat-

ment and de-institutionalization of people with chronic psychiatric problems. She argues that current policies are detrimental to a very troubled segment of our population. Her association with the psychoanalytically based Austin Riggs Center is significant. After the recent demise of the Menninger Clinic, it is important to be reminded of the yeoman service being done in this Western Massachusetts center, with its Erikson Research Institute bringing together top-notch clinicians, such as Marilyn, along with historians like John Demos, whose wife Virginia is a therapist at the center, and psychohistorians like Vamik Volkan. It is a thriving community based upon applied psychoanalysis.

Geoffrey Cocks of Albion College, the author of the well-received *Psychotherapy in the Third Reich: The Göring Institute* (1997) who is currently writing *Sick in the Night: Illness in Nazi Germany*, reminded me how much ideas about health care can be shaped by ideology. An extreme example is that shortly after coming to power, Hitler instructed doctors that "racial hygiene was to be the [first] task of the German physician." Although we Americans have no official medical belief system, how we treat "dis" "ease" is enormously influenced by our views of the world. One aspect of this is our love affair with expensive medical technology. Another is the ideological aversion to governmental involvement about which David Lotto writes.

Long Island psychoanalyst Tom Ferraro has some interesting ideas that I would label "diagnosing the health insurance industry." He presents fact after fact and argument after argument in furtherance of the thesis that the pathological pursuit of profits by the industry is detrimental to the health of America. After all, payments by insurance companies to reimburse patients who bought insurance for precisely this purpose are listed as "losses." In his view the insurance industry, even if Obama and the Democratic congressional leadership achieve their reforms, will continue to be an ob-

stacle to the health care of Americans. According to Ferraro, if it were an individual, its condition would be listed as a "psychopathic personality disorder." Although there are moments, especially when I think about the high overhead costs of our for-profit insurance companies, that I am sympathetic to Dr. Ferraro's approach, I also remember the competition among the German insurance companies who have adopted a model of competing for the benefit of the patient rather than for their own profit.

Historian Nancy Unger suggested that the paranoid belief in a suppressed cure for cancer, covered in this issue in Nathan Carlin's article, is a reflection of the enormous comfort some people can find in this thought: "Cancer which seems uncontrollable can in fact be controlled." Certainly we have made some progress in effectively treating some types of cancer, although the "War on Cancer," the popular name for the National Cancer Act signed by President Nixon in 1971, has yet to yield a victory. A most respected colleague, who prefers to remain anonymous, was so touched by Angela Davies' account of the treatment of her and her brother's cancer in Germany, that he fervently and indignantly asked the question, "Why not [universal health care] in America and why not now?" Many share this sentiment.

The fee for service payment system in medicine encourages greater medical intervention at enormous cost and often without bringing benefit to the patients. More is not necessarily better and it may even increase the chance of dangerous medical errors. Epidemiologists have established that about a third of all care—at a national cost of 600 billion or more dollars—does not result in better patient outcomes. Starting in the early 1970s, Dr. John E. (Jack) Wennberg of Dartmouth College discovered that there were enormous variations in the rates of medical procedures in communities near each other, based upon factors other than patient need. Considerable evidence has been compiled concerning back

surgery, hemorrhoid operations, hysterectomies, mastectomies, prostate operations, and tonsillectomies. The more doctors in an area, the greater the likelihood of surgery (Alix Spiegel, "The Telltale Wombs of Lewiston, Maine," National Public Radio, All Things Considered, October 8, 2009: see http://www.physicventures.com/news/telltale-wombs-lewiston-maine).

The research of Professor Wennberg and others who have followed his path of inquiry points to the iatrogenic (adverse) effects of medical care. Even aspirin, a great healer and lifesaver, kills many people every year. Fortunately, even in television advertisements, the negative consequences of prescription drugs must be referenced.

The need for so many people to somaticize rather than talk out their feelings adds to our national health care bill, as do those with Munchhausen's Syndrome. Illness, whether real, imagined, or feigned, can serve as an escape from disagreeable and tedious life/school/work situations. It may become a life pattern, as it did with Charles Darwin. An anxious relative, traumaticized by a childhood illness involving a lengthy separation from her mother, seeks reassurance that she is healthy by going to doctors without any significant medical issues three or four times every month. Rutgers Professor and Psychohistory Forum Research Associate Ted Goertzel is writing an article for an international journal on why people fail to protect themselves with vaccines and organize their diets around scientifically unproven beliefs regarding consuming special organic and other foods. Research I did in the early 1980s pointed to commonly held poison fantasies among residents of Northern New Jersey.

Such fantasies and other forms of "magical thinking" further the deterioration of the current health care system. The evidence is overwhelming, America needs universal health care coverage. If the current legislation is passed, it will be an important step closer to achieving that goal. Com-

plex economic, political, and psychological forces render health care difficult to fix. A single piece of legislation will not solve the problem: Like life itself, a health system requires adjusting to changing needs and technologies. Universal health care is no panacea, and it will add to our deficit spending unless we are able to cap many of the expenditures associated with the fee for service system. Health care is about warding off our greatest fears—loss of autonomy, dependency, helplessness, illness, and ultimately death—all enormously anxiety producing. ❑

Psychohistory of Barack Obama

The Transformations of Barack Obama

Ken Fuchsman—University of Connecticut

If you read about a child whose parents had a shotgun wedding, whose mother and father separated before the child was a year old, each of whom later had a second divorce, and he hardly ever saw his father, you probably would not expect that such a youngster would be elected President. Barack Obama overcame these odds and is now our Commander in Chief.

Children from divorced, single-parent, and blended families are likely to have short-term and long-term behavioral problems. As a child, Barack Obama experienced all these family structures. Yet, he has emerged as a disciplined, often inspiring, figure. What transpired that enabled this often-troubled young man to be a model for others? I will discuss four factors in Obama's background, biography, and character that helped him transcend his family background.