

## The dystopic future of U.S. healthcare: “Free” care for all those who NEED it

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**T**he title will seem to be a contradiction to many. Is not free health care for all those who need it exactly what we want? The key is that NEED is not the same as *need* and does not mean what many people think it means. The usual lowercase *need* implies something that is objectively necessary. Every reasonable person would agree that each of us needs air to live. NEED, however, is subjective; different people with access to the same facts will disagree about whether a patient qualifies for a certain expensive therapy, for example. The following discussion will explain how differences of opinion about the subjective NEED get resolved to determine whether the NEED is satisfied or not.

### MARKET-BASED HEALTHCARE

A market-based healthcare system balances supply and demand for scarce resources labeled as healthcare. Healthcare is scarce, so the supply is limited. Unlimited demand cannot possibly be satisfied, no matter how unfair we might think that limitation to be. We would all prefer longer lives to shorter lives, all other things being equal. We all want any healthcare that would make our lives better. As the two famous British philosophers wrote:

*“You can’t always get what you want.  
But if you try sometime,  
You just might find,  
That you get what you need.”*  
Mick Jagger and Keith Richards

As the Rolling Stones memorably pointed out, want is not the same thing as need. The distinction between want and need is similar to the distinction between NEED and *need*. In a market-based healthcare system, each patient expresses the degree of want by

what the patient will voluntarily exchange to obtain the healthcare in trade. The patient is in absolute control of determining the degree of want within the finite limits of the patient’s resources. This limitation due to finite resources is considered to be unfair by some. Some label it as market failure, because the market failed to deliver what is impossible to deliver: unlimited demand. This criticism of the market is like claiming it is unfair that we cannot jump to the Moon. The physical universe does not care what people think is fair.

### SINGLE PAYER HEALTHCARE

The trap of all subsidized healthcare, whether the subsidy takes the form of single-payer government provision or private insurance coverage, is the illusion that healthcare is no longer scarce and, therefore, is free. However, it still takes material, energy, and time (all of which remain scarce) to produce the healthcare, so the healthcare has a cost to the providers. If the providers are not sufficiently compensated, they will not produce the healthcare, so healthcare will not be available to anyone. If a single-payer is asked to pay the cost, **THE SINGLE-PAYER** becomes the sole judge of NEED. When Medicare was enacted, everyone thought it would be great. Physicians thought they would determine NEED, and government would pay everything prescribed by physicians whatever the cost. Physicians would have a monopoly on determining NEED making their services more valuable than in a market system where patients could get whatever they wanted as long as they could find a supplier of what they wanted at a price that they were willing to pay. Patients also thought Medicare would be great as they also thought that the government would pay for anything prescribed by a physician whatever the cost, so the patient could shop around until the patient found a physician willing to claim what the patient wanted was a NEED. But, as everyone has found out, the government determines NEED and the government rules often seem capricious, arbitrary, and stupid.

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**DOI:** 10.12746/swrccc.v12i51.1319

Examples of this problem that I see on a regular basis are patients with lung disease who are short of breath. Many years ago, the standard for NEED of supplemental oxygen was an oxygen saturation less than 90%. This proved to be more common than the government wanted, so the threshold was reduced almost 40 years ago to 88% or 89% with other conditions. More recently, Medicare has added capricious and arbitrary conditions to the 88% threshold. I have had a request for supplemental oxygen denied even though the patient satisfied the government definition of NEED based on oxygen saturation, because the durable medical equipment (DME) supplier claimed that Medicare would not pay for a diagnosis of chronic respiratory failure with hypoxemia. Whether the DME supplier misunderstood Medicare's restrictions, or Medicare's restrictions were capricious, arbitrary, and stupid made no difference to the patient who was short of breath.

The situation described for Medicare is no different for private insurance payers. A commonly cited reason for the increasing rates of physician burnout is the frustration of dealing with insurance companies who refuse to pay for services or products prescribed by the physician. The payer determines NEED, and the opinion of the physician counts for nothing. Neither Medicare nor the insurance companies care any more about what patients and physicians think is fair than nature cares about frustrations that healthcare is a scarce resource. Payers will pay when they think it is in their interest to pay. The rules defining NEED will be written in accordance with payer interests rather than patient interests. If the payer interest aligns with patient interest, it is purely coincidental. This process is called regulatory capture by the regulated.

## **OUTLOOK FOR PHYSICIANS**

The outlook for physicians in this dystopic future is grim. Physicians are no longer needed to determine the services and products that patients NEED. Rather NEED is determined by payers who can make up whatever rules (guidelines) the payers want. There are two possible futures for physicians in this system. One possible future is to have intellectual curiosity and empathy for patients replaced by a fundamentalist devotion to rules labeled as guidelines. This is already

in progress. Critical thinking is being replaced with blind obedience. In this possible future, hospitals and clinics will resemble the Department of Motor Vehicles. I suspect that this is the future for physicians in the U.S., but it may be more difficult to stamp out curiosity than I think. If trainees prove to be more resistant than I believe will be the case, then the other possible future is that human physicians will be replaced by machines that are absolutely obedient to programming. Popular media are already conditioning people to believe that robots will be superior physicians to humans by being more precise. Robots will be superior at keeping track of a very large number of rules (guidelines) and will even be able to prioritize rules that conflict with each other. Robots will also be superior at accepting updates that cancel previously accepted guidelines, create new guidelines out of thin air, or even change guidelines to be exactly the opposite of what was previously accepted as truth. As George Orwell wrote in 1984, "Oceania was at war with Eurasia: therefore, Oceania had always been at war with Eurasia." Robots will be far superior to humans at accepting the logical contradictions of Newspeak and doublethink. Arguing with a robot about the NEED for supplemental oxygen will be even less effective than current arguments with Medicare or insurance companies.

How about the creation of new and improved rules or guidelines? Won't we NEED educated and intelligent physicians to create new products and the rules or guidelines for their use? New products are not necessary when the payers can force people to accept the NEED for old products. Patients were denied medical services if COVID vaccination was declined. Travel was restricted if COVID vaccination was declined. Employment was terminated if employees refused COVID vaccination or the wearing of masks. The government determined that it could make the people accept whatever NEED the government decides is necessary. All the government needs to repeat these acts are docile courts.

## **CONCLUSION**

The future of U.S. healthcare is grim. I think it will mostly resemble George Orwell's 1984 with ever declining standards of healthcare dressed up as utopia by the popular media during the daily 2-minute

hate. In 1984, the 2-minute hate was a daily ritual during which everyone would watch a short video broadcast on the ubiquitous telescreen exhorting viewers to hate Emmanuel Goldstein (the individual regarded by the Party as public enemy number one) and to adore Big Brother (the leader of the Party). Following one telescreen broadcast, the central character in 1984 (Winston Smith) notes "For the moment he had shut his ears to the remoter noises and was listening to the stuff that streamed out of the telescreen. It appeared that there had even been demonstrations to thank Big Brother for raising the chocolate ration to twenty grammes a week. And only yesterday, he reflected, it had been announced that the ration was to be REDUCED to twenty grammes a week. Was it possible that they could swallow that, after only twenty-four hours? Yes, they swallowed it." Acceptance may be spontaneous, like in 1984, or acceptance may require a dollop of Huxley's *Brave New World* to ease the transition from present conditions to dystopic future.

Medicare offers bonuses for physicians to accept unpalatable choices, but the bonuses for compliance quickly become penalties for non-compliance.

**Keywords:** Health care, cost, provision, denial of care

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**Article citation:** Berdine G. The dystopic future of U.S. healthcare: "Free" care for all those who NEED it. *The Southwest Respiratory and Critical Care Chronicles* 2024;12(51):26–28

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**Submitted:** 3/11/2024

**Accepted:** 4/1/2024

**Conflicts of interest:** none

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