Choice And Hope For Health Care

A Primer on Comprehensive Health Care Reform

Francis W. Price, Jr., MD

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Forward

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This book is designed for health care consumers and for those in industry and government who want to understand why our health care costs are out of control, how our current health care system is likely to further increase costs while limiting our healthcare choices, and how we can have an alternative that will both be cost effective and still allow access to new advances in medical care.

"Health care should be as readily available and affordable as the food supply we have in this country."

"Successful health care leads to longer life expectancy and increased costs over a longer lifetime. In other words, it is not in the government's financial interest to have successful health care that allows individuals to live past their working years."

Chapter 1

Introduction

Health care represents about 1/6 of the U.S economy and it touches the lives of every person in the U.S. – over 300 million in all walks of life. With such diversity, it is difficult to keep discussion of reform simple, but that is the goal of this booklet! It is divided into 7 Chapters.

Introduction

1. An Overview – Where are we now?
2. A Short Story to Put Health Care Economics in Perspective
3. The basics needed for high quality and affordable health care without rationing
4. Two templates for possible demonstration projects
5. Implementing Health Care Reform on a National Level
6. Why you don't want the government making key health care decisions for you.

Let's start out by reviewing the things that most of us agree on:

- Most people think our system of health care is broken.
- Most people who look at the numbers realize that there is not enough money to continue paying for health care for more than a few years, given the way we are currently paying for health care. The cost is crippling individuals, businesses, and government. The government was already facing insolvency with Medicare, and has taken on staggering new obligations in the healthcare reform act.
- Everyone would like to have access to high quality care and new technology.
- Some feel that everyone should get deluxe healthcare, regardless of cost, and that somebody else should pay for it.
- Much of the cost for health care is actually for legal, regulatory, billing, and administrative expenses rather than for the actual delivery of care to people.

How can we reconcile the desire for the latest and greatest health care with the overwhelming cost? On the bright side, we currently have a robust infrastructure in our health care system. I have a very positive outlook on health care and the ingenuity of the American people to come up with better solutions.

What I hope to accomplish with this primer is to review some of the fundamental problems, which I believe CAN be fixed, and to show how we can maintain the best health care system in the world by redirecting our energy. I believe we can make our health care system much more cost effective while maintaining the quality.

Sometimes people become so polarized they do not really consider alternatives. So first of all, please keep an open mind and read all the way through this primer. Then think about it. And if you come up with a simpler, more efficient and cost effective way of redirecting healthcare, or if you have other constructive ideas, please let me know.

Chapter 2

An Overview: Where Are We Now?

The Supreme Court has narrowly ruled that the Patient Protection and Affordable Care Act (PPACA, a.k.a. Obama Care) is a tax and is thereby constitutional. In November 2012, there will be a national election and the next Congress and possibly a new president may repeal some or all of Obama Care. If it is repealed, it will create a void - but also a new opportunity for reform!

How will our government respond? Unless there are new alternatives, Congress likely will re-enact a lot of the regulations that are in Obama Care, because historically, that's what it has done: create more regulation and increase federal government control. We need a better plan! We need to cut through the "Gordian Knot" of health care reform.

Some in Congress will be looking for alternatives. I would like to propose some better alternatives. But first we need some background.

The Gordian Knot of Health Care Reform

You may remember the ancient Greek legend: anyone who could untie the Gordian Knot would conquer Asia. Many prominent rulers and heroes tried to untie the knot; only Alexander the Great succeeded—by cutting it. Recently we have witnessed a political party and president try to untie the Gordian Knot of Health Care by passing the Patient Protection and Affordable Care Act (Obama Care). Unfortunately this law does not adequately protect patients and isn't even close to being affordable. This law has proven to be very divisive. It has not gained bipartisan support and is unpopular with voters, most notably because it seeks to "fix" things by taking away personal freedom of choice and imposing mandates and new taxes.

To "fix", or reform, health care, perhaps we should take an entirely different approach: aim for bipartisan and popular support by giving people more freedom to choose, instead of giving the government more power. But, perhaps this notion seems too radical at this point in our discussion – so let's first ask a few questions and tell a story.

Keep in mind that health care, and health care reform, is just not about doctors and nurses. Additional providers include hospitals, device and equipment manufacturers, drug companies, retail drug stores, and those who make nutritional supplements. Most importantly, healthcare is about consumers. And it is consumers who are the key to solving the health care problems.

What are your thoughts?

Think about the following questions. How do you feel? Your answers will be influenced by your line of work, political opinions, religious views, age, economic situation, and health status.

- Do you want access to new technology in medical care – such as improved treatments for cancer, autism, Alzheimer's disease, and heart problems?
- Do you want to have a choice about your treatment and who provides it?
- Do you think you should be able to compare prices for health care services like you do for other things you purchase?
- Do you think everyone should have access to health care?
- Do you think the government can and should pay for everyone's health care?
- Do you think the government should stop paying for health care?
- Do you think there is too little government regulation in health care?
- Do you think there is too much government regulation in health care?

Keep these questions in mind as you read on.

Chapter 3

A Short Story to Put Health Care Economics in Perspective

One question I've wrestled with is why is government regulation of healthcare increasing? Is it a "love thy neighbor" desire to make things safer and better? A diabolical plot to socialize medicine? Just bureaucracy gone wild?

To understand increasing regulation in health care, let's compare it to food. Food is even more essential and needed for survival and wellbeing than medical care.

"Free Food" A Short Story

Our story is about a prosperous country that was blessed with many resources and had a high standard of living. The country decided that the government should provide free food for all of its citizens and visitors so that no one at all should go hungry for any meal no matter how rich or poor they are.

Just so that everyone would be equal – the government paid for everyone's food – everyone got free food.

Being practical, the government told everyone that taxes would need to be increased but they would save money by not having to purchase their own food. Moreover, because the government would be buying in such large quantities, the food would be cheaper, fresher, and of better quality than what one could buy on their own.

Each person was given a food card – like a credit card. When food was "purchased", the retailer swiped the card and the cost of the food was then billed to the government. Retailers stopped listing the cost of food items for the public, people just purchased whatever they wanted to eat.

At first, people purchased food like they normally would. However in a short time there was a sharp increase in the demand for things like steak, lobster, organically raised produce, and hand made pastries. This caused the government to pay a premium for these items and the government's cost for these items skyrocketed.

Naturally everyone expected to have the highest quality produce and baked goods. There were no longer any sales on day-old baked goods, imperfect fruits and vegetables, or cheaper cuts of meat – why would anyone accept less than the best?

There was also a more insidious, or subconscious, change in the way people purchased food. They no longer had any budgets or restraints on the number of items they purchased. They tried more expensive foods, bought larger quantities, and indulged their kids and their own desires for things they would not have purchased before. Since their taxes were paying for it, they now felt entitled to buy whatever they wanted – even if they did not eat it all.

Overall, people just expected to have lots of fabulous food for every meal – you might say – almost every day was like Thanksgiving.

Soon the government had to develop a complex system of regulations to protect itself from fraud from retailers like markets, grocers, and restaurants. Large government bureaucracies were created to enforce the regulations.

First the government instituted uniform price controls – or fixed prices – on all produce and foods that were similar to prevent retailers from over charging the government for these items. This meant a pound of apples cost the government the same no matter where it was purchased. To do this, the government determined what something like a pound of apples should cost. This had the unintended consequence of raising the cost of goods for the government in some cases. A ¼ pound hamburger cost the same where ever you got it – whether in a fast food or fine dining establishment. This led to short or no supply of some items in parts of the country where it just was not possible to provide those goods at the fixed price.

Their Food and Drug Administration (FDA) increased inspection standards for all food retailers to make sure that none were selling inferior food to the government. Wisely the government had to make sure that no day-old bread, stale potato chips, bruised fruit, or old milk was charged to the government. Large civil and criminal fines were imposed for anyone who sold the government food that was less than perfect.

Because of the large number of food purchases, the government needed to pass strict regulations on all retailers to insure that

all transactions for food purchases actually occurred and that fraud was not being committed by producers or retailers, or even government workers. Thankfully the country already had bar codes on food items so the retailers were able to itemize each purchase for the government.

Before long, the government became concerned that perhaps too much food was being purchased – much more food was being sold than had been sold before the government began paying for it. So, additional regulations were imposed allowing the government to verify that the sale of the food not only occurred, but that the people's choices were appropriate, and they were not taking more food than they needed. These regulations, too, were enforced with stiff criminal and civil fines on the retailers.

The government was careful to make all the regulations and fines only apply to those who produced and sold the food, not to those who bought it – the voters.

Two perplexing issues arose with food purchases in restaurants. First, it did not seem fair that some people could purchase food in restaurants and still also get food from markets or groceries, so additional layers of regulations were gradually placed on food distributors. A complex computer system was proposed so that the government could track and verify the food consumed by each individual. The computer system included complex calculations for age, sex, race, job classification, height, and anticipated activity level based on the weather, for determining each individual's food allotment. A system of penalizing retailers who did not adopt this system was phased in.

The second issue with restaurants had to do with the fixed price for items like the ¼ pound hamburger or a mixed green salad. It did not seem fair that a fast food restaurant was paid the same for these items as a 4- or 5-Star French restaurant, so the government began to pay more for food items provided in sit-down upscale establishments. These highly rated restaurants, since the free food mandate, had seen a dramatic increase in their sales and had become much larger than before. And with the uniform price controls, many had become non-profit, mega-restaurants with sites in many locations. (Since they were non-profit, it was argued that it was appropriate for the government to pay them more for the same food items also supplied by the for-profit restaurants.)

Now, the government was paying two rates for the same food depending on where someone got it. (Actually they were paying three rates – someone could purchase the goods at a market or grocery and cook it themselves which would be even less expensive – but fewer people were cooking now since the government was paying for everything.)

The complex system of regulations and reporting drove up the cost of food for retailers, hitting the smaller, local retailers the hardest since they did not have the cash flow to purchase the expensive computer tracking systems or pay for consultants to interpret the complex regulations that could easily result in civil and criminal fines. As a result, many small markets, grocers, and restaurants either went out of business or joined larger groups. This led to consolidation of the food industry and concentration of food distribution into a few big providers (like the mega- restaurants) – who were also more likely to make large political contributions and fund lobbyists than were the small stores and restaurants that were closing.

As costs for the food system continued to spiral out of control, some in the government alleged that corrupt retailers were defrauding the government with excessive charges or other deceptive practices, and if this fraud could be stopped the government would not be losing so much money. Some in the food industry said the increased costs were from feeding all the people who were starving and missing meals before – but few seemed to believe that. So, the government continued to issue more regulations, each with progressively stiffer civil and criminal fines. The government also increased the number of inspectors, regulators, and policing agents. With each new layer of regulation, the cost of providing food increased—both for the government and for the food industry.

As the cost of food continued to further increase the government realized that the cost of food was now taking up most of the federal budget and there was not enough money to pay for it.

So the government went generic – everyone was encouraged to eat peanut butter, catfish, and collard greens. These foods were praised as being just as, or more, nutritious and tasty as the foods people usually ate. Private Advantage programs were started where people who enlisted could get rebates - these programs provided "special" diets at reduced costs. Retailers were paid an extra commission for switching people to generic and lower cost foods. However, these programs proved to be unpopular, so the government began to introduce new regulations that limited the production and distribution of certain

"over utilized" foods. These new regulations were instituted because of perceived quality problems and the new regulations were said to insure better safety and quality of the "over utilized" foods like steak, lobster, organic produce, and hand made pastries. This decreased the supplies of these popular foods so that in many areas there wasn't enough and only less desirable foods were available. In other words, the government regulations made it difficult for most people to get the most popular foods unless someone was very rich or worked for the government.

-Temporarily stepping away from the story-

Up to this point in the story, everything is quite predictable for any goods or services that a government decides to administer. And we can all have a big laugh about it because we know that what we have in the U.S. now – plentiful and cheap food – works well when it is entirely free market. The government simply regulates the safety of the food supply and helps those without means to purchase food themselves. We have a food system where you decide what you want to buy and the government is not involved in your purchasing decision.

Finally, there can be a darker side to the free food story if the hypothetical country adopts some of the practices our country has for health care - for example, when the government crosses the line from passing regulations designed to protect either the government or its citizens to passing regulations to increase government revenue and help offset the costs of hugely expensive programs.

-Back to our story-

When the government started collecting fines for the mistakes retailers, growers, and distributors were making in their record keeping of food sales, they found they were bringing in millions of dollars. To the public this sounded like there was a lot of fraud in the system, but actually the mistakes were a small part of the total sales – there were just a lot of sales, and it was a complicated system for retailers to comply with and mistakes were made in keeping track of the confusing regulations. Complex and costly computer systems were required so that the government could track what was being sold. The more complex the systems became, the more likely there were to be mistakes – just human errors. More mistakes led to more fines – and more money for government!

The government started charging larger fees to inspect processing plants and any new items introduced at restaurants. The government noticed that fancy new food products tended to cost more, so they made it harder to introduce new food products by requiring big studies and government fees.

The government enacted the Overeating Prevention and Affordable Food Act (OPAFA). Some just called it AFA for short. The AFA levied huge criminal fines—$10,000 to $50,000— against fast food and other restaurants for inadvertent mistakes in their bills. Food providers also faced possible criminal penalties. Similar fines were levied on food producers who spoke of health and nutrition benefits without government approval. The fines often reached over 1 billion dollars per large producer.

As part of AFA, the government licensed for-profit "bounty hunters" to go out and review the computer records of the retailers. The bounty hunters received a percentage of any errors they found and were graded based on the amount of fines and refunds they said were owed to the government. By their pay structure, these bounty hunters had an incentive to interpret honest mistakes as fraudulent malfeasance. They were not commissioned to look at the quality of the food, just at mistakes in documentation. (And yes, Obama Care does this to doctors, hospitals, and other providers of health care.)

AFA also established a special Independent Payment Advisory Board (IPAB)* appointed by the president with the goal of decreasing the cost of food each year for the government. To make this board independent and supposedly not subject to politics, the board was not under any Congressional or Judicial review and could implement almost any regulation they wanted except they could not decrease the cost of government payments by allowing people to pay for any part of the food. This meant retailers could not question or dispute their rulings.

The law for IPAB mandated that payment reductions were placed on the independent retailers of food but not the large non-profit mega-restaurants that had now grown to be over one-third of all government payments for food. With an increasing

population in the country which meant more people eating food, drastic cuts in the payment for food items were necessary in order to decrease the total amount paid by the government for food each year. All of these cuts were placed on the smaller retailers and restaurants. While the independent food retailers were squeezed, the large mega-restaurants were flush with cash allowing them to buy up the remaining smaller independent retailers. In turn, this led to even more consolidation of the food supply under the control of the non-profit, mega-restaurants.

Interestingly, as the payments to independent retailers were cut further and further, the cost of food for the government kept going up as more food was supplied by the mega-restaurants. Remember the mega-restaurants were getting higher prices for the same food because they were highly rated, plus they were spared from IPAB cuts in payments. The government basically forced the less expensive options out of business in favor of the more expensive ones. Not surprisingly, the non-profit, mega-restaurants had made huge contributions to the politicians who passed AFA.

Once the distribution of food was totally controlled by the mega-restaurants with rapidly increasing food costs for the government, payments even to those institutions had to be cut and the fines and criminal penalties were turned onto them. Other than token approvals of new food items to give the public the perception that there was hope for something new, no innovations were allowed in the food supply so that costs could be more accurately predicted. A gradual nationalization of the food supply occurred with everyone involved with food production and distribution becoming a government employee – food distribution became the same as the post office.

** IPAB is a real board established by the Patient Protection and Affordable Care Act with all the powers mentioned in the story. Internet Search: Social Security Act Section 1899A. This section is 18 pages long and 6 have to do with convoluted Congressional procedures if Congress wants to override the board on recommendations for Medicare, actions taken on the rest of health care are not reviewable by Congress, and none of the recommendations of the board are subject to judicial review - at least as mandated in the law. The Secretary of Health and Human Services is also given all the powers of the board and in 2013 may be able to make decisions not reviewable by Congress or the Courts. The United States Secretary of Health and Human Services is the head of the United States Department of Health and Human Services, concerned with health matters. The Secretary is a member of the President's Cabinet. The office was formerly Secretary of Health, Education, and Welfare.*

What the Story Tells Us

So here we are –

There appears to be a tragic ending, because the country's food system is crushed by the increasing regulations and fines. Every mistake on a restaurant or market bill became subject to a $10,000 to $50,000 fine whenever the government decided it should. That may seem outlandish, but fines of $10,000 to $50,000 for mistakes in healthcare transactions of as low as $8.00 are what we now have in Obama Care. When the effects of these fines on doctors and hospitals begin hitting home, it will be devastating to health care delivery! What doctor or other health care provider should be part of such a program?

What this story demonstrates is that any system is doomed to failure when someone other than the purchaser/utilizer of the goods being purchased pays for the service.

Why is our food so cheap in the U.S.? The consumer makes the choices on food with minimal government intrusion. Most consumers shop to get the best price for the quality - as they see it. Retailers compete to meet the needs of the consumer. This is how a free market works to give people what they want. Supply and demand control costs.

Throughout history, whenever a government controls food distribution and related services, it eventually leads to rationing and supply shortages. The Soviet Union and China are great examples. In both of these countries, the basic supply of food also deteriorated. In Russia, farmers were forced to cut down fruit trees to avoid taxes. In China small gardens and fishponds were replaced by large collective farms. In neither country have these collective farms been anywhere near as productive as small independent farms.

While I was visiting Russia studying some novel surgical techniques, I saw a common souvenir that bespoke ironically of the problem with top down management in Russia's farming. The souvenir was a set of wooden dolls that nested within each

other. In one collection that depicted Russian leaders, Nikita Khrushchev was shown holding a small cornstalk in reference to his attempt to have all Russian farmers plant corn so they could be as productive as U.S. farmers. As most farmers know, you need hot weather to grow corn, and Russia is essentially north of Minnesota – so all across the cold Russian countryside, the corn that had replaced other crops grew only about 3 feet tall resulting in a great famine. Nikita Khrushchev's dream soon became a nightmare for millions of poorly fed Soviet people. That's what happens when politicians decide what is best for an industry they do not understand.

This food story correlates directly to medical care. If the consumer of medical care is not the one paying the bills, the very same problems develop in health care as they do with food. Either government or insurance company - when someone else pays for all expenses, the consumer loses concern about how much is purchased and demands only the best and some of everything available. Why not? But if everyone demands only the top of the line, the only way to control costs is rationing.

There are three ways rationing can occur: the first is to limit the amount each individual can have, the second is to limit the amount generally available and let individuals compete/fight over supplies, or the third is to limit available sources to get the supplies and slow access by long lines and delays.

Yes I know our elected leaders have told us we will either get to keep our current health insurance or get the best health care if the government pays for it all – but our parents may have told us that Santa Claus and the Tooth Fairy left us presents too. Magic food and magic health care are simply not possible except in fairy tales and political promises. Simply stated – It is too good to be true!

We are not going to have a significant reduction in health care costs while maintaining even modestly acceptable standards for access and quality unless the consumer is in control of purchasing and also responsible for payment.

Being responsible for payment is quite scary for most people today because of the artificially inflated pricing system that has developed due to government and insurance company price controls and associated regulatory expenses. This is something we need to fix!

We do not have a free market in health care. The government and insurance companies essentially set the fees actually paid. We have artificially inflated prices for many aspects of health care – essentially all that are paid by government or insurance companies. For instance, many insurance companies demand a percent discount in fees from doctors and hospitals – like 30%, 50% or more. This has led to artificially raising prices to counteract these reductions. And currently, when someone does not have insurance, they are charged the inflated rates! Plus, we are all paying for the increased cost of regulations and the legal expenses of providers of health care as well as paying for the insurance companies and government to administer them.

Because of government and insurance company control of the costs, there is no transparency. Just as in the food story, no one has any idea what anything costs. Each of those two groups is trying to regulate quality – but no one is better at judging quality than the consumer when outcomes and costs are made public. For example, let's say that either the government or some designated insurance company that you must buy food insurance from is now in charge of paying for all your food. Who do you think would be the best judge of what you can buy for food each week at grocery stores and restaurants – the federal government, an insurance company, or you?

Even people with food stamps get a choice on what they buy now. Currently in the U.S., individuals with food stamps budget their own food purchases and are able to buy whatever food they want, and when someone wants to get a non-covered food item, like beer, the individual has the right to pay for that food out of pocket. Just as importantly, these individuals can price shop and essentially go to any store they choose – a convenient and more expensive store or a discount store. There is no government price fixing of what items cost as there is with health care, and the individual chooses what they want and how much with in the limits of their food allowance. Why haven't the same ideas been used in health care for Medicaid? Everyone could have basic health care as well as the option to select special items they desire beyond basic health care or to upgrade the type of care they receive.

For Medicare patients, there is a portion of the drug benefit plan that is not covered by Medicare. Essentially what happens is that there are drug benefits up to a certain dollar level, then the consumer has to pay the full costs for the drugs between that level and another threshold, above which the government again picks up the cost of prescription medicines. The area without

government coverage of drug costs is called the donut hole – nothing in the middle and payment on both sides of it.

What has the hated "donut hole" in Medicare drug benefits shown us? When there is no government or insurance payment of prescriptions, generic drugs can be purchased for $4.00 from many retailers! How much are the government and insurance plans paying for generic drugs not in the donut hole – a lot more than $4.00. This is a national disgrace!

Currently there is a drug that costs $2,000.00 each month to treat macular degeneration, the leading cause of severe vision loss in people over age 60. It has been truly a wonder drug. If people were paying out of pocket would the drug be priced this high? It is doubtful. Over the last few years, the company has made record profits on this drug, and there is a low cost alternative made by the same company that costs about $25.00. But the government, actually we taxpayers, is paying this inflated cost.

One can have medical testing done at a private or physician owned center for a fraction of what it costs at a hospital owned facility – with similar or better quality. Why doesn't Medicare and insurance companies demand that all out patient testing be done in these centers or refuse to pay hospitals more? If you were paying for it you would! (See Tables I & II, Pages 57 & 58). Is it any wonder hospital lobbies are trying to shut down these independent centers in Congress?

As non-profit hospitals "buy" up independent physician practices, laboratories, and testing facilities, the costs for testing and minor procedures are skyrocketing because hospitals charge more and are paid more (often multiple times as much) by both Medicare (the government) and insurance carriers. Where is the consumer outcry? If consumers were paying these inflated costs themselves, there would be an uproar! But since none of us are directly paying the bills there is not a whimper. If you personally, could save hundreds, even thousands of dollars by going to a private center with the same quality outcomes, what choice would you make?

In closing this chapter it is essential to understand the concept of "first dollar payment" of health care costs. What this means is that there is no upfront deductible or co-insurance payment by the consumer, and often no consumer payments are required at all. The insurance company begins paying immediately. "First dollar" payments in insurance plans became popular with union contracts for groups like the autoworkers. Now even Medicare with supplemental coverage is essentially a "first dollar" payment plan.

Whether for food or health care, first dollar payments lead to distortions in both supply and demand, leading to increasing costs and regulations to control purchases and prices.

Remember the three essentials to keep a free market functioning:

1. The consumer must be in charge of purchases and know the true costs.
2. The consumer must be responsible for payments.
3. The supply of the good being sold or supplied must not be subject to government price controls or over-regulation.

If you don't have these three essentials, it will lead to rationing of some sort to control costs or supply. Think food!

Post Script to Story

Some liberal or progressive minded individuals will say that if the government just nationalized all of health care, or food production, things would be okay. However as noted above this has never worked efficiently before. It can be done, but there would be little innovation and limited access to all but basic care for nearly all of the population. For food this has been tried a number of times by socialist countries, for instance Russia or China as noted above. Likewise nationalizing an industry is really the same as feudalism in the old World Monarchies where favorites of the government were given land or other resources to develop and manage. Corruption is pervasive with all of these systems, and productivity, efficiency, and innovation are never comparable to those of the free market with Capitalism and individual incentives.

For a good analysis of the problems with too much government regulations regarding current military purchases look up: "What if Apple Designed an i-Fighter?" by Arthur Herman – Wall Street Journal, July, 2012. Herman recounts how the icon of progressive, liberal government, Franklin Roosevelt had to waive restrictive union rules and allow private industry to design and produce military equipment for World War II. Prior to his decision, the military had been supplied primarily by government owned production facilities. The result of his decision was not only more efficient production of equipment, but increased innovation and more cheaply supplied equipment.

Chapter 4

The Basics Needed for High Quality and Affordable Health Care Without

Rationing

Many of us panic at the thought of paying for our own health care with little or no support. The same has been true for those who have lived in government-controlled systems of food distribution when the government stops providing for them – there is panic in the cities (not farms).

People become dependent on the government.

The question here is one of Choice – will you have the freedom to choose your own health care or will you give that choice to the government? An old saying is that he who has the gold (or pays the bills) makes the rules. Do you want to give your "gold" to the government so it makes the rules and choices, or do you want to make health care choices yourself?

Using the free food story as a guide, we can see that the cost of food increased for a number of reasons. The most important reason was that the consumers were no longer the decision makers regarding what they wanted to buy and how much they were willing to pay for it. They had no skin in the game. A second reason was the increased costs associated with government regulations. Remember the multiple layers of regulations increased costs in two ways: the cost for the government to administer and police the system, and increased costs for the food providers to comply with the regulations. Essentially large bureaucracies are needed for both the government and food providers to comply with the regulations. So a government controlled system for food or health care has to also pay for two expensive sets of bureaucracies as well as pay for the food or health care – (and that does not even count the lobbyists and political contributions that I will not get into).

So to make health care more affordable, like food, we need to make the consumer responsible and decrease the associated costs of government or insurance company control. Transparency about costs is key. Who would think of going to a grocery store where you didn't know the cost of the item until you got to the cash register? Why do we tolerate that in health care?

What consumers need to make informed decisions about health care purchases:

1. Prices for services should be transparent and posted on the Internet and places of service.
2. When appropriate or possible, providers should report their outcomes for prospective patients to see.
3. Choices and competition to lower costs.
4. As in all purchases, it helps if the consumer is educated about their options.

What health care providers need to offer lower costs for services:

1. Open up the health care market and encourage competition.
    A. Remove barriers to entry. Allow physicians to start up and own hospitals, surgery centers, laboratories, and other facilities.
        i. Physician-owned facilities pay taxes, supporting local communities whereas hospitals generally charge more and don't pay taxes.
    B. Allow non-physicians to own portions of medical practices.
2. Reduce the cost of supplies, drugs, and devices.
    A. Reduce the cost of bringing drugs and devices to market by stream-lining the FDA approval process, more like that used in continental Europe for devices.
        i. Accept data from approved European studies.
    B. Reduce product liability costs, like Canada. High product liability costs and high regulatory costs associated with FDA approval are two reasons drugs are so much more expensive here than in Canada. (A third is a broken purchasing system.)
3. Allow doctors to provide service in the most cost-effective manner. For example, don't force them to adopt expensive computerized medical records. Reduce the cost of doing business.
    A. Computerized medical records and billing systems can increase the cost two ways.

i. One is by slowing down the doctor or other providers because they have to take time to manually type in data that can be done in most cases more efficiently with paper forms.

ii. Computer systems can be expensive and need to be replaced every few years as well as requiring staff to maintain them.

B. Reduce government regulations on coding and billing. When the government is not the payer, these regulations will not be necessary.

i. "The truth is that most of what the government calls fraud and abuse results from simple billing errors and the problems inherent in complying with Medicare's more than 100,000 pages of rules and supporting documents," said Michael Carius, MD, president of the American College of Emergency Physicians. http://www.ama-assn.org/amednews/2002/09/16/gvsa0916.htm.

C. Increase cooperation of certifying and inspecting agencies with those in the business so that providers are not being overwhelmed with busywork. Regulations and recommended practices should be based on sound issues regarding patient care and outcomes not on hypothetical problems that seldom or never occur.

4. Eliminate provider networks and secret contracting by insurance companies with different providers.

A. Insurance companies should list the amount they pay for services on the Internet and allow patients to seek care where they find the best value.

i. This would also help consumers decide which insurance company to use and which insurance policy they want.

B. The primary purpose of insurance policies should be to cover catastrophic expenses, not routine care. Why pay an insurance company to cover routine costs – it just adds expense. (You wouldn't pay an insurance company to cover toothpaste or food would you?)

C. Insurance companies should recommend providers for you to see, but not limit your choices.

Additional basics needed in Health Care:

1. A fall back system for providing basic health care to everyone.

A. It is in the public's general interest to provide basic care to everyone so that diseases are not transmitted through the population.

B. Basic care can be provided in the most cost-effective way through basic care clinics.

i. This does not mean to provide 24/7 Emergency Room services to everyone for anything. That is like using 5-Star hotels to house the homeless. Basic care clinics would need to be available and mandatory for routine issues.

C. People could choose to be treated for basic care at an emergency room if they want to pay for it themselves – which few in their right minds would do.

2. Basic no frills health care through the government available to anyone, as in Singapore (shared rooms in hospitals and no choice of doctors – one takes whoever is on call or working in the clinic).

A. Two choices in the delivery of health care: government and private. This generally corresponds to our transportation options: city bus or transit versus private car or taxi. We need both options, and they each keep the other competitive.

Let's discuss in more detail some of the key issues noted above.

Transparent Health Care Costs

There should be a mandate that all costs for services be posted on the Internet and available to see at the time of service. This step is essential to allow the consumer to be in charge, and to eliminate insurance companies' control of private health care delivery. Currently it is virtually impossible to determine the costs of many treatments ahead of time, as well as what and when the insurance company will pay.

Health care should be like going to a grocery or restaurant – you see what it costs *before* you make the purchase.

Provider groups will have to collaborate on how the services are grouped so there is a consistent method of reporting costs and outcomes. The reporting has to be consistent so consumers can make reasonable decisions. All providers would also have to use the agreed upon methods.

Similarly, all insurance plans, including government plans, would need to post in a standardized method, the exact payments for services, limits, and costs of their insurance plans so that consumers could compare varying plans in an equitable manner. This would help alleviate the bait and switch techniques that some plans currently employ.

Eliminate first dollar coverage of health care costs by insurance companies where the consumer has no "skin" in the game and no incentive to pay attention to what the real costs are for health care.

Insurance companies should be required to put a barcode, or other electronic marker, on each customer's insurance card that providers could scan so they could tell the patient exactly how much their insurance will pay for a given procedure and how much would not be covered. Consumers could shop for their care knowing the exact amount covered by the insurance company. This would decrease costs in two ways. First, since consumers would be comparing costs, health care providers would be competing for business, resulting in lower costs. Second, consumers would avoid care they felt was unnecessary rather than accepting the need for tests without questioning their value. Transparency in pricing would go a long way to control costs. A free market would make health care less expensive – as it does everything else!

This system would also allow for patients to receive whatever level of care they choose as long as they decided to pay additionally any expenses for the upgrade. All patients would also have access to county health departments that provide lower cost basic care. These changes would allow charges to be based on standard economic factors – for instance when the economy is in a recession as it is now, one would expect overall prices to go down – not stay the same as is the case with government and insurance company price-fixing.

Our current Medicare system limits all physicians to the same payment and forbids collections over and above those payments – price fixing. Payments are the same regardless of outcomes and experience. If someone other than the government was to set prices like that, it would be illegal. Certainly, no sector of the economy works efficiently with wage and price controls where payment is the same regardless of the quality of the service provided.

The important difference with a free market approach is that while the government or insurance companies would pay a fixed amount for their portion of the cost, the consumer would decide if they wanted to pay more for premium services they deemed worthwhile. The consumer decides if a provider – physician, laboratory, hospital, surgery center, etc. – is worth the price or is over-priced. The consumer decides if the quality of care, posted outcomes when appropriate, and need for treatment justify the cost.

We don't all go to the same grocery stores, restaurants, and fast food stands. We won't all go to the same providers for health care. In fact, for the free market system to work best, there would be little or no government or insurance company payments for routine care – it just adds expense to involve a third party in routine transactions. It would be just like if you paid an insurance company or government to cover your weekly food or restaurant expenses – it would just increase costs. Or, like if your car insurance included paying for your oil changes, gas, and windshield wiper blades.

Patients, the consumers, should be free to shop for the services they need. This system would provide competitive pricing and increase the customer service by the health care sector just as it has in all retail sectors where we have competition. The ability to comparatively shop is why food, clothing, and transportation are both plentiful and so much cheaper in the U.S. than in so many other countries.

Why do we need to decrease government regulation?

We are currently witnessing a revolution in information delivery and access because of the Internet. The Internet provides a wonderful means for finding information on a variety of topics including health care, health care outcomes, and basic health maintenance. We should allow the free access of knowledge and information to help people make up their own minds on how they want to access their health care.

The government is never efficient or cost effective. Increasing government control and regulations increases cost. Currently our government is adding countless layers of bureaucracy and regulations to fix problems that either don't exist or seldom are problems. If the government is going to pay for everything, then the government "needs" a non-sustainable and huge bureaucracy to regulate, oversee, and control every aspect of the delivery of care.

Any solution for decreasing health care costs has to involve streamlining and reducing government regulations. Currently physicians are spending an increasing part of their time making sure their coding for billings are compliant with an overly complex system where the government has imposed severe penalties for mistakes with civil, criminal, and monetary fines far out of line with the amounts actually billed.

An example of a wasted government regulation: mandates for electronic prescribing of medications. The government fines physicians who do not do this, but the doctor has to keep a paper form which they sign for each electronic prescription they send (not the prescription itself or which drug – just that they sent an electronic one). Why doesn't the government track this electronically? Appears to be just another way to collect fines.

Certain regulations limiting use of physician extenders for portions of exams and delivery of care need to be lifted. With a physician shortage as well as the high cost of training them, physicians should be encouraged to utilize physician extenders to facilitate the delivery of care so that more patients can be served both efficiently and cost effectively. Currently significant civil and monetary fines are being imposed on physicians who do not personally perform certain portions of exams. Let's not also make engineers or architects screw every bolt or hammer every nail in things they design or oversee.

From a training perspective, physicians are the most expensive piece of the health care delivery team. Physicians should be allowed to set up teams of health care delivery providers to provide a coordinated delivery of care without risk of penalties for not providing all the "face to face" portions of the exam. As a result, more patients would have access to care if regulations allowed for these physician extenders. *But of course, if the government was not the one paying, then there would be no need for these regulations and patients could choose the type of care delivery they want.*

Another example of over regulation is the drive to have computerized medical records in all doctors' offices. While this is a laudable goal, the technology is not here yet to make computerized medical records either cost effective or efficient. I have utilized electronic medical records for over 12 years in my practice. While it has specific advantages, it also dramatically decreases efficiency due to time requirements necessary to enter data. As technology advances, it should become increasingly cost effective and efficient. The current big push for this is more for government auditing of billing and coding – essentially for audits to collect fines rather than to increase quality of care.

These computerized systems add a tremendous cost to primary care doctors – often more than they can afford. In a few years, as computing power increases and costs drop, these systems will be cost effective even for primary care doctors. Think of the bar-codes for food. Big players could afford to do it first, then smaller ones, when it got cheaper and more efficient. Computerized medical records will be universally used once they are cost effective for the benefit they provide.

Currently while the Federal government is requiring computerization of health care providers, it has not set up guidelines about which information should be available or retrievable between systems. In other words, they are setting up a Tower of Babel where different systems will not communicate.

Another option: federal, or state, guidelines on how basic health care information for individuals is to be kept on some type of either portable or fixed information system such as memory sticks, Internet computer storage sites such as cloud storage, or means which may change over time as technology evolves. Patients could decide if they would participate, and if they preferred to keep the information on a memory stick or have it kept in central location. This would allow better care for individuals in both emergency and routine care situations, decrease the time needed to evaluate older historical information on individuals, and minimize errors in care due to inadequate information on past and current problems. This alone would do more to improve quality of care than all the new IT regulations in Obama Care.

The impetus for people to carry their health information on a memory stick or store it on a cloud database should be with the individual consumer, not the providers. Providers could offer a discount if patients have their history on a stick – from my experience, it would be worth it!

The Safety Net, or Basic Care Fall Back Option

Everyone in the country needs access to basic health care – including illegal aliens. Quite simply, you don't want people walking around with tuberculosis because they are afraid to seek treatment. County health departments need to be adequate to serve the needs of those who cannot afford care. This care does not have to be lavish with private rooms and valet parking, but it needs to provide high quality treatment and results.

The county health departments would be the safety net, or universal care option. In this basic care system, consumers would not have a choice as to who their physician or other healthcare provider would be. Depending on circumstances, it would not be individual one-on-one instruction for patients, but group instructions, shared rooms, and generic drugs and devices. This type of care is essentially what Obama Care will become in a decade or two anyway. However, under the model proposed here, basic care would be provided without the huge bureaucracy and associated enormous costs of Obama Care.

Other than billing a person's health savings account, the county health system would not have to generate complex billing and coding thus eliminating the need for all the bureaucracy to oversee it by the federal government. Just as importantly, by eliminating the complex billing and coding, it would free up the physicians and other health care providers to spend their time caring for patients instead of filling out forms.

Much of the complex billing we have now was originally instituted to make sure the government was being charged honestly by providers (doctors, hospitals, labs, etc.). More recently, there is movement towards a highly complex coding and billing system which will require different codes if you are hit in the eye by a flagpole vs. a baseball bat. As the coding becomes more complex, it takes physicians and billing staff, or hospitals and other providers, more and more time to fill out the extensive documentation – in some cases up to half the encounter time with the patient for physicians. Mistakes in the coding and billing are leading to fines in the millions of dollars supposedly for fraud, but in actuality most of it is due to honest mistakes or ignorance of the new regulations demanding more documentation to justify the need for testing and the results of testing and procedures. Just as in the Free Food Story, it would be a lot more efficient and cost effective to have the consumer determine if they actually received the service and if it was needed.

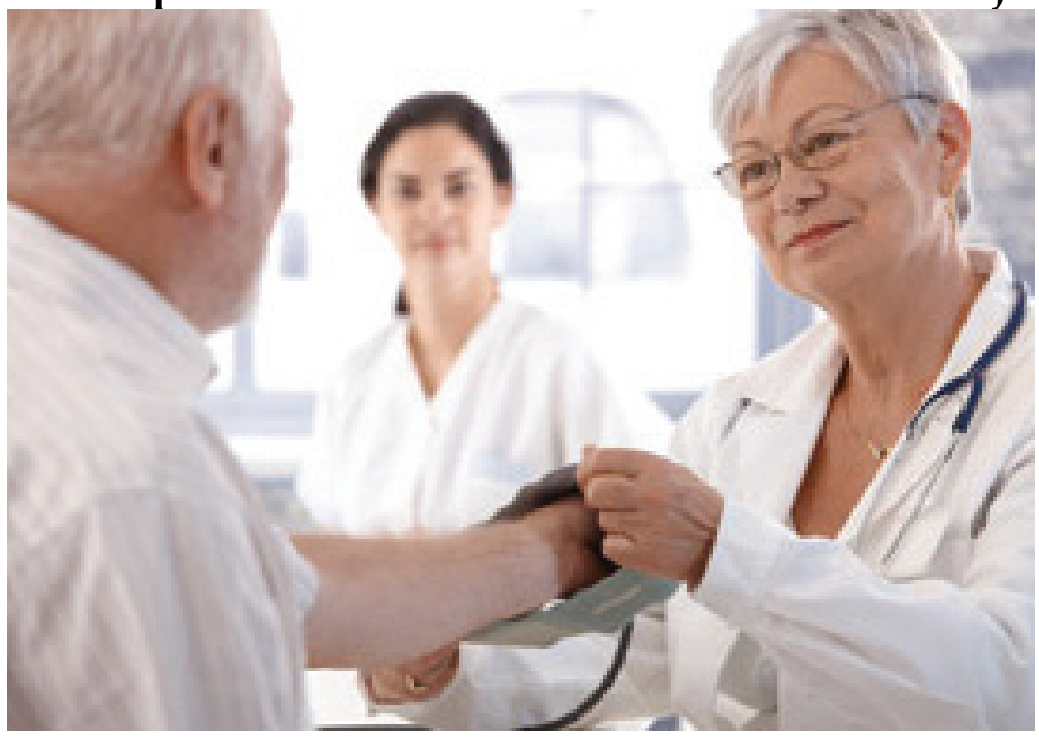
The expanded county health departments could provide care at a considerable cost savings from what would be done with Obama Care. However as noted in the Free Food Story, no government system alone can provide efficient health care delivery as a stand-alone system. The county health department system is a back up system, and most people with the means to do so will prefer to access upgraded care elsewhere.

Importantly, the county health departments will provide a reality check, so to speak, to hold costs down on alterative free market options. For instance, if vaccinations become too expensive in the private setting, then one will have the option to take their kids to the county health department and stand in line for less expensive vaccinations. On the other hand, if the county health department becomes too oppressive or does not provide adequate technology, then more people will migrate to the private alternatives.

Another good way to contrast the difference between the safety net and private options health care is to look at how it is done in our legal system/government. People have the option to use public defenders, or court appointed lawyers. Those with means have the choice to hire lawyers on their own with a range of costs and experiences to choose from.

Chapter 5

Two Templates For Possible Demonstration Projects



Before moving toward a free market for health care, we would first need to evaluate some demonstration projects. Those on both sides of the issue should support demonstration projects. The doubters to show it won't work and supporters to show it will!

It would be just as unreasonable to institute a complete privatization or free market change for all of health care as it was to force the opposite, a vast expansion of government control of healthcare (Obama Care), onto the country. As noted earlier, most people would be really frightened about having to pay all of their health care costs.

The demonstration projects have to be big enough to actually change the delivery of care and reduce costs, because the health care system is intertwined and dependent on many different providers and producers. One cannot really reduce so many built-in costs unless a large market segment is included. Moreover, it would be necessary to phase in the conversion for any demonstration project.

Demonstration projects could either include all health care in a given region, or include a segment of health care on a national level. This would be consistent with Alexander the Great's method of attacking the Gordian Knot - slice it off by strands instead of trying to smash it all at once. Demonstration projects should realize substantial savings, but the most savings would be with complete conversion of the whole health care system to a free market like we have with food today.

Therefore, I will present two possible types of demonstration projects where one is a regional test for all of health care, and one is a market segment over the entire country.

State or Regional Demonstration Projects

A particular state or region could institute the reforms outlined in Chapter 6. The state, or region, would be given all the money typically budgeted for them for Medicaid and Medicare payments, including all educational grants for physician training programs, and other health related programs. This would exclude scientific research grants – which could be the topic of another book.

The goal of the demonstration project would be for the state to gradually wean itself off of federal government subsidies. Ultimately, if the federal government is going to get out of health care in this state or region, the state(s) would need to take over the collection of health care-related taxes.

Eye Care as a Free Market Demonstration Project

As I am intimately acquainted with the ophthalmic, or eye, portion of health care, the second approach could be to make eye care a demonstration project. Eye care is ideally suited to be a stand-alone system because some of it is already patient pay with varying levels of free market competition for eyeglasses, contact lenses, Lasik, and some plastic surgery.

Eye Care/Ophthalmic Care could become a stand-alone demonstration project for a free-market approach. Eye care is a small part of the whole medical care pie. Eye care delivery is primarily out-patient and in freestanding clinics. Many eye care providers are involved with retail sales outside of the typical health care payment system or in separate systems of payment. There is also little overlap with other areas of medicine.

From my perspective, eye care tends to be entrepreneurial and I know that it can be provided much more efficiently and less expensively than it currently is. The outline for eye care as a demonstration project is explained in detail at the end of this chapter.

Summary of Objectives for Demonstration Projects

The goal is to put the consumer in charge of purchases, and eliminate artificial controls that have removed the health care consumer from the costs associated with purchases.

We need to eliminate first dollar payment for health care services (where the patient pays nothing at all and therefore has "no skin in the game"). This would be difficult to achieve in an eye care demonstration project, but when all of Medicine could be in this, then a system with medical savings accounts for health care could be instituted. A good example is the healthcare system in Singapore. There, even the Medicaid type patients have medical savings accounts.

In Singapore, if one is attentive enough in utilizing one's health care account, then some of the money saved can be used for down payments on homes or apartments. This adds "skin in the game" even for the indigent or Medicaid patient.

If the consumer is in charge of purchases, then the cost should be driven down substantially. Obviously for that to work, we have to drive down the cost of doing business for providers and suppliers (drugs and devices) as well. That is why my proposal also includes the FDA and regulatory bodies that have put in place expensive regulatory hurdles that in many cases do not lead to significant improvements in patient care.

Just like every other aspect of society, we still need laws and police to enforce those laws in medical care. However, we can greatly reduce and simplify what we currently have.

While this is a monumental task – it would be well worth our while to attempt demonstration projects like these. As noted in the beginning of this primer, we currently are on a path that is non-sustainable.

Detailed Outline of Eye Care Demonstration Project

This outline goes into some of the nuts and bolts, or specifics, of setting up and carrying out this demonstration project. So read on if you are interested in how it would be carried out, if not, then move on to the next chapter that will discuss how to change our overall healthcare on a national level.

My proposal for free market Eye Care has 8 key points.

1. Spin off all of eye care for those 16 years old and up. (Start without pediatrics)
2. Remove the current coding systems of ICD and CPT and replace them with ones designed by organizations in eye care. Design ones that are practical and efficient so we do not need to advance to the ICD-10 system with 130,000 diagnosis codes.
3. Develop a comprehensive review of the regulations and restrictions we face as businesses, providers, and suppliers of health care that directly add to the cost of providing health care with minimal if any improvement in the care provided.
4. Spin off a segment of Health and Human Services for eye care.
    A. Provide complete transparency for fees paid by Medicare, Medicaid, and private insurance companies.
        i. Require each third party payer to list the fee they pay for a procedure on the Internet, and patients could decide where they will go for treatment and what if anything they will pay over and above the covered fee.
        ii. Standardize the rates paid by third party payers for a given procedure regardless of where they are performed – doctors' facility, office, or hospital.
    B. Allow balance billings
        i. Require providers to list procedure fees on the Internet
        ii. Providers groups or organizations will have to decide on what will be included in the listed procedures and fees so that patients can compare similar products between providers (apples to apples).
        iii. Balance billing refers to the practice of charging a patient over and above what the government or insurance company pays. Currently, physicians cannot do that in most cases, but hospitals can. With this system it would need to be allowed in order to have a free market pricing system. The providers (doctors, hospitals, labs, testing

facilities, clinics, etc.) would list their costs for services, insurance companies list what they will pay, and patients decide who they want to see and what service they want performed. Depending on market conditions, prices could go up or down for things, but typically we should see a huge drop from current pricing levels.

a. One advantage of this system is that with reduced burdensome regulation, all services should get less expensive to provide. As providers can provide services less expensively, then the prices should drop.

b. In the current system because the only payment for services is from the government or insurance companies, the providers who are less skilled, or who provide less efficient care are paid the same as those who provide more efficient and higher quality of care. The current system leads to rewarding mediocrity rather than quality. Balance billing would allow patients to pay more for those who they deem provide better care – if they don't see a difference then they can go to providers that take what ever the government or insurance pays.

C. Establish a fall back system for those who have no means of support.

i. This would work best if it included all medical care, as discussed in the last chapter. For this demonstration project which would only include eye care, other options would need to be considered:

a. The care could be provided by the county hospital systems.

b. The fallback eye care could be provided by teaching programs or county systems that currently provide eye care.

c. Private groups, universities, or practices could contract for this book of business with the states that administer as is currently done for Medicaid.

ii. Consideration should be given to allow residents, and certainly fellows who reach a given level of competency to work independently providing care for these patients – as we did during my training.

iii. Increase the residency training programs by one year, and consider ending the government support for these positions. Costs could be offset by billing for services provided by residents, and by those physicians who benefit from their services. At the same time we should increase the number of positions in training programs so we are turning out more ophthalmologists to meet the needs of our growing and aging population.

a. Keep in mind that if we decide to increase residency training numbers for eye care or other specialties it could take 15 to 20 years to see any affect with increased number of doctors.

5. Eye care, rather than Medicare, should provide the certification organization for all eye-specific surgery centers and hospitals. This would allow us to have a practical set of guidelines based on what works and what is safe, instead of being based on hypothetical situations that might happen but have not been observed to be recurring problems.

A. The goal is to ensure safety, yet allow cost effective operations. The work to address and eliminate TASS, a rare, but severe, inflammatory condition after some eye surgeries, demonstrates this is possible utilizing current professional organizations. In contrast, we are now inspected and regulated by individuals who have little or no actual knowledge of eye surgery and eye diseases.

B. Those providers that work in general medical hospitals would still be subject to the standard certification and regulatory systems now in place for those facilities while working there. This is an important reason to have this initial project only include those over 15 years of age, as most children are operated on in hospitals.

6. Spin off the eye care portion of the FDA into a separate entity.

A. This is essential to lower costs for ophthalmic drugs, devices, and supplies.

B. Develop specific guidelines on what has to be done to gain approval with a time line for key milestones from start to finish.

C. Include a review mechanism for individual cases so that companies have the ability to contest arbitrary decisions or what currently appear to be unreasonable delaying actions.

D. Provide for public education on what the purpose of the FDA is, and the risk-to-benefit ratio that is used for drug and device approval.

i. Present a more balanced picture of the large numbers of people who are suffering and not able to get new sight and life-saving treatments because of long approval delays. Explain that because people differ, sometimes treatments that help many people may hurt a few.

ii. For instance, the wonder drug aspirin could never be approved today because of the side effects. That is ridiculous.

iii. Currently no one now runs interference for the FDA if they are criticized in the press for products that have risks. So we have a situation where it is safer just not to approve anything. We need to change that.

iv. We need approval of new and better products, which if done correctly should allow more efficient, safer, and yes, less expensive care.

7. Set up a panel to evaluate drug prices, FDA-related expenses and patent protection for companies, and establish guidelines for these areas.

   A. Allow this independent body to sit down with regulatory representatives from the FDA and industry to help set standards for regulatory costs and timelines and appropriate fees to avoid the extremely high prices that we have now for Lucentis™ (The $2,000 a dose drug for macular degeneration) and many eye drops and brand name products. If we reduce the cost and length of the approval process and increase the likelihood of approval, companies could charge much less for the products and still achieve a reasonable return on investment.

      i. It should be noted that with a system where the consumer is making the purchasing decisions (paying for the treatment) the cost of these drugs would almost certainly plummet in most cases as pharmacies and manufacturers compete for the patients' business. This would also have a ripple effect over time for most devices as well, as price competition increases.

   B. This body and its proceedings have to be exempt from anti-trust and restraint of trade rules.

   C. The goal here is to provide a reasonable return for companies on the investment they make to develop new drugs and devices and make it less expensive to bring new drugs and devices to market. If it is less expensive to get to market, and the risk of being tied up in the regulatory process is reduced, it should be possible to offer the product at a lower price and much sooner.

   D. These together with the transparency of the cost of services, drugs, and care should all lead to more competition and lower costs to the consumer.

   E. Allow physicians to dispense medications in eye care – i.e. sell prescription ophthalmic drugs in their offices without having to hire or pay a pharmacist. This would allow ophthalmologists to control the costs to a greater degree than they can now for the medications, specifically eye drops, they frequently prescribe to patients.

8. Tort reform for eye care

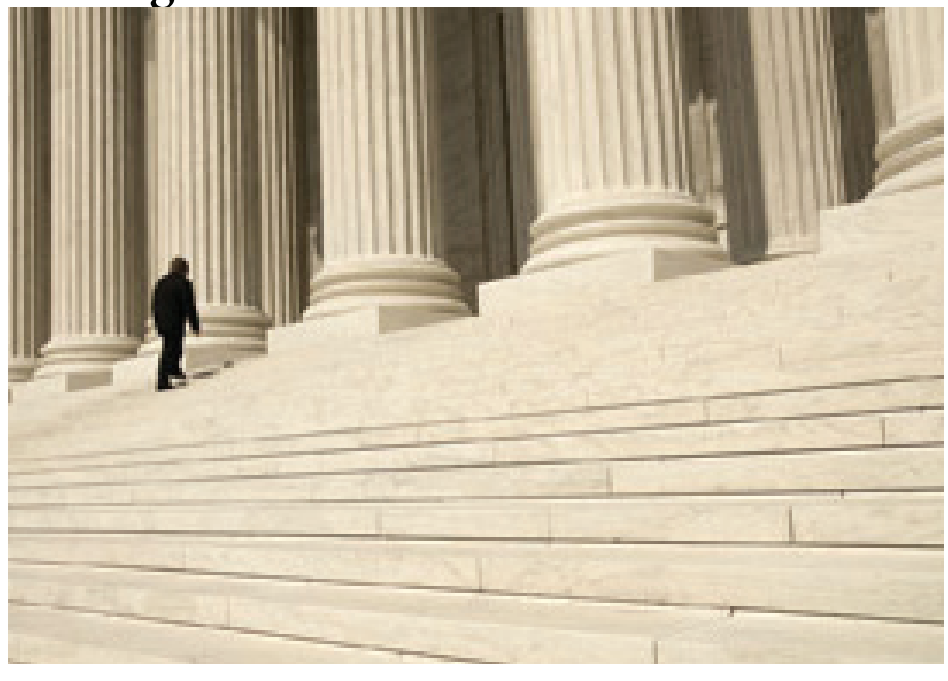
   A. This is part of the change needed to reduce costs although it is a sacred cow for some.

   B. This reform would include product liability, which is also needed to reduce the cost of goods sold such as drugs and devices.

   C. Tort reform for all of healthcare does not seem to be an achievable goal at this time. Perhaps we could chip away at this problem by reforming eye care to start with.

Chapter 6

Implementing Health Care Reform On A National Level



This chapter provides an overview of how our health care system could be converted to a free market system for most Americans along with a safety net for those unable to care for themselves. This is not a stand-alone section. The earlier sections are essential foundations for this chapter.

The alternative to a free market in health care – government controlled and regulated health care – will eventually lead to rationing of care either by limiting access to advanced treatment (as in England), limiting access to what many of us consider routine care here in the US with long waiting lists for routine surgeries (as in Canada), or a deteriorating infrastructure of physicians and facilities (in many countries).

Perhaps one of the best ways to identify important areas on which to focus is to examine the groups that lobbied and funded promotional campaigns for Obama Care – look for the fat. These were large insurance companies, hospital associations, and the pharmaceutical industry. The AMA supported Obama Care as well, but they represent a small portion of the physicians in the country and unlike the other groups haven't achieved their goal - improved physician payments.

As noted in earlier sections, it would be difficult, if not impossible, to privatize the government portion of civilian health care all at once – just as it is a long, involved process for Obama Care to socialize or "governmentize" all of civilian health care. Demonstration projects are needed to show which approaches work best.

Actually those on both sides of the issue should support demonstration projects. The doubters to show it won't work and supporters to show it will.

Any change to health care on a national level needs to be done in stages. The stages are required partially to allay fears of change that everyone has, and also because of the sheer size of health care– about 1/6 of our economy at this time.

There are 15 steps needed to allow health care nationally to be free market while at the same time providing a safety net for those who need it. Such a system would enable health care to be affordable while also allowing development and access to new technology so that we can have improved treatments for heart disease, cancer, autism, degenerative neurologic diseases such as Alzheimer's, and other areas.

The 15 steps are divided into three stages that I think are also the most practical way to implement the reforms in health care. The steps of the final stage are likely the most difficult to achieve, but like the others, these final steps are essential to have a true and successful reform of health care.

15 Steps to Rehabilitate U.S Health Care:

Initial Stage: Simplest steps to implement

1. Set up demonstration projects to evaluate and prove/develop concepts of free market approaches to health care. **
2. Make transparent all health care costs and all payments by those other than the patient. **
3. Eliminate disparities in payments for a given service based on where it is provided (for example paying twice as much or more for a procedure performed in a hospital owned facility compared with the same procedure performed in either a private for profit center or a doctor's facility).
4. Open up health care to competition. **

***As discussed in Chapter 5.*

Stage 2 : Put the consumer in charge, reduce costs for supplies and delivery, and protect the needy.

5. Set up a safety net of basic health care for those unable to provide for their own health care payments.
   A. Ideally this system should be locally based such as county health departments and hospitals with state or regional

referral centers for more complex situations.

   B. States should have the option to take this concept and either utilize Medicaid as a model or change it into a program specific for their needs.

6. Set up Medical Savings Accounts for all Americans, including what are now Medicaid and indigent patients.
7. Reform the FDA
8. Dismantle the onerous layers of regulation on health care providers and come up with a simpler set of regulations to ensure safety and quality of medical care delivered to patients.
   A. Regulations should be based on sound cost benefit studies, not trying to prevent some hypothetical or rarely occurring problem.
   B. Stop the government from funding more bureaucracy by using both civil and criminal fines to raise revenue.
9. Begin the discussion of who should be in charge of "government" payments for the safety net system or other promised government systems like Medicare.
   A. This choice is between having the states or the federal government in charge of health care.
   B. The more local the administration, the more efficient and cost effective it may prove to be.

Final Stage: Insuring the Future Viability of Health Care

10. Set up a non-partisan, non-political panel to evaluate drug prices, FDA related expenses, patent protection for companies, and establish guidelines over these areas without threat of restraint of trade.
11. Set up a non-partisan, non-political panel to establish long-term needs for health care personnel such as doctors, nurses, and other physician extenders.
   A. Provide limited federal funding for training subsidies in areas of potential need for national well-being and defense.
12. Take away the non-profit status of most "non-profit" hospitals, which now operate like for-profit businesses in terms of executive pay, marketing budgets, and widespread purchasing of for-profit entities.
13. Tort Reform – Change the legal system to reduce frivolous lawsuits and unreasonable awards and legal fees.
14. Honestly acknowledge the size of our national debt, which has increased each year since 1969, and develop a plan to pay it down without token efforts that do not take effect until years in the future.
   A. Without this there will be no economy to fund anyone's health care or ability to have thriving businesses.
15. Require members of Congress to have the same health care as their constituents.
   A. This will be the most effective way to insure that Congress will not raid the "cookie jar" of health care by having their own health care plan safely protected.

Why these 15 Steps?

The recurring themes in this primer are: 1) placing the patient in control of health care costs and payments and 2) reducing government regulation.

Earlier sections of this primer already explained some of the above steps, and now some in-depth discussion behind some of the other steps.

Universal Health Savings Accounts – The step that most defines the difference between this Primer and Obama Care

Obama Care limits and will eventually end health savings accounts and high deductible health insurance plans. In Obama Care, the coverage is typically "first dollar payments" with many areas such as wellness care and screening tests stated to be "free" or without charge (tooth fairy economics). Obama Care proponents say this is so everyone can have care and have it

cheaply. Hopefully this primer has dispelled that myth – there is no free lunch or free health care.

Health Saving Accounts and similar types of insurance policies allow a person to have a savings account in which the money can be used to pay medical bills. The person decides where to spend the money. While payments from the accounts typically are for routine health care costs, sometimes it may be for things not typically covered in standard insurance policies like elective surgeries (Lasik, plastic surgery), over the counter drugs, or non-standard treatments. More importantly, medical savings accounts are a way to have a high deductible medical insurance policy with the safety of having funds allocated to cover health care expenses during the high deductible period.

Why do people typically have high deductible car insurance or health insurance? It is cheaper! Because it is high deductible, it is not used for routine expenses, just major expenses that could be difficult for the person to pay for without the insurance. (Remember the insurance company essentially makes a profit on all payments, so if they pay for routine tests and procedures – they cost more!)

Medical savings accounts can be set up so that if the person does not use the money in the account in a given year, it remains in the account for the following years in case it is needed for expenses at a later date.

With either Health Savings Accounts or high deductible insurance plans, the patient decides what is being paid for most routine claims – and decides if they want to go forward with treatment. The real insurance kicks in for large claims i.e. catastrophic claims that are very expensive and more than the deductible limit in the plan –such as injuries from an accident or major surgery/sickness that requires hospitalization.

This is similar to a high deductible car insurance policy – if your deductible is for $5,000, you might not turn in claims for a dented fender – or you might not even get the fender fixed. If you do want the fender fixed, you are more inclined to try and negotiate or shop for a lower cost for the repair.

On the other hand if you have a low or no deductible plan and your insurance pays for everything, you are more likely to turn in claims for any scratch or dent. You have no incentive to shop or negotiate a lower cost for the repair if you have a "first dollar payment" car insurance plan.

You might think health care is not the same as car care. It may be closer than you think! Consider a patient I examined as a medical student, who came to the emergency room with a stubbed toe. I asked the patient why they came to the emergency room for that and was informed it was none of my business, as their insurance paid for it. That visit could easily cost hundreds of dollars and, unfortunately, such things happen all the time. If the person were paying, I doubt they would have even considered seeing a doctor.

Just as more money is spent to repair fenders with "first dollar payment" car insurance than with high deductible car insurance, more cost will be associated with "first dollar payment" insurance in Obama Care than in a free market system with universal health savings accounts where the consumer is spending their own money for routine care. Also understand that a "cost" for medical care is involved in a totally socialized health care system where no one "pays" for care and all doctors/nurses work for the government – here the cost is the time and resources used to administer care. If a lot of "free" services are offered, it takes up resources that could have been used for treating/preventing disease, and if used for "minor scratches and dents" it is a waste of taxpayer dollars and adds to the inefficiency of the system to provide care.

Obama Care may actually be designed to not only cost more for medical care, but to further strain the system and potentially cause it to fail – more failure would be grounds for Obama Care's supporters to ask for more government control of pricing and delivery, which will lead to even greater rationing and limitation of care.

The requirement for pricing to be posted online will only be helpful if the patient has some skin in the game, so all patients, including Medicaid and Medicare, should have medical savings accounts where a portion of the payments comes from their accounts. While Americans should not be forced to either buy health insurance, or have a medical savings account, it should be a mandatory part of any private or government health insurance or network. By expanding the number of companies who offer medical savings accounts, more individuals who work would have a portion of their income go into these accounts. Those who do not work, are on Medicaid, or are disabled would have the government contribute to their accounts.

The Singapore government has done a nice job of developing a system that could be used as a template to set up trial systems in the U.S. When the amount accumulated in a medical savings account surpasses a certain limit, they allow a portion of medical savings accounts to be used for a variety of other expenses including home purchases. The key is to give every American a reason to be concerned with, and to pay attention to, what they spend on health care just as they are now concerned with what they spend on food, clothes, and housing. More importantly, these savings accounts could also be used in a government-run, safety net system like Medicaid and expanded county health departments so that even those in these plans would have incentives to choose appropriate care.

Who should be in charge of administering government supported health care systems like Medicare and basic health care needs?

Basic health care will always be provided on the local level, and it makes sense to also have it administered locally. This allows different states like Massachusetts, Oregon or Indiana to have their unique plans and systems they have already set up. This may require investing in the infrastructure of county health departments and hospitals that have in many cases been purchased or taken over by large mega-hospitals. Should these local county hospitals stay as part of a large conglomerate or should they be spun off again to just provide backup indigent or basic care? Should these local hospitals stay part of the large group to have access to new technology that otherwise would not be cost effective for each one to purchase? Should they remain as a feeder source, sending patients and referrals to the larger mother ship hospitals? These should be local issues.

Medicare administration poses some unique concerns compared to just providing the basic health care alternative. Medicare was created for the elderly, and is now promised to working Americans for their retirement years. It has grown to include many who have never or will never work and this latter group should most likely be spun off into the basic care delivery. However for those retirees with Medicare, the option of a federally administered plan permits them to relocate to different areas of the country from where they worked which has obvious advantages to states with large retirement populations. On the other hand, having individual states administer Medicare would allow more efficient and local solutions to health care needs and reduce costs compared to having the federal government administer it.

Whoever administers the programs should also collect the associated taxes. There is no reason, other than control of power, to have the federal government collect taxes and return them to the states. Therefore this portion of reform could evolve as each group (state and federal) jockey for who gets the money.

Step 7 – FDA Reform

In order to decrease the high cost of drug and device approvals by the FDA, we need to educate the public, Congress, and the FDA that some risk and unwanted results are inherent in any drug or device. To eliminate all risk, as we are trying to do at this time in both the FDA and the legal system, is unworkable. Consider if the FDA had to approve every car or motorcycle on the road – we would all be walking if the current mindset for approving drugs were used for these vehicles.

There has been a dramatic increase in the number of employees in the FDA and exponentially increasing costs to get new drug and device approvals through the system without an increase in the number of drug and device approvals. In fact in a number of areas, the approvals have almost stopped.

We have come to expect amazing healthcare advances and many do not realize that bottlenecks being created by the FDA are now restricting our access to health care improvements.

A basic problem is a bureaucrat receives no reward for approving a good device or drug, but they can be made a scapegoat for any drug or device that is approved and later shows some problem. Unfortunately, one solution to this problem is to not approve anything, or to make it virtually impossible for drugs/devices to gain approval. We appear to be approaching that situation now. Only by public education that some risk and complications are to be expected with any treatment can we reverse this disturbing and dangerous trend.

Remember that simple aspirin would not pass through the current FDA approval process! Our health care system would be even more expensive and less effective without aspirin!

Set up a non-partisan, non-political panel to evaluate long-term needs for health care personnel such as doctors, nurses, and other physician extenders.

Currently, we are experiencing a decrease in the number of physicians each year as judged by the number of new doctors trained compared to the number retiring. At the same time we have an aging population that will inevitably require more care. This trend of decreasing numbers of physicians coupled with increasing need for care will lead to shortages of care in many areas – especially rural ones. We need a blue ribbon panel to set goals and offer guidance of where medical school and other health care provider enrollment numbers should be. It may take 20 years to make significant changes in the doctor pool once a decision is made, and currently there does not appear to be any planning for our national needs or health security.

The looming doctor shortage is further exacerbated by the decreased workload that many new physicians want to have compared to those physicians who are older. This desire for a shorter work-week will reduce physician availability at a time when the need is growing.

Likewise, while many Medical schools appear to set their enrollment goals based on federal subsidies, that reliance should be lessened or even eliminated in favor of more state sponsored medical education in association with state/county health departments so that training programs could more closely work with these safety net systems of health care. Training could be tied to all or partial loan forgiveness in return for time devoted to practicing in the subsidizing state, providing educational services to physicians and other health care workers, serving patients in the safety net system, etc.

Re-evaluate the non-profit status of many hospitals.

Initially when non-profit status was designated for hospitals, they were small charitable organizations that operated on a shoestring with little or no intent towards profit. Today, many of our hospitals are large corporations, mega-hospitals, buying up large segments of the healthcare sector such as doctors, laboratories, and office buildings. Walking into many of these hospitals reveals grand edifices which are often second only to the government in excesses and lavishness.

Mega-hospitals now use their tax free profits to purchase taxable business like physicians, surgery centers, county hospitals, and laboratories. This leads to increased fees (hospitals typically bill and receive much more than private centers or physicians for the same service). By employing the formerly private doctors, the large hospitals also capture patients within their system, stifling competition, and causing loss of taxable income for the local communities.

The Hospital Association paid millions to support PPACA, apparently in exchange for not having their non-profit statuses investigated and to prevent physicians from expanding or building their own hospitals – i.e. to limit their competition. Our country should be open to anyone building quality hospitals, or outpatient surgery centers, that can deliver care, especially if it is more efficient and cost effective.

At a minimum, there should be investigations of the non-profit status of these large hospital groups who are buying physician practices. Making large hospital groups taxable would help local property tax receipts and make the system much more competitive.

The expansion of county health departments to provide basic and safety net care will also eliminate the necessity of continuing “non-profit” status in exchange for caring for the indigent. Just like private physicians, these hospitals could still bid or contract for the safety net portion, but they would not need non-profit status to do so.

Physician owned surgery centers, labs, and hospitals can often deliver care less expensively, more efficiently, and still pay taxes. Why limit them?

The loss of non-profit status for hospitals could be phased in over 5 years and coincide with expansion of the county/state health departments providing basic, low-cost care that could also help lessen the reliance on emergency rooms for delivery of basic health care.

Emergency rooms are designed for emergencies and, as a result, provide non-emergency care at a much more expensive rate than clinics could. Currently, uninsured individuals frequently utilize hospital emergency rooms for routine care. Using a housing comparison, this is like going to a five star hotel to sleep each night instead of getting an apartment at a monthly or yearly rate.

PPACA provides payments for "currently uninsured" individuals to continue to frequent emergency rooms – that only increases the cost of health care without fixing a root cause of the high cost. Once again, this demonstrates the importance of those with Medicaid or no health insurance to have some skin in the game.

Tort Reform

Tort Reform refers to reforming the legal system so that lawsuits without merit cannot be as easily brought against people and businesses. By bringing these lawsuits, lawyers routinely extort payments from defendants who want to avoid the even greater expenses of time and money it would take to defend against lawsuits – even ones without merit!

The U.S. has more lawyers per capita (per person) than any other major country. Anyone can sue anyone else with little repercussion. Lawyers advertise for class action suits for anything from hot coffee spills at fast food restaurants to a pill one may have taken.

As noted earlier, most countries do not allow this wonton excess of lawsuits. That is a big reason that drugs are cheaper in Canada. Also in Canada and England, there are not many lawsuits against doctors. Lawsuits in the U.S. have become like lotteries where people think they will make a bundle. Often though, it is the lawyers who walk away with most of the money.

Let's look back at our story of free food. If retailers of food were required to provide a nutritious balance of food for people, and they did not – could they be sued for huge amounts? If they could, then they would likely have to purchase insurance against that. What if they had little control over whether people purchased nutritious food but they were still liable to be sued if people just bought potato chips and soft drinks? What would they do? Here are two possibilities:

1. They could make sure that everyone left the store or restaurant with vitamins, green leafy vegetables like kale, and a high protein source like liver – even if they didn't need them or would never eat them. Would this drive up the cost of food? Yes! Would it help protect them against suits for not providing nutritious food – yes. Is this like a doctor ordering extra tests just to make sure nothing is missed and to prevent lawsuits – yes.

2. They would start paying more for liability insurance. This would lead to more expensive food. Do you know that some types of doctors pay $100,000 or more each year for malpractice insurance? This is not because of how that doctor practices as an individual, it is because their specialty is frequently sued – obstetrics/gynecology and neurosurgery are two examples of specialties hit with particularly high costs for insurance. Does this raise the cost of health care – yes. Do the doctors just magically pay this out of their income without passing it on in some way to the person or group who pays – no. Remember there is no Santa Claus or Tooth Fairy in real life despite the promises of some politicians.

Do we need tort reform? Did you know it is quite difficult to get any American company to manufacture immunizations because of the risk of being sued for unproven health risks like autism? Did you know that some scientists working with the trial lawyers faked the data that immunizations increase the risk of autism? Is the system broken – yes! Is it a national security risk to not be manufacturing our own immunizations? I think so.

Chapter 7

Why You Don't Want The Government Making Key Health Care Decisions For You

If Americans want access to ever improving technology, and the ability to choose their own doctors, hospitals, and other health care facilities and providers, we need a free market system where the consumers make the choices, not government or insurance panels. Ultimately, both the government and insurance companies would need to restrict or ration care to control cost if they are the one paying for care instead of the consumer. There is no other possibility. Everyone loses in such a system. While the poor suffer the most because they can't afford to pay for care outside of the system, the disastrous effect on development of new treatments affects all of us. (Who would invest in a product when the ability to see it rests solely on the decision of the government?)

Remember this as well, none of us will know what new and beneficial – even life-saving – treatments would have been there for us or our loved ones if their development had not been stifled by government control of the health care system.

But limiting access to care is only part of the problem with having the government control your health care choices and payment for care.

We also need honesty about the increasing cost of successful medical care. Successful health care does not necessarily decrease long-term costs for the one paying the bills.

As an example, consider the costs to care for a diabetic person 65 years old. If the system does not work, the person develops complications of the disease from poor control that leads to death in a few years from heart disease, vascular disease, or diabetic crises. However, if the system works and their diabetes is successfully regulated, heart disease and generalized vascular problems like kidney failure are prevented, and the person may continue living for another 20 years, or until they are 85 years of age. This means that the person will continue to generate health care costs for an additional 20 years. The case is similar for acute heart disease and many other areas of medical care.

Successful health care leads to longer life expectancy and increased costs over a longer lifetime. In other words, it is not in the government's financial interest to have successful health care that allows individuals to live long past their working years. So do you really want the government deciding what is best for your health care as well as paying the bills?

This revelation may explain why the advisory boards that President Obama initiated have recommended either eliminating or decreasing the screening exams for breast cancer, colon cancer, and prostate cancer. Treatment of cancer is typically more successful when found early. Finding cancer when it is advanced typically has a poor prognosis and with a poor prognosis, the government controlled health care systems will most likely not recommend treatment. If you wonder what this might be like, check and see how it works in England, the health care system that President Obama's chief advisor on health care – Dr. Emmanuel – noted was the goal for America. What typically happens when someone has cancer there – or cardiovascular disease? Do they have the access to treatments we currently have now in the United States? Do they have to wait for treatments? Are their success rates even comparable to ours? The answers are not complimentary to their socialized system of health care.

So where are we now? It's all about Choice and Hope.

Are we going to stick with Obama Care, the largest tax increase in American history, and a tangled group of laws and regulations, the cost of which continues to escalate almost every day as new revelations come to light about its true nature?

Are we going to accept the severe restrictions on personal freedoms that Obama Care imposes on us? **This is all about Choice** – the choice of freedoms both in health care and our daily lives.

I hope this primer helps us, the patients and consumers of health care, make more informed decisions on how to actually improve our health care.

I hope this primer also helps physicians see that we need to radically change the way we look at health care and how we approach the government regarding reforms to the system. Physicians frequently seem to be reacting defensively: trying to modify planned regulations of their businesses, surgery centers, and practices; dealing with increasingly complex coding and billing requirements and mandatory electronic medical records; addressing the release of "bounty hunters" to recover fines

for the government; and on and on. Instead of trying to put Band-Aids on the problems, we need to overhaul the delivery of health care.

I hope this primer helps those in industry and other business areas understand some of the economic basics of health care delivery.

With our current system, industry leaders fruitlessly continue to try to lower costs by working with insurance companies to have competing provider networks, drug card plans, and even in-house physicians to lower costs. The common theme of the insurance companies is to demand a percent decrease from providers but in reality little is done to lower costs. As a result, the charges providers list for care are inflated numbers developed in response to insurance discounting schemes. This causes the listed prices for procedures, treatments, and drugs to be as misleading as the list prices on new cars.

Health Care should be as readily available and affordable as the food supply we have in this country.

The proposals in this primer are diametrically opposed to those of Obama Care – It is all about Choice and who makes it – you or the government. It all comes down to who you want making those decisions for you.

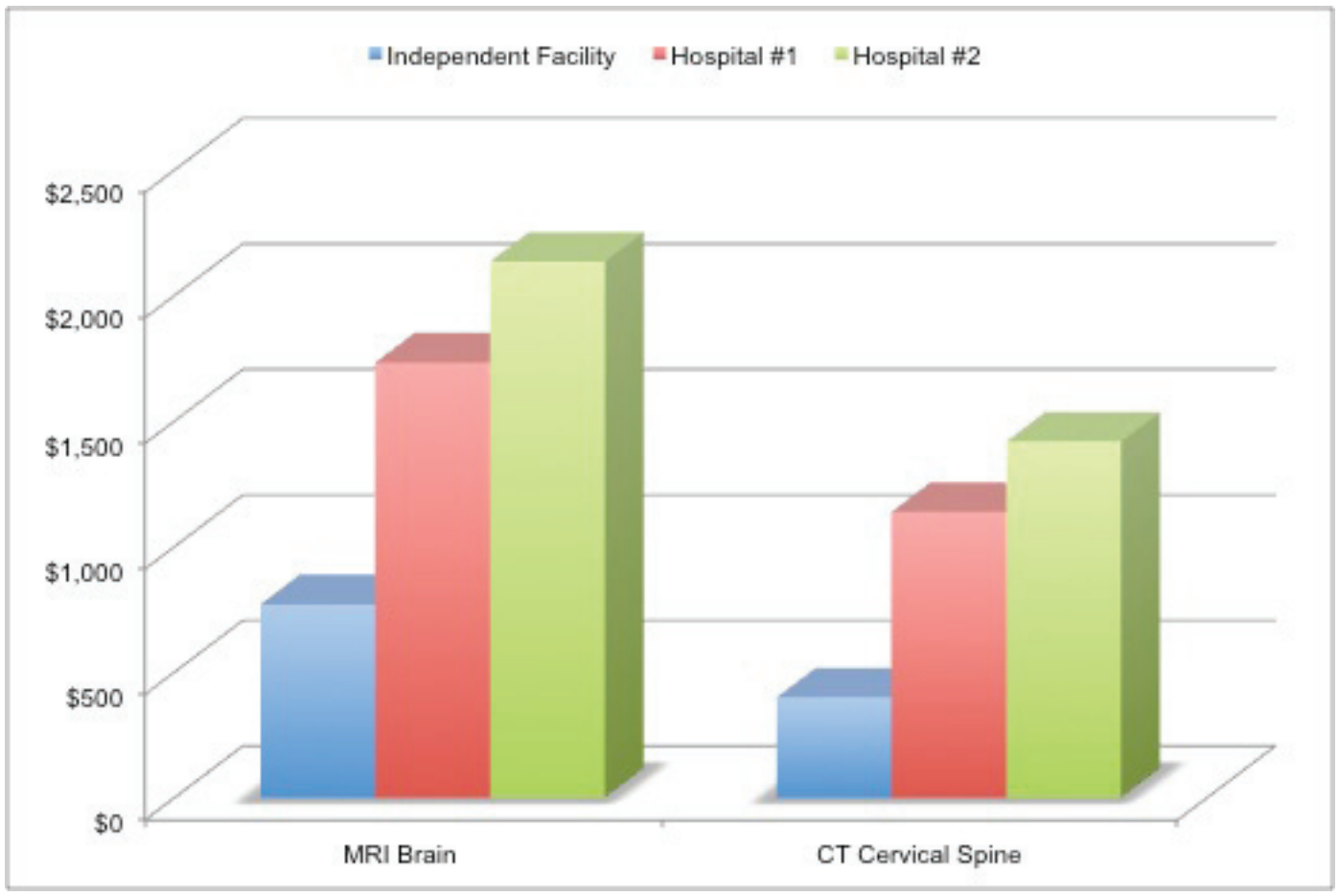


Table I

Relative Costs of 2 Radiology Scans Between Independent For-profit Center and Non-profit Hospitals. The above costs are for self-pay patients without insurance, not the list cost given to insurance companies.

Each type of scan has an associated CPT code used to designated what each exact procedure it is. Note the great disparity between the independent, for profit total charge and combined charge for the hospital and doctor to interpret the scan.

This data is taken from three facilities in central Indiana. Hospital charges are for outpatient charges.

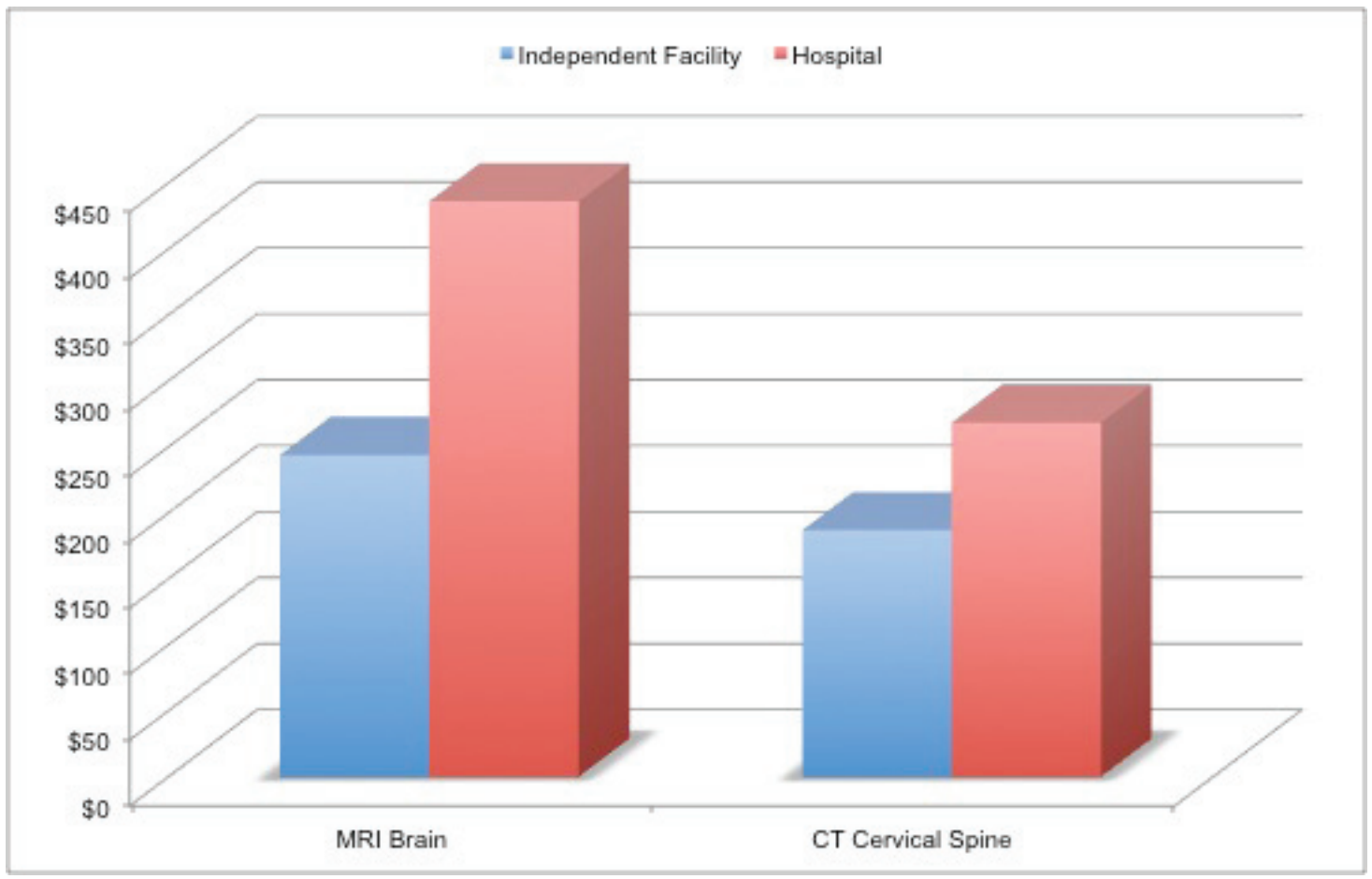


Table II

Comparison of Radiology Scans Between Independent Profit Center and Non-profit Hospitals

Comparison of Medicare allowable amounts in Indiana for profit facility and non-profit hospital.

Hospitals are also allowed to 'balance bill' or bill extra charges in addition to the Medicare allowed amount if they have other additional costs during the procedure. However, the independent center is not allowed to bill over the Medicare amount no matter what other cost they may have occur during the procedure.

Useful Resources

For additional supporting information, please use the following links.

http://www.PAACnow.org for current information and downloads

http://youtu.be/I7pqRjHQ9BU to view an animation explaining Health Care costs

http://youtu.be/cWt8hTayupE to view an interesting explanation of budget cuts and our national debt

http://online.wsj.com/article/SB10000872396390444873204577537200616881794.html *What If Apple Designed an iFighter?* by Arthur Herman; Wall Street Journal, U.S. Edition; July 24, 2012, page A15.

About Francis Price, Jr., MD

Dr. Price is an internationally recognized ophthalmic surgeon. He has helped pioneer new techniques which have changed eye surgery around the world including training over 500 physicians from 30 countries that have traveled to his practice in Indianapolis.

His unique background includes not only being a practicing physician, but managing both a private clinical practice and an ambulatory surgery center. He has served on a committee for 30 years which oversees a medical association health plan with about 5,000 insured, and actively participates in developing new technology both with pharmaceutical companies and surgical device companies.

He is a Phi Beta Kappa graduate of the University of Notre Dame and is a 1977 graduate of Indiana University Medical School, where he also completed his residency in ophthalmology. He has served as a principal investigator or medical advisor for studies on ophthalmic medications and devices, as well as surgical procedures including cornea transplants and Excimer lasers. He is also a teacher, lecturer and inventor holding U.S. patents for special devices used in ophthalmic surgery.

Dr. Price is passionate about both finding better ways to improve vision, and finding solutions to the current dilemma in health care.

“I have a very positive outlook on health care and the ingenuity of the American people to come up with better solutions.”