An economy may not survive half socialist and half free. Freedom will always be consumed by socialism… and individual initiative with it.

Health Care, Fairness and Free Enterprise

BY ROBERT E. WESCOTT

Creating the partnership that will guarantee Americans the world's finest health care, while restoring responsibility and primacy to the patient.

HEALTH CARE, FAIRNESS AND FREE ENTERPRISE

I.

HUMAN NATURE AND LAW

The dual "crises" of Health Care and Health 'Coverage' (insurance) are examples of human nature – human nature reacting to economic pressures and opportunities. We should not be surprised at, nor jump to regulate, the actions of the many participants in these two connected, imperfect systems.

Just as a baby will cry until fed, a child adjust his behavior to obtain best reward or consequence, or virtually *every* adult respond to *whatever* profits motivate him or her, so do insurers, doctors, patients, nurses, lab technicians, regulators and politicians act in their own best interests. Capitalism, in this sense, is innate and a trait that may be set aside by edict, only partially or temporarily.

Of course, when the *profit* motive is made illegal, the population of criminals will increase dramatically – which is very poor statecraft, best avoided in a democratic republic.

So, let's not condemn the profit-seekers, or act surprised by their innate humanness, else rational observation and reform will be impossible.

DEFINING GOOD AND FAIR LAW

To understand law that serves everyone the same way, we should reflect on four basic motivations: 1) Self-service that is detrimental to others, including most criminal action – we'll call it type D; 2) Self-service that is inadvertently good for others, which describes most commercial activity – particularly that of independent, competitive, free-enterprise companies. Call this type I; 3) Self-service that is overtly good for others, which can describe some commercial activity and all "community service" and other volunteer activities that may enhance the status or opportunities of the "do-er," which we'll call type O; and, 4) That body of motivations called type C, which stem from a purer love of the doing, including selfless charity and *sacrifice* for the benefit of others. This is more widespread, at least in the United States, than many recognize, forming the basis of idealism, charitable giving and even heroism.

There does exist what amounts to a *fifth motivation*, which is selfless sacrifice for those who don't want it done! It is a sort of idealistic, sacrificial *imposition,* and could include activities as diverse as terrorism and socialism. It holds great sway among government types, who know our desires better than we do.

The reader knows his or her own type.

In any case we each exercise one or more of these profit motivations, depending on where our personal "profits" lie. In any human interaction we will satisfy one or more of these motivators or else we'll react and adjust and even *fight* until our personally profitable result is within our reach. Without attempting to dissect the millions of decisions people make as they attempt to "profit" from each task, action or imposition, let us step back from the passions that lurk around "health care" and consider how good law-making accommodates virtually everyone's motivations.

THE EXCELLENT EXAMPLE

The octagonal, red stop sign is a ubiquitous feature of intersections. It doesn't care *why* a driver stops at the sign – the effect is potentially good for him or her and for every other driver at the intersection! The stop sign (law) applies equally to everyone regardless of social status, race, color or wealth; it applies to the disabled and the mighty.

Driver number 1 may stop out of selfish concern for his own safety (type I motivation); driver 2 might obey the sign because she doesn't want to hurt anyone – herself included, probably type O motivation. Yet another, number 3, may stop *because* it may be good for others, regardless of the inconvenience or sacrifice by his or her type C self.

Finally, since the stop sign is the epitome of good law, type D behavior, such as not stopping at all, is properly criminalized and sanctioned no matter who has resorted to the act.

Clearly a well-crafted law can have the effect of rendering even selfish activity beneficial for others. We shouldn't lose sight of the fact that human nature is often selfish – no law can eliminate that – nor can any law force type C motivations onto anyone; certainly not on to any industry.

BAD LAW AND UNINTENDED CONSEQUENCES

There is no <u>good</u> reason why all crafting of laws and regulations could not follow the logic of the stop sign. It amazes that so many laws are enacted that might have worked only if the majority of the regulated population were motivated by type C selfless charity. Consider the decimation of the luxury boat industry in the late 1980's.

Following imposition of a federal 10% "luxury tax" on pleasure craft, potential buyers simply ceased buying, throwing thousands of people out of work. Was

Congress surprised? For a luxury product like boats it is obvious that no purchase is made other than for type I or, possibly, type O motivations. Whether to brag about the luxury, or even the price paid, or to feel the pride of ownership or to display wealth – perhaps to enjoy the thrill of controlling a large craft, some personal *profit motive* caused the purchase. The sense of value that works in every market, was upset in this one by an added cost of 10%. That tax had no perceived value, certainly, and was resented, killing a large number of purchase decisions.

Obviously there are selfish decisions that should not be discouraged by a government "…of the people, by the people and for the people…" The selfish purchasing of expensive pleasure craft was *beneficial* for many others. Had Congress the wisdom to evaluate the *effects* of pleasure-boat buying, it might have imposed a 1% or 2% tax that would have netted real, new revenue, believed to have been needed at the time. Instead, a very *bad law* was passed, the purpose of which was to punish those who could afford pleasure boats, thereby NOT treating everyone equally, like a stop sign does, in a foolish attempt to thwart human nature.

LAWS AND HEALTH CARE

Issues of health care carry with them what could be termed "polygenic" effects on laws and regulations. That is, health issues generate political power and interest, which generally leads to some very bad law, indeed. *Political Correctness*, a whole subset of polygenic effects, has caused the government to skew the health-care marketplace with a mountain of bad law (and regulation). This risks destroying the tremendous innovation of American health scientists and practitioners, and places the possibilities of real cost reduction further and further from reality. Despite myopic lawmaking, everyone in the various health industries has adapted and always will adapt, or adjust, to the regulatory, social-engineered artifices of our increasingly socialist health-care system; each does so to maximize his or her own profit / satisfaction / fulfillment. Otherwise he or she would just leave the industry: no shock, there.

The anecdotal evidence that some doctors or other providers were, historically, selfless, type C servers of humanity, should not be construed to mean all were then or are today. Nor is there any form of regulation or socialization of care that can make the "system" perform as if they all might be! Marketplace valuing has been distorted, but can't be eliminated. Lawmakers must resist *polygenic allure* and stop writing laws as if their own magnanimity will magically transfuse into regulated workers – all politically correct hopes notwithstanding.

II.

THE BIG QUESTIONS

Fundamental to any discussion of good and bad law in health care, is some agreement on which areas of human interaction (and human nature) are within the province of government – particularly *federal* government. Which aspects of our lives and responsibilities should a *Constitutionally limited* republic do its best to encourage and which to discourage? Do we not agree that regardless of which specific actions are scrutinized, the governed ought to be encouraged to commit acts of self-service that either purposely or coincidentally benefit others? And, given that our progress and quality of life is derived entirely from the engines of free-enterprise, that great amalgam of enlightened self-interest, should that not be encouraged, also?

Type C selfless charity ought probably to be neither encouraged nor discouraged under proper governance, but in the present mish-mash of regulation and impersonality, it needs to be defended at every turn.

But, there are many "hot spots" that dominate debate about health care and political motivations have intruded on what should be valid business and personal, value decisions. As we analyze the questions to follow, let's use words that mean what they are defined to mean, and avoid inflammatory rhetoric, often made more so by the misuse of words.

Question one: *How much health care should be provided to those who cannot pay for their own… and who will pay for it?*

Question two: *Should government at any level control prices and wages in health-care industries, including the earnings of doctors?*

Question three: *Should the "government" provide health care, directly, or pay directly for it?*

Question four: *Can health insurance be rendered more "fair" or accessible by government action?*

Question five: *Who is ultimately responsible for any individual's health and, therefore, for his or her health care?*

Question six: *Should private enterprise be forced to "pay" other than the wages and benefits employees agree to work for? From where in the Constitution are mandated benefits derived?*

Question seven: *Can there be fair and accessible health care that will both spur medical discovery and invention… and reduce costs?*

BEFORE WE BEGIN

There are some hurdles we must leap before considering the questions, above. The greatest of these may be summed up in yet another question: **Is health care itself, and, by extension, health insurance or 'coverage,' a *basic human right*, or, by any stretch of the Constitution, an "inalienable right?"**

How we, the People, answer this is fundamental to our ability to be free, and to pursue happiness in a free-enterprise economy.

III.

WHAT HEALTH CARE IS

Health care is a set of products and services delivered by a complex and costly infrastructure of people, facilities and technologies. It is fueled by a seemingly endless supply of dollars. People "in" the health care industry are motivated in a thousand ways, variations of type C, type O and type I behaviors. There exist among health-care employees all of the following: altruism, compassion, intense curiosity, financial need and even greed.

Many are rightly proud of their high levels of skill and education, and of the efforts to achieve both. Others find health care to be a solid, no-layoff kind of career, and are willing to tolerate some discomforts for that security. More and more, health care is an entry point of employment for immigrants.

Some became health-care providers/workers because they enjoy good wages and benefits and the luxuries that may obtain. Some have a nursing "gene" that is satisfied only by providing direct comfort and care to those in need. Each performs at his or her own level of competence, derived from education, experience, training and talent, and with his or her own level of initiative.

No matter what management does to incent its workforce, ultimately each health-care worker acts from his or her own short and long-term "profit" motivations. Indeed, every industry is peopled by those who are attracted to it by interest, money, love or bare opportunity. What is there about "health care" that causes some of us – government types in particular – to regard it as a sort of amorphous utility that cries out for central regulation and limitation, with wage, profit and price controls? Treating health care like a utility is not very logical, at all, and can lead to very poor statecraft.

THE UTILITY COMPARISON

Utilities are highly regulated, even under "de-regulation," to the point of being forced to provide minimal services or products to the indigent. Because of the monopoly nature of the kinds of facilities and infrastructure necessary, it is both logical AND efficient for certain products and services to be provided by publicly licensed utilities.

It made no sense to have eight or ten or even TWO telephony companies running their own poles and wires down the highways and byways of America, so regulated monopolies were created to hold telephone capitalism in a sort of check, while assuring that what was of vital importance for millions of people and enterprises was actually available to them. The public shared the benefits of a stable phone

system and welcomed the solidity of the Bell system as both provider and investment vehicle.

Just as logically, however, as technology obviated the value of a single provider – and even of its wires – government forced that utility to split apart, unleashing a flood of innovation and options and falling prices. In an increasingly wireless economy where voice is but a fraction of digital messaging, the idea of making *individual* communication needs and desires part of a single, collective utility is laughable. Still, under the old utility model, *the* phone company was required to provide minimal phone service for lengthy periods of non-payment, due to the potentially life-threatening consequences of losing access to the only means of communication.

Unfortunately, the federal government now plays the role of free telephony provider, allowing copious fraud and waste. It may not be an improvement.

Electric companies are still regulated utilities, now including being limited to transmission or generation. The health risks of having one's electricity shut off without warning are so great that it is a difficult process for electric utilities to go through. It is just as logical, today, that no more than one transmission utility have its power lines run from pole to pole or underground.

Yet the *purchase* of electricity is virtually UNregulated! And how could it be otherwise? Our lives are replete with devices like refrigerators and furnaces, air conditioners and resistance heaters of all sorts that make automated purchases of electricity practically *on their own*. Except in times of emergency shortage, people are free to purchase as much electricity as they wish. Transmission and generating companies are free to sell them all the delivery service and volts they want. One electron moving down the wire is indistinguishable from the next, and the same might be said of its uses.

Health care is different. It may NOT be freely sold and it can't be freely purchased.

DO WE WANT MONOPOLIZED HEALTH CARE?

People are very accepting of having health decisions made for them, probably because we cling to the hope that our trusted doctor is as far away as decisions are being made. Until the Great Society and Medicare, doctors did make most of the decisions. They also provided huge volumes of free care for the indigent. So did hospitals and numerous charitable agencies. The system was imperfect, certainly, and needed enhancement, but the sloppy, fatuous insinuation of the federal government into the mix cannot be seen as having simultaneously introduced perfection… or even efficacy.

Government, by its nature, requires its systems to be structured, rule-based and *enforceable*. By definition the devolving of individual responsibilities *requires* the loss of freedom. Sometimes the loss is pleasant and palatable, even profitable. We all accept the need for traffic laws, signal lights and our friend, the stop sign. We are not free to drive any which way we please, but we have a superior driving system that actually increases our personal freedom, barring abuse of the rules and strictures we accept. In this there exists a balance between licentious freedom and tyranny (central government) that serves society very well. Under our Constitutional system, the proper balance can enhance individual liberty in part because the side that tends toward tyranny is *limited* in what it may impose in rules and regulations.

At least, that's what the document says about the original plan that has made America the beacon of hope for the world.

Increasingly, however, our old acceptance of *limited*, external decision-making has been usurped by a series of "crises" in health care, of which most were concocted for political, and not health purposes. These have replaced our trusted personal physician with bureaucrats.

The infusion of federal tax and, worse, expensively *borrowed* money into the health-care marketplace, and the web of regulations that is its conjoined twin, have skewed the system and cost structure to the point that HMO's and insurance companies are being attacked – together with doctors and hospitals (a new "crisis") – as incapable of delivering or paying for "proper care" (as determined by still other bureaucrats who work for politicians) and that the only answer to the crisis is *greater* intrusion and control by that once-limited government! Whew.

Somehow, "We, the People" accept this.

Whereas Utilities were and are the most efficient ways to deliver their products and services, centrally controlled health care is the *least* efficient means of restoring or enhancing health.

"We, the People," ignore this.

One could draw a parallel with theoretical "worm holes" that scientists believe might shortcut enormous distances between stars. Some demonstrate with a large sheet representing space-time, bending it until two distant points are brought together. Those gigantic distances represent sending money to Washington and expecting it to get back to your relationship with your doctor, just the way you'd like it, when you need it!

Why not pay your doctor or provider yourself, skipping all that distance (and loss of liberty) in-between?

Even as we observe the daily losses of liberty and responsibility over our very lives, a growing number of Americans are clamoring for *federal* solutions to the apparent crisis that afflicts us. There must be an affliction too great for Americans to resolve on their own: Senator Whosis and Congressman What's-his-name have told us so, over and over and over again.

Health care is not fungible. What is provided to one person is most likely NOT what is needed by the next. It is delivered, aside from intensive surgery or cancer and other exceptional treatment, in relatively decentralized facilities and in often unplanned patterns. That is, if the patient is the focal-point of it all. While it matters very little that electricity is purchased without much planning, we do everything possible to avoid unplanned health-care purchases, and plan carefully for those we foresee. But the casual flipping of a light switch needs not only little planning, it needs little government oversight or regulation. This is because the decision is financially *personal*. The buyer pays for his own juice!

Purchasing health care, however, invites severe regulation precisely because the "buyer" is not the person actually receiving the products and services. The consumer of health care is not the buyer – an ultimate shifting of responsibility for one's personal decisions. And it is this wide chasm of non-responsibility that is leading many of us to encourage politicians to finish destroying American health care.

MONEY IS POWER

For as long as civilizations have kept records, following the money usually has led to the holders of power… or their allies. It is no different in our modern, market-based economy, albeit a democratic republic where power is ostensibly in the hands of sovereign citizens, regardless of wealth. In socialist, or *statist* societies, we see power, itself, as the currency that matters.

By following the money in health care, especially the money *decisions* in health care, we can readily locate the power and it is not in the hands of the consumers of that care. Real power – decision-making power – is in the hands of the several third-party payers, to no one's surprise, and the consumers are rightly restive. Unfortunately this restiveness is not leading toward restoring the power of the consumer/patient by restoring his or her role as the buyer. Rather, and paradoxically, it is leading toward removing that power even further from the patient!

Evidence is mounting that a large fraction of Americans, despite all evidence to the contrary, (there being none in our entire history or anyone's else, that would buttress a belief that government decision-making will improve our lives, our liberty or our

health) believe that the transfer of financial power and health-care decision-making to the federal government is the preferable answer to the supposed crisis that afflicts us.

This is astonishing.

Do you need prostate surgery? Do you want the operation? "Of course!" Is there a lump in your breast? Do you want it removed? "Yes, yes!" What is that worth to you? "Whatever it takes! Just do it in time!" What will anesthesia cost? "Who knows? Who cares? I must be anesthetized… and by the best there is!" Besides, we all say, I am covered by 'insurance or by my "HMO,' or by Obamacare.

More and more of us are covered by a federal bureaucracy whose primary mission is cost containment, and not care.

Do you have *permission* for the operation? "Of course," We, the People, say.

ANOTHER PUBLIC WELL-BEING EXAMPLE

Automobile manufacture is a noisy, dangerous business. Even so, some auto workers truly love the cars they build, as they love the art of building them. These are they who might work for lower pay just for the joy of assembling engines and differentials and rocker panels. Other workers love being in powerful union positions. Still others tolerate factory conditions because they need the $30 or more per hour, plus benefits. Some work because these are the only jobs available or the only ones they know.

Still, a case could be made that cars are a virtual necessity, today. Unless one could walk to a local grocery it could be damned difficult to feed and care for one's family. Difficult, as well, to get to the pharmacy, or to church.

One possible solution to the high cost of personal transportation would be to lower the cost of cars by lowering factory wages to the level that those type C, car-loving auto workers (dare we hope that these are also the *best* auto workers?) will accept – then limiting the prices that dealers (like doctors and hospitals) can charge for these essential devices. Maybe car loans, like health coverage, should be controlled in price, or subsidized, to guarantee everyone's access to happy motoring.

The program will really work if the government (*taxpayers, anyway)* will simply *give* a car to those who cannot afford their own! Only then will every American… no, *resident* have his or her share of the American Dream. Surely a basic automobile is as much a right as a free cell-phone. God forbid that a child might die because his car-bereft mother could not drive to the CVS for the subsidized prescription her government doctor wrote out that afternoon!

Frighteningly, this premise is no longer ludicrous.

Once we accept the idea that certain people are, by some powerful, "polygenic" measure, entitled to the goods and services for which others must pay, then it becomes an ever-smaller leap to the next plateau of free lunch, and the next… and the next.

The automobile example could be refuted by reference to the availability of mass transit, but so could the fascination with government-provided services altogether, one would think.

Do we really want our health care provided at the lowest common denominator levels of Amtrak, the M.B.T.A. or the I.R.S.?

Regardless, we still must answer whether health-care and health-insurance are products to which we are all entitled?

Are they "rights" conferred by birth, citizenship, or mere presence?

If they are rights, then at what level? Do we really mean to say that everyone is entitled to *minimal* care at public expense – like minimal electric service? Do we have even the fortitude to provide LESS than maximal care at whatever expense?

IV.

LIMITS OF HEALTH CARE

Unlimited access to unlimited health care is unattainable, even if able to be attempted. Apportionment, rationing or deprivation of health care has always existed and always will, unless we intend health care to become a mere jobs program – which will fail for other reasons. And, with the federal government attempting to manipulate the numbers of doctors that medical schools produce, the jobs in that program won't be medical ones.

Most of the hand-wringing derives from WHO CONTROLS THE APPORTIONING. Who will hold the power to limit health care?

That is the greatest power in the entire health-care industry.

We hear great clamoring for a federal, single-payer health system, even in the land of the free and the home of the brave. As well, we can see that this means a further removal of individual power and responsibility over one's own or one's family's health care. The automatic corollary of that concept is the removal of the power of *apportionment* of care to the farthest point from the patient. Underlying all calls for the government(s) to eliminate our health-cost worries is a fanciful, even diaphanous belief – or hope – that when there is an automatic "right" to care, that the individual will still obtain all the care he or she demands.

That no centrally-controlled, government health system exists anywhere in the world, under which this is possible, never mind, *permitted*, makes this belief astonishing, too.

Left to financially irresponsible consumers, the choice of WHO will decide what care they receive will always be themselves; the degree of deprivation always would be slight.

Evidence accumulates from England, Canada and our own V.A. and Medicare, that budget (and/or *union*) concerns, calculated by bureaucrats unrelated to health care, are the determinants of whether an older citizen gets a kidney transplant, or another senior may get a heart bypass, or whether a years-long regimen of chemotherapy is even an option. And not all that senior, either!

Deprivation is part of health care, however benign and by whatever name we give it. There is not an infinite amount of care possible, nor are there enough desks or bureaucrats to sit behind them, to make the millions of limiting decisions that individuals ought to be – and hope to be – making for themselves.

WHO'S ON FIRST?

More money in the system does not guarantee better, as in higher quality, health care. It may not even yield more *widespread* health care, particularly if it is infused without profit-making potential for recipients. The farther away from free enterprise that "we" drive health care, the less and less efficient it becomes. This means that costs will increase for the same – even for LESS – health care, overall.

Is it more efficient to clear patients from hospital beds just two days after a mastectomy? Perhaps.

Good, enlightened regulation is a vital part of making health-care quality improve – and it is a proper role for a limited government to perform. Everyone who ever needs care will benefit from actually receiving the care he or she purchases. The flaw in our current direction is that we are *fantasizing* that placing both regulation AND financial responsibility in the same hands *other than the patient's*, which is to say, in the federal and states' governments' hands, will be more effective. The opposite is in evidence in many ways.

The ultimate regulator is the patient / consumer, him or her self. Do any of us really believe that providers fail to perceive that they are working for the *payers*? Do providers fail to grasp that it is the so-called *third party* to medical transactions who is their real employer? The patient is the one who has become distantly tertiary in the money formulas that lubricate and fuel health care.

Is this not somewhat backwards? Should it not be the insurers and other payers who are tertiary? Isn't the patient *primary*?

Unfortunately, we have constructed a system that cares for its patients only when face-to-face, and that ever more rarely. There's no profit in it! The rest of the infrastructure cares first about pleasing the money people, be they insurers, HMO's or the Federal Health Care Financing Administration. A key factor in the survival of hospitals, for example, is their ability to cut and contain costs. The *second* is care quality – and it is not the hospitals' fault that this has been allowed to evolve.

By including money and regulation in one set of hands (Medicare, Medicaid, government hands) and with budgetary constraints constant, looming problems for governments, the immediate reaction to spiraling costs is to cut wages and prices and complicate cash flows with endless haggling and auditing. Hospitals' only available reaction is to hold down costs and that means payrolls… comprised of care-givers, primarily.

Are we really hoping to have all health care subject to Congressional budget machinations? … or I.R.S. compassion?

Like most unionization, the organizing of health-care employees is a reaction to poor management. While some hospitals, like some auto-body shops, are better managed than others, all are forced to manage to a level below optimum in the face of severe financial restrictions and regulations from the federal level. Somewhere a bureau believes that health-care workers will accept inadequate pay and incentives because their job is caring for others. But, as noted above, workers will adjust and adapt until their individual profits / satisfactions are realized – else they'll leave the industry.

Nurses go on strike. Are we simply waiting for physicians to strike, also?

We contend that the greatest amount of service at the best average cost will be delivered when providers are able to maximize their individual return, or profit, on their labors. This is the story of mankind and of the United States in particular, yet we insist on facing problems with socialism rather than with what has worked.

RIGHTS OR WRONGS

So, let's face the question of whether health care or coverage is a basic human right. We submit that the path to a fairer, more encompassing and compassionate system begins where we admit that health care, itself, is not a "right" at all, while clearly a widespread *want*. There are many who specifically avoid the kind of "Western," chemical and mechanical repair-oriented health care that some propose to make universal. Forcing them to adopt and pay taxes for a system they abhor is wrong, if not wrongheaded. Forcing them to insure or be insured for "approved" health care costs incurred in the "approved" system while denying them coverage for their preferred care, serves to deny a true human right to a large group.

Where else in society are citizens forced to relinquish rights so that another group may enjoy their own? All examples seem to derive from government monopolies, be they education, transportation or others. We seem to be willing to create another government monopoly in health care, but it comes at a huge cost in individual rights… and liberty… and in care, itself.

Inventing new rights that force Americans to choose among their constitutionally enumerated rights is very poor statecraft – not the stuff of being American, one hopes.

DO YOU HAVE PERMISSION?

Another little-discussed effect of declaring health care to be a "right," and there for the business of government to 'protect' (it is worth remembering that the constitution was promulgated on the proposition that the rights of the people are only *marginally* the concern of the central government) is the political control, and, now,

enforcement of a monolithic medical structure. This single, approved health-care system will be sanctioned by its access to taxation and its errors will be MORE difficult to expose, not less. Such a system's theoretical underpinnings will become patriotic credo, impossible to refute!

Medical breakthroughs are the product of multiple pursuits, multiple motivations, competing minds and theories – competing profit opportunities, if you will. It is the relative chaos of the medical marketplace that has made improvements in care and treatment, not monolithic management. Neither the care nor the means to buy it, are "rights."

We should be clever enough to regulate health care without smothering it while we restore the patient to the center of the system's concern.

DOCTOR, DOCTOR

An insidious side-effect of "managed" care, which means "controlled" care, is that the absolute quality of doctors is declining and will continue to do so. It is not a function of technology or altered instructional methods or of socio-economic origins of doctoral candidates. It is a function of separating the doctor from his or her unique position in the entire structure that purports to care for and restore the health of individuals. Most of our patient-population grew up with a reverence for the man or woman with the "M. D." designation. We trust that person to know what needs to be known about the labyrinth of activities both in and out of hospitals, that will make it possible for us to become healthy, or stay healthy, or be able to survive in as comfortable an unhealthy state as possible. Reverence.

This relationship weakened a little with the rise of specialization, but remained the basis of trust. Patients believed "their" doctor always would refer them to the best specialist for their special needs. Is has been assaulted even more with the introduction of Medicare, HMO's and statist, socialist health care systems.

What has developed is a schism in the reverent connection between doctors and patients that we dream once existed. Even quite mediocre doctors can now make a nice living in a "primary" care-giver role. All that each must attain to is acceptance into the HMO or other approved fold. Once "in," and by being artfully careful, they can receive the same fee for office visits, reviews of tests, physical exams and follow-ups, and for the all-important *referral* to the specialist who, we now hope, truly knows how to guide us back to health. No longer is absolute personal expertise a requisite for a successful medical career. Pharmaceutical companies will provide both the ongoing training for these medical mechanics, and the political power to make

medication and monitoring of medication's side-effects the basis for "managed," cost-containing, official, authorized, bureaucratic "health care" system, which is now being cemented into place around us… and the pills.

Younger doctors just entering the field will have no connection to the golden era when doctors were, often, true giants among us. Small-minded and impersonal providers who prove their ability to process ever larger numbers of patients will become our primary care-givers, and there will be no defense against the blindness of the third-party-payer system.

We must devise a system that puts the patient back into the center of concern and control. We must.

V.

CARING FOR THE INDIGENT

Human nature is the key to a fair system. Government's long-standing error is the destruction of individual responsibility by entitling certain groups to the necessities others must earn. Free care for the 'poor' is a disaster. This is partly because it is not free, and partly because the means of obtaining payment by providers is a burden that detracts from care, even as it attracts medical thieves.

Free care is the most expensive care delivered. Minor ailments are turned into emergency-room congestion that can delay treatment for many. Some inner-city centers have been forced to close due to extra-high costs and risks and due to limited financial rewards. Care for these individuals is thrown onto larger institutions that can "afford" to provide underpaid or delay-paid care. Few are truly well served.

The ultimate *fairness* would be to force everyone crowding hospitals for free care, to pay for what they receive. The result would be an immediate – and cruel – drop in the number of patents. This is not a plan, obviously, but somewhere between NO free care and a growing health-care irresponsibility, there must exist a level of responsibility that can serve to restore the role of even a poor patient as *the* customer of health care. Free stuff is not valued by recipients and it is certainly not an aspect of personal responsibility when provided as an *entitlement*.

Good law-making should be able to devise a system of profitable clinics where both type O and C providers can profit, and profit more by being efficient and successful. At the same time, customers of clinics should be able to *pay for* proper care. This is not a proposal for simple subsidization, per se – that is poor statecraft and teaches no economic lessons. There is abuse and profiteering where the source of funding is "the government" rather than someone known to the abuser. Worse, in order to subsidize one group, police powers are used to confiscate the property of others.

No. Poor recipients of health care products and services ought to PAY for it or insure themselves just as responsible patients have learned to do. What is lacking is not improved confiscation – the statist response to all problems – but the right kinds of facilities and means to finance health care and coverage – a pay mechanism by which even the most unsophisticated members of society are enabled to "buy" proper, economical, unbiased care.

Faced with real economic choices, parents and individuals will make those that determine the level of care each wants (the 'pursuit of happiness') for him or her self and for children. Not everyone can afford every known procedure. It is the worst UN-fairness to take resources from some citizens in order to provide superior

health care – or anything else – to select others. Many "confiscatees" have chosen to not obtain certain kinds of care that government insists will be available to the select, less responsible others.

The restoration of personal responsibility and *patient* satisfaction in the health care system, should not exclude the poor. Free care is not only a misnomer, it is antithetical to real solutions to indigent care problems. None of the many forms of altruism, charity and type C charitable behavior should be interfered with, but welfare agencies should encourage and enable ways to provide lower-cost care and facilitate *economic decision-making* and *responsibility* by poorer care recipients.

We need more choices, not fewer.

VI.

CHOICES

The popular component of public debate today is "choice." We should have unlimited choice in abortion and restricted choice in schooling. We should be allowed to choose a comfortable language, but have little choice in hiring or pay rates. We can choose to be a man or a woman or a woman trapped in a man's body, but we can't choose to exercise religious freedom. Choices, choices, choices.

Our economy proves its success by affording us so many economic choices. There are dozens of ways to finance a new home but fewer and fewer ways to purchase health care. Some intend that we have no choice but a federal, single-payer savior.

Why are we trusted to choose some things but not others, particularly when it is we, the people, whose ostensible sovereignty is protected under the Constitution?

PROTECTING OUR CHOICES

For most of the last century, individuals who wished to drive motor vehicles, thus placing the property and even health of others at risk, were forced to purchase insurance that protected themselves and others from the consequences of their choice… to drive. That coverage is essentially tied to individual drivers and not their cars, their mechanics or their auto-body shop. The elements of risk could be identified and quantified and insured against. There were and are choices about the levels of coverage one wishes to purchase and choices about how much risk one would assume (finance) for him or her self.

Almost everywhere there existed a mandate for minimum coverage if one were to drive legally. Individuals still could choose to own a car or not, to drive a car or not – and we accepted laws that treated everyone equally, like stop signs. We all benefited from enforcing responsible actions that potentially benefitted everyone. We all gained in economic and civil freedom by taking part in a system that resolved accidents and damages as fairly as possible. We couldn't protect ourselves against total stupidity by others, but we were reasonably assured / insured, that an accident would not inflict unbearable financial harm.

It is just as logical and would serve as well if individuals were required to provide their own health insurance or financial wherewithal for medical needs. It would be a mark of reaching personal responsibility to insure oneself. Enforcement raises questions, but no barriers, to a personal health-care mandate.

Any number of economic activities might be tied to proof of personal financial

responsibility or coverage: purchasing tobacco, alcoholic beverages or firearms are three obvious examples. Buying or driving motor vehicles or power equipment should require proof of financial responsibility. Even entering school, obtaining pilot hunting, or professional licenses could be tied to proof of responsibility for one's health care. In effect, individuals should prove their "independence" in order to function in ways that might have medical or health consequences for themselves or others.

A CAMEL'S NOSE

The presence of a federal interest in the health expenses incurred by almost everyone, has provided a pathway for central government to control those expenses, our lives and our personal economies with them. It is the logic behind the specious intrusion into tobacco use and is being employed to insinuate the federal government into diets, driving habits and a thousand other areas of individual and states' rights that are reserved FROM the federal government under our Constitution. Now that we all "share" through taxation, the cost for someone's health care, courts and politicians seem comfortable with the proposition that we all – through our benign and efficient government – have something to say about that care and, indeed, about every aspect of that individual's manner of living… to the finest detail!

Is it the intent of this nation that passing a certain milestone of years (subject to political, budgetary problems) will automatically strip one of his or her rights with regard to his or her body and health?

Do we mean to trade our independence and privacy, responsibility and self-control for some lowering of costs of hospital visits, office calls and "co-pays?"

Once we are age 65, or 67, or whatever age budget problems dictate, is it our intention that we shall slip back to the common denominator level of health care of welfare recipients who have never paid their way while we have for years? Is that what we have striven for?

Are we sure we want a system that prevents us from buying any better services – from providers who wish to sell them – than the average, uninspired care that fettered management and organized labor contracts will provide?

Everyone cannot receive every kind of health care that exists. If inventive companies and individuals are prevented from earning profits from a better idea than the approved, permitted medicine, why would they ever bring it forth? Health care egalitarianism is health care atrophy.

Rather than encouraging the competition of ideas, plans, methods and profits, monolithic health care (inevitable under a single-payer regime) limits competition and will stultify greatness.

Costs will continue to rise, probably faster, than under well-regulated, free-enterprise medicine. Moreover, federal regulation *of its own system* will decrease, in fact, while it increases in personnel and activity – certainly in paper! – while smothering providers with reportage and audits undreamt of.

INDIVIDUAL RESPONSIBILITY FOR PAYING

The concept of mandatory individual responsibility for health care may find opposition in part because there will be no one to sue except the providers. But the structure and options are simple and overpowering. Whether one chooses familiar forms of health "insurance" or a medical savings account or some kind of renewable medical bond, individuals should have the methods and means to provide for their own health care.

Companies may wish to offer "cafeteria" benefit plans as real, perceived advantage to their employees (a valuable perception that is lost when health insurance, or care, is an entitlement). Employees would accept the financial help in order to meet what are truly their own responsibilities. Companies would not be targets of suits in the event care proved inadequate.

Individuals would have their own contracts with insurers or providers / HMO's that meet their own demands and needs, leaving those third parties in their original roles and subject to suit only for professional negligence. Families could make their own plans and insure them through savings accounts and/or insurance companies. As savings accounts grow beyond anticipated needs, those monies could be siphoned off for other family uses or to replace the insurance portion of their plans. The unused portion remains the property of the owner's family, able to be passed down to the next generation subject to even-handed laws that restrict use of the funds to medical expenses, until certain reserve levels are exceeded. And, the capital in those accounts would be available to the economy for investment and growth.

Health Savings Accounts could be started at birth for one's children or grandchildren, and left to grow for years within a body of flexible regulations. Interest income from such an account could be used to purchase increasing amounts of "major medical" insurance as the healthiest years are left behind.

In any event, the implications of having to prove that one is adequately insured before buying guns, ammunition or sky-diving lessons are eminently sensible. The

government is left OUT of the individual decision-making that comprises the pursuit of happiness, and less of the economy is fodder for litigation.

VII.

THE MISSING LINKS

What are missing are TWO key elements of Responsible Health Care: patient knowledge, or awareness, and catastrophic coverage.

Most patients are medically ignorant – increasingly so with declining financial responsibility. In the halcyon days of pay-as-you-go patients and doctors making house calls, more was known about folk medicine and home remedies. Expectations of some illness and felling less than well were universal and doctors were the final authority for everything else. We have both progressed and regressed from that fabled time.

Today we believe in the advertised myth that no one should feel like he or she has a cold, a toothache or an upset stomach. There is an analgesic something for everything we don't like. We also think we know more about prescription medicines and diagnostics than most doctors and, indeed, are urged to second-guess professionals at every turn – in part to avoid lawsuits, sometimes with life-saving results. Most doctors are "specialists," even general practitioners. All are well-stocked with sample pills. Some are able to maintain practices like some real estate agents – the ones who only list houses, never selling them. If someone is really sick he or she will be "referred" to a specialist.

But the basic knowledge of what to do when, and where, is not well understood and has retreated, actually, in the past few decades. We are at the mercy of people who know how the system works, which procedures get paid for and which reduce liability. Often we are subject to otherwise caring physicians who are evaluated on the number of patients they can 'see' in a workday and, worse, by how many hospital admissions they can avoid. If admitted, how few hours the patients remain. We do what we are told. We accept a medical merry-go-round, victims of a financially skewed system – as are most practitioners. Sometimes we get well.

PATIENT IGNORANCE AND SAVING MONEY

The largest single factor in controlling costs is patient knowledge. Most of us simply do not know enough to know whether what is prescribed or ordered for testing is valuable to our health. With increasing incidence of over-medication causing many doctor and even hospital visits (and addictions), there is pressure to sue not only doctors and hospitals but also HMO's when so many "things" go wrong. The patient becomes the center of attention only when he or she goes to court. If there were a way to hire a medical "agent" licensed to know what to question and where

best to obtain needed treatments, perhaps the patient could be restored to primacy… perhaps the majority of litigation over health care could be avoided. Certainly the patient would be satisfied more often and there would be far less useless treatment, including even operations.

HEALTH CARE AGENTS

Consider the security of being able to consult with an unbiased 'agent' who works for neither the providers nor the insurers. This professional would be licensed and required to know where the best care for which problem was available. This person, or firm, would be hired by an individual or family on a form of retainer, and be empowered to represent his or her clients in both emergency and planned medical care incidents. With no other interest in health care transactions, the health care 'agent' could fairly evaluate first and second opinions. He or she would know which facilities had the worst and best records in which kinds of procedures.

Even in cases of emergencies and accidents an "HCA" could negotiate care, coverage and paperwork while the patient receives attention. This could both speed care and provide a knowledgeable source of information and evaluation for the consumer. *This is not available now* except where individual, professional excellence bridges the gaps that remote financing creates.

In effect, ALL case management would be outsourced, whether from government bureaus or insurance companies. HCA firms would form self-insurance pools amongst their member-families. They'd purchase major-medical coverage based on actuarial, quantifiable financial exposure by the insurers. Individuals and families would be *required* to maintain Health Savings Accounts for basic costs. Partnerships with banks would provide growth of these accounts – and management – possibly with other benefits negotiated by the HCA.

WHO IS REALLY INSURED

With the presence of professional health care representation that works for the patient/consumer, the responsibility for paying for one's care can and should return to the patient. That is, one's health-care insurance should be insuring the patient RATHER THAN THE PROVIDERS which it essentially does, now.

If it became necessary, once again, to please the *recipient* of the products and services that comprise health care, it is a practical expectation that care quality will improve. The relationship between the provider, whether individual, group or institution, and its *customer* would be on the proper basis. That is, where the customer is King –

not the financier. There is NO structure of rules, sanctions or bureaucracy that can force providers to care about the patient in that way. The patient must be the *payer*.

Part of the HCA's responsibility will be to guarantee prompt payment by his or her client, except where official challenge is filed against a charge or invoice. The HCA role will cost a fraction of a single-payer federal system or of a free-wheeling litigation-based quality environment such as the "Patient's Bill of Rights" engenders. Our dollars will not have to make a trip to Uranus in order to compensate the doctor sitting before us.

Is it not a little distorted that a law called the "Patient's Bill of Rights" is even thought necessary? Is it not clear that the abuses it supposedly addresses by liberalizing the ability to sue everyone in sight, would not exist if the *patient* were always the center – rather, *customer* – of attention?

CATASTROPHES

The last financial key is coverage for catastrophic medical problems. One way or another most of us are "covered" for these extraordinary and relatively rare occurrences. Most families WON'T face childhood cancer or spinal injury or Hodgkin's disease, thank God. But these or dozens of other possibilities are a threat to all of us. As medical science stretches its abilities and wondrous mechanisms, the likelihood of needing one or another very costly procedure or regimen will go up. Where before there were no artificial hearts, for example, now there are. As that and other devices gain acceptance by the FDA, more of us will have the option to choose one for ourselves or a relative.

Who can possibly pay for a $50,000 or $250,000 (if those are, in fact, the costs/prices) operation? Who can afford two or ten years of oncology? Somehow we are able to receive these things, now, including many who have never paid in for any kind of coverage. This is because the costs are spread over large numbers of "group" members who do pay.

In fact, we all overpay so that some who don't will be covered, although only when a procedure or product is "approved."

We all know of cases where the court of public opinion must be entered in order to shake loose coverage for what are still considered "experimental" procedures. The payer for the procedure is attempting to *apportion* health care on the basis of probabilities of success, denying the lowest.

We don't accept this when the case becomes highly visible, but it is happening constantly in less visible, and no less crucial ways. The means are insidious.

Doctors are pressured to reduce procedures by their de facto employers: insurers, HMO's and HCFA (Health Care Financing Administration). This sometimes requires the setting aside of medical ethics and is unsettling to older professionals. Naturally, a new generation of professionals is growing up in this distorted "cost trumps ethics" environment, and they are less likely to object in the new age of socialized decision-making.

It wouldn't happen at all if the patient, with intelligent advice behind him or her, were the one who was going to pay the medical bills. A doctor, in that circumstance, will request the tests that matter to his or her patient's health – and no more. The patient will happily pay for those tests from his or her insurance, HSA or other personal funds. He or she will be receiving, after all, goods and services that carry a desired, personal benefit.

There are endless examples of overcharging. We all know of $6.00 aspirin tablets dispensed in hospital. Hospitals are allowed to use such overcharges as a means of compensation for unpaid and underpaid services. What kind of "system is that?" How can there be management or oversight of it?

AN EMPLOYEE'S SON required surgery on his feet to correct abnormally high arches that threatened his high school sports career. Fortunately his mother was a nurse.

Following a completely successful operation they received copies of the invoices, including for three packages of surgical staples. Only certain sizes from each package were appropriate for the size of the boy's feet. Maybe the rest had been discarded. However, the price shown for each package was a whopping $750.00! My employee didn't know enough about such costs, but his wife did. She began to raise questions about the $2,250.00 cost our insurance was willing to pay 80% of, proud of "saving" $450.00.

With repeated probing the cost fell first to about $500.00 per package, and ultimately to close to $100.00 per package, a difference of over $1,900.00! That's about a 600% overcharge and the staples were still probably profitable at the final price.

Multiply this event by several million and you can grasp why Medicare will never contain costs, and why the myriad laws that purport to control health-care costs will never be enforceable, and therefore very poor statecraft. As the system is and trending, now, no one who really cares about the individual patient is watching out for costs OR quality.

Do we really think that sliding further in this direction will, somewhere in the space-time continuum, meet a shortcut where different results obtain?

What does it *really* cost to cover catastrophic illnesses? There is no real measure, now, and never will there be one until the patient/payer/consumer is personally affected by both the procedures and their costs.

VIII.

WHERE'S THE MONEY?

Most people do NOT experience significant medical expenses in any year – 'most' being 80% to 90% of any significant portion of the population. Most, therefore, will accumulate HSA dollars. Clients of an HCA would also qualify for borrowing from a Federal Extensive Care Fund, with repayments of moderate size accepted by family members, friends, church communities, other charities… or other members of the HCA "group" of perhaps 10,000 members.

Comprehensive "health care" spending around the world, per capita, ranges from less than $200 to more than $8,000 per year in the United States. Yet actual life expectancies don't follow the same curve, with some of the highest occurring in countries with close to the lowest per-capita expenditures – and with the U. S. not enjoying the highest life expectancy despite our exorbitant costs.

Clearly, the costs in the U. S. are NOT driven simply by providers' determination to impoverish patients. There are far too many hands out – too many entities to please - in the tortuous path from patients' pocketbooks to providers' incomes. There are numerous "culprits" to blame for our exorbitant expenditures – some very good, some intelligently avoidable:

- Advanced technologies
- Costly pharmaceuticals
- Over-medication, excess surgery
- Government over-regulation
- Increasing health irresponsibility
- Health ignorance
- HMO price-fixing (required by government)
- Malpractice insurance, tort costs
- Defensive medicine
- Lack of competition
- Clerical/administrative cost (required by government regulation)
- Politicized resource allocation
- Legal and illegal immigration of less-healthy populations
- Expansion of welfare/entitlements
- Growing fraud at all levels

When purchases and payments are determined by buyers and sellers, *most* buyers will purchase either *quality* at whatever price, *low price* at whatever quality, or some combination of quality and price that seems comfortable. When buying medical care, services and products, most buyers seize on a perceived source of

authoritative expertise, or *brand* that makes them comfortable in the selection. But, most buyers are ignorant of what is truly best or required for their own health. This leaves a vacuum that government is happy to fill, with no provable increase in either quality or price/value.

On average, actuarially, about 1% of people experience what may be called "catastrophic" medical conditions in any year. Prudence defines "catastrophic" as medical expenses in one year that exceed $50,000. "Major" medical expenses impact another 8% of patients, where expenses are more than $5,000 in a year. That is, such extraordinarily costly medical needs do not last forever for most patients. Some are due to severe injuries, some are from deep illness that is eventually cured or coaxed into lengthy remission. Thus, in a population of 10,000, about 100 people will be incurring extraordinary, possibly uninsured medical expenses at any one time. In addition, approximately 2% of the total, 200, will be living in some form of assisted-living facility, some with full nursing care. Their expenses will average $50,000 per year.

Health-care expenditures now amount to more than $8,100 per year, per capita, in the United States. The results of all those dollars are not as good as those in many nations where spending is far, far less. Even poor Cuba, where annual spending is in the low hundreds of dollars, somehow enables an average lifespan as long as we enjoy in the U. S. Is the average *quality* of life equal? Absolutely not; but there is some indication that a whole lot of our expenditure is administrative or fraudulent, and not medical. In the past few years we have committed ourselves to federally INCREASING the administrative cost of delivering health care. Amazing.

Our "Health Care Agency" group of 10,000 insured, on average, accounts for a whopping $80 MILLION of expenditure. Let's estimate that our 100 "catastrophic" expense patients will consume $10 Million, leaving, supposedly, $70 Million. Our "Major" expense patients will consume $6 Million, leaving $64 Million. Our 200 elderly, assisted/nursing care residents will consume $10 Million, leaving $54 Million for the other 9,000 members of the "group." That's about $6,000 per year, each(!), when average expenses will likely be less than HALF of that total. Where are the other $25 Million going, now?

Admittedly, these numbers are not ever as neat as "averages" might calculate. But, clearly, there are huge volumes of "health-care" dollars transferring to thieves, fraudsters, wastrels and relatively wealthy administrative agencies, companies and individuals. Best estimates are in the 21% range of total expenditures being "excess" administrative cost, or something in the order of $120 Billion to $150 Billion per year, nationally.

And that's based on our already administratively top-heavy care-delivery model. What if people, assisted by health-care agents, essentially paid their own bills to providers and retailers? What if doctors - *and every other provider* - had a quarter of the administrative cost to manage their businesses?

IX.

THE NATIONAL EXTENSIVE CARE FUND

We propose a means of obtaining funding for extraordinary medical expenses that will allow control over costs and overall satisfaction to remain with the patient. Rather than force everyone to pay for all coverages, including catastrophic coverage, a revolving fund from which individuals, families, various groups or HCA groups might *borrow*, would provide a solution for the worst of contingencies – and keep the patient / consumer in control. We are assuming a form of Health Care Agency that guarantees that all proper charges will be paid.

The immediate reaction to this proposal is that no one could "afford" to pay for his or her own care when it becomes so expensive, nor could he or she afford the loan to pay for it. But these are not structured like 3 or 5-year car loans, or even mortgages. Our premises are that people should pay their own way, and the fact that part of that way includes health care doesn't change that fundamental. And, that help should be available equally to everyone if he or she wants it.

The next reaction is that some procedures or care levels will have to be rejected by some people! And so they will; and so they are RIGHT NOW. The main difference is that people affected and those who actually do care about them would be making the limiting decisions. What are the real options people will then have?

A well-to-do individual with, let's suppose, a net worth of two million dollars, might be faced with the need for multiple bypass surgery at a projected cost of, say, $60,000. He is covered by an insurance plan that has a payment limit of $10,000 per year – insurance that is inexpensive. To complete his coverage he has maintained a growing HSA (Health Savings Account) that contains about $30,000.

Rather than deplete his savings he borrows the amount needed (after costs are negotiated by his HCA) and pays his bills with oversight and advice from his HCA.

The "NECF," charging only the costs of administration for interest, signs a contract with our well-off bypass patient. The terms are flexible for repayment with a fail-safe proviso that attaches sufficient proceeds from life insurance or the disposal of other assets, including real property, for the eventual repayment of the loan. Until that becomes necessary, a portion of every paycheck or other income is automatically directed to the repayment of the loan with interest.

ACCESS GUARANTEED

The NECF performs its function of assuring access to major operations or treatment regimens. The recipient of the wondrous services and products that comprise a multiple arterial bypass procedure and recuperation, eventually pays his own obligations: a perfectly balanced commercial transaction between seller(s) and buyer. Except for financing assistance, the "government" has nothing to say about whether the procedure was proper, at the right price or performed to the patient's satisfaction. But all involved in the operation and its aftermath is going to pay the closest attention to the good health and satisfaction of the recipient of their work: the person we call their *customer*.

This is not to say the government hasn't an overarching obligation to assure through license and oversight, that the persons providing the services are qualified and competent and that the products sold are what they claim to be.

"Well," you might say, "that's easy for someone with that kind of net worth. He's probably making a couple-hundred thousand a year. What about the 'working family' that has three kids, a car payment and a mortgage on $55,000 per year? They don't have $30,000 in an HSA and they depend on an HMO for coverage. How are they assured access?"

Actually, they are. Let's suppose this family has a $100,000 mortgage on a small ranch, costing $1,100 per month, a car payment of $250 a month and, with five dependents, perhaps $300 of uncommitted income that always seems to disappear into non-recurring expenses… every month!

The HMO has a deductible for the family of $2,000 in a year, or $1,000 per person until it's reached. They pay co-payments of $15 per office visit and a larger, variable amount for prescriptions. Their middle child is diagnosed with cancer and treatment is "covered" by the HMO, but ancillary expenses and co-payments easily amount to $1,000 per month that they simply do not have. The husband's job includes a pension plan but there is a severe penalty for early withdrawal of vested funds, which amount to only $15,000 at the time.

The 'working family' can turn to the National Extensive Care Fund.

The cancer care is estimated to cost $350,000, largely covered by the group HMO. But, over the three years of treatment the family faces expenses of about $44,000. For this they contract with the NECF and the administrative expenses are pegged at $1,276, or 2.9% simple interest. A term of 20 years is selected and this family eventually absorbs a monthly payroll deduction of after-tax dollars of $188.65. Medical tax deductions probably save about $40 of that.

As a fail-safe there is also a delayed lien on life insurance and disposal of estate assets in the event the breadwinner dies before completing the contract. Many families would add special life-insurance specifically for that possibility, as is done for home mortgages.

The result, overall, is that the rest of us helped a family in need; obligations were met by those responsible; products and services were obtained and delivered in a timely manner. The example assumes the management of a Health Care Agent who might have as its client the entire company group. The HMO *would make its payments to the insured employee* who would pay his or her bills, now rendered understandable and justifiable by providers who are concerned with the *buyer's* (HCA's and the customer's) satisfaction with all transactions.

And the NECF is paid back in full.

AND THE POOR?

"Well," comes the obvious next question, "you're still talking about someone 'rich' enough in skills to merit a good HMO plan. Where would personal responsibility leave a poor family – a family already on welfare?"

Public assistance takes many forms, including, but not limited to, direct cash aid (EBT) based on family size, clothing allowances, fuel assistance, transportation vouchers, WIC, TANF (food Stamps), and subsidized housing. It also includes "free" health care with relatively few limitations and many inclusions that are ludicrous if not outrageous. These latter might include cosmetic surgery, trans-gender operations and fertility treatments. (Whether those on welfare should be allowed to have additional children is worthy of debate.)

The worst effect of welfare is that it codifies irresponsibility and non-responsibility. Do we really intend to provide free care for heavy smokers on welfare? Or, for alcohol and drug abusers?

Is it not better to have welfare parents learn about financial responsibility regarding health care, and learn the connection to personal responsibility, too?

At SEVEN DOLLARS or more per pack of cigarettes, should welfare recipients have unregulated financial rights for some purchases while shoving their personal HEALTH responsibilities onto the shoulders and pocketbooks of others?

We propose that welfare assistance take the form of financial education, among other topics, and that welfare parents be required to learn budgeting skills – including the purchase of health-care coverage and life insurance. Rather than providing free care, the estimated cost per family, in cash, should be deposited into a restricted

Health Savings Account with oversight by a licensed HCA who is required to accept a certain percentage of "public" clients. Parents should learn the costs of care and the cost of wasting care. He, she or they should also know that keeping health care costs down would have eventual financial benefits as the HSA grows.

The welfare parent(s) should also have to buy life insurance, even if the money to do so is not *earned* per se. It seems a folly to support ignorance, but wise to support increasingly intelligent parents who can use welfare for a stake in the future as a day-to-day helping hand. Lifestyle decisions ought to have similar financial consequences for public wards, else the behavior that renders them non-responsible will just grow and continue from generation to generation. The oh-so-true saying about teaching a man to fish applies just as well to teaching the economically ignorant how to manage resources as opposed to just providing resources for today, as if by magic.

So, our unfortunate welfare family, probably a single mother with three children, is provided with a Health Savings Account – literally a cash-in-the-bank account – from which her assigned HCA shows her how to purchase health and life insurances. The money left over remains to accumulate. Each year more restricted money is added to the HSA, at a net cost much lower than "free" public health care and its bureaucracy.

The state might even provide part of the fee for the HCA who incurs extra costs in having to educate as well as administer.

In any case, once the life insurance is in place, this family has the beginnings of a net worth and an estate. In the event of a catastrophic event or illness, this mother will also be able to contract with the NECF, but with some differences.

Suppose a son is hit by a car while riding his bike. He needs several surgeries to repair bones broken in several places. The cost is projected to be about $35,000 more than the minimal health coverage provides. Here, again, the HCA is monitoring all recommendations and helping select sources for treatment, including price negotiation with providers, most of whom agree to reduce rates or prices for this patient.

Obviously the monthly repayment will be small, possibly only $30 from her welfare stipend. It will be so small as to require a "co-contractor" from the mother's family who agrees to a small monthly payment, as well.

Suppose a steady-working brother is asked to accept $40 per month, making the total paid $70 per month, to which the NECF agrees, with ultimate fail-safe in, now, two life-insurance policies. The term is 30 years and the administrative costs amount to 3.5%, making the total to be repaid $36,225. The total contract also includes small monthly payments withheld from the income of the three children once they complete their educations, amounting to a total of about $125 per month at that time, since the

initial $70 payment covers only $25,000 of the contract. We might also assume that this parent eventually becomes a wage-earner and able to increase her payments, possibly obviating the brother's or one or more of the children's withholdings.

But look at what has happened! This relatively indigent person has learned to purchase insurance and health care, has been able to contract for a sum that would otherwise be astronomically out of reach, and she has had her son cared for by the best physicians and institutions. During that care there was no diminution of care or caring because he was a "welfare case." 'He' has purchased his care the same as any other patient, with the same choices for care, from providers intensely interested in his and his mom's satisfaction.

Do we think it is somehow unethical to expect his siblings or an uncle to pay a small amount of pre-tax dollars toward this family medical debt? Why? Because they might be embarrassed to ask? Because *you* would be embarrassed to ask someone you knew to assist you with medical expenses, but not too embarrassed to ask all of us you don't know to not only help with health care, but to actually *give it to you*?

Why? Why is that less commendable than making others who are not related to this family or child, pay for his care through confiscation (and incredible waste).

Further, there is nothing to prevent charitable sources from helping this mother meet her obligations. One is assured that with the "state," as in *taxpayers* seen as obligated to pay, familial obligation is perceived as no longer operative. This should not be so and is a false lesson for the state to be teaching its citizens of any status.

The HCA to which this family belongs, may have prepared for borrowings from the NECF by its members, either by purchasing "umbrella" coverage or by eliciting small fees from all members to cover such loans.

God forbid that this mother should die before the 30 years are up, but her small $50,000 or more life insurance policy will make the NECF whole again, completing the contract for all involved.

And what if our stereotypical welfare mom is faced with a chronic disease of one of her children, with extended care costing $300,000? How is access to care maintained while the system retains its solvency and fairness?

Part of the NECF enabling legislation would state that no one can be turned down for a health-care loan who has at least the stability of a permanent address, an assigned HCA and life insurance. What would change as the scale and complexity of financing increases is the rate of administrative costs on the loan, and the need for more co-contractors to pledge portions of their life insurance or other real assets in support of the repayment plan. No one would be forced to impoverish him or her self or

hurt his or her family to repay a health-care loan. If the family can afford only $100 per month, then the term will be extended to the actuarially feasible maximum and more of the principal will be repaid from life insurance or the disposal of estates.

Our welfare family could agree to the have the three children's eventual life insurance proceeds also committed to satisfy their loan.

Do we mean that repayment could take eighty years? Yes.

ELDERLY HEALTH CARE CUSTOMERS

What happens when the patient him or her self is 80 years old?

If that person has a family the ultimate decision is up to them. Will they commit their life insurance and some monthly dollars to the cost of a bypass operation or a kidney transplant? If not, is it because their HCA has provided a thorough analysis of medical prospects and prognoses and the anticipated added life and quality of life is quite small?

Are there sufficient assets to cover the costs in the patient's own eventual estate? If not is it not better that one's own family be the consultative body as to the application of limited resources to low-return procedures? If the family *won't* agree to share the expenses over many years of an NECF loan, why should the rest of us be forced to pay? Does public assumption of responsibility render the chances for a mechanically lengthened life somehow better than if the family eventually pays it all?

This is a problem that will exist as we phase in to a personal responsibility / personal choice health system, but which will become less common as we go forward 20, 30 or more years. The reason is that people will be preparing to cover their own obligations. A thirty-year-old HSA will have grown substantially. Some of its proceeds could have been purchasing additional major medical coverage and/or extended care coverage.

For the start-up period some provision would exist for decision-making by public/private boards, including the family's HCA, with repayment limited to the patient's own assets. In the case of a family's refusal to participate in repayment and the "board" decides to proceed with the care, future needs by that family would carry added rate factors for NECF loans they might request.

Family dynamics will change, as they should. Whether for late-life medical procedures or extended nursing care, no longer will there exist a means for care recipients to shed assets and throw themselves onto the taxpayers for huge, personal expenses. Yet the existence of the NECF will make it possible for both medical and

extended care to be afforded and budgeted over many years, avoiding the loss of family assets.

EXTENDED CARE

Why should recipients of products and services we call "health care" expect that taxpayers will suddenly become responsible for them the day after their 65th birthdays? Or, *as federal budget follies dictate*, their 67th or 70th birthdays? Why are not the assets one accumulates properly available to purchase the items for that one's own benefit? Why should my, or anyone's assets, be confiscated to protect the assets of a stranger?

Do you suppose that extended nursing care might be more responsive to its customers if they were responsible for paying their own bills? Most likely. With laws now preventing better care for paying residents as compared to welfare/Medicaid residents, is it any surprise that average nursing home care is what there is?

It is impossible for everyone to receive all the care that's known. The question is, and the power lies, with who should determine the limitations and who should be the center of service attention?

It ought to be the patient / resident / customer. The NECF could also perform its crucial function in the affording of quality nursing home, or in-home care.

Suppose our working-class father retires with an HSA totaling $110,000. He has been purchasing long-term care insurance that will pay the first $100 per day for nursing home care. This limited coverage is fairly inexpensive and the interest on the HSA is more than covering the cost since he started purchasing the policy at age 50. Like most of the young, and with justification, working-class dad expects never to need a nursing home. Unfortunately, since he has also been a smoker, he suffers a serious stroke at age 72, requiring care that his equally aged wife cannot handle.

Now dad has to check in to a nursing / rehabilitation facility that costs $300 per day. After insurance there will be a $200 per day expense to cover, or $73,000 for the year, plus there will be 'rehab' services costing $14,000 in the first year. Without knowing how well the 'rehab' will work, the family, consisting of the wife and two grown children with their own families, agrees to borrow $7,250 per month for ten months, or $87,000, at least. With his own life insurance and other assets, Dad's estate amounts to about $600,000 of which $200,000 is life insurance. The NECF contract includes a guarantee from these assets after both spouses are deceased.

So, Dad's wife and children commit to deductions of tax-deductible amounts based on $3.90 per thousand per month, ramped up as the loans accumulate. The term

is 20 years and subject to additions and extensions as needs may arise. Mother accepts responsibility for up to 20 repayment units per month, or about $78. Child number one accepts 26, and child number two, 40 units. This agreement covers the scheduled $335.40 per month repayments for the eventual initial loan.

Future extension of term and additional principals will change the number but not the nature of the plan. Dad and his family are free to purchase the best nursing and rehab care they want; providers will be doing their best to make Dad and family happy, else they'll lose a good-paying customer.

The extended care insurance is paid to Mom's and Dad's HSA. The loan moneys are also paid to the HSA with the same restrictions on use, under the guidance and guarantees of their HCA. Medical and care decisions are familial and personal; quality concerns are immediate and carry immediate financial consequences for the providers. The government will have met its obligation to help but not control the transactions, the care, or the patient.

I like this plan!

X.

EFFECTS OF PERSONAL RESPONSIBILITY

We have described a way for virtually everyone to buy the health care he or she chooses. The automatic corollary is that everyone also will have to be responsible for his or her own health and coverage/purchase of health care. It also means that the government withdraws from these most personal and familial decisions while providing funding assistance through the NECF, also to virtually everyone.

Here are other points to consider:

1. There will be a direct financial benefit to individuals and families who take better care of themselves and who purchase health care wisely and otherwise keep health costs low.
2. The supply of doctors will be controlled by financial profitability – that being the best way to value those services and products that are in long or short supply. It makes no sense for the government to control the number of doctors as a means to REDUCE HEALTH COSTS as preposterous as that sounds.
3. As with every other area of free enterprise, growth and innovation, potential profit is the engine of new things. Health care providers at every level will be free to sell as much care as empowered citizens wish to buy.
4. Poor customers will have the means to independently purchase care from the same sources as wealthier ones.
5. Insurers and HMOs will focus on the customer / patient and pay their benefits directly to that CUSTOMER / PATIENT.
6. Health Care Agents will contract with consumers – individuals and families – or with suitable groups, and represent them for the purpose of advising and guiding them in the obtaining of the best, most economical care. "HCAs" will not be beholden to providers or insurers, only to consumers, nor will they make more money specifically because of higher or lower costs, which doesn't rule out bonuses for better savings or quality achieved. It is no one's business but the Agents' and their clients'.
7. The National Extensive Care Fund will be self-sustaining because everyone, or his or her estate, will pay back the costs of health care borrowed from the fund.
8. One seventh of our economy will not lurch toward fascism, but, instead, will evolve into an economic and inventive engine that will lead the world into an

age of ever more phenomenal medical and care advances of which we only dream, today.

9. The very finest people will be attracted into health care because of potential personal profit – whatever form that may take.
10. Government will resume its proper and essential roles of regulation and oversight, guaranteeing quality, competence and honesty within health care and related businesses.

SUMMARY AND HOPE

The majesty of American Free Enterprise works only in an environment of unfettered opportunity. Politically, our recent history is one of attempting to *fetter* it at every turn.

Some in power *fear* an unbridled people. Some see all problems as the province of a central government, but it need not be so.

The system toward which we are racing, is not the one that made us great and rich. It is important that Americans be reminded of the essence of free-enterprise capitalism, and that we recognize that centralized control is not a solution for everyone – only for those holding centralized power.

Our economy and our future are in our hands. We must, by definition, oppose solutions that rely on centralization and the concomitant loss of freedom that entails. Let's embrace solutions that *enhance* our Liberty.

I pray that his pamphlet will help that happen.

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