U.S. HEALTH CARE – STATUS AND REFORM

Stephen L. Bakke, April 2009

Contents **Page**

For a Quick Review **1**
Background **1**
Definitions **2**
Commentary – Points and Counterpoints **3**
World Health Organization Study **3**
The Commonwealth Fund "Weighs In" **4**
Michael Moore, "Sicko", and Cuba **7**
More About the Canadian Health Care System **8**
Insurance **11**
Drugs and Drug Companies **14**
Overall Costs **16**
Effectiveness of Care **18**
Young Get "Help"; Old Get the Shaft; We All Get Government **19**
My Opinion on Reform **21**
Commentary **21**
Summary of Reform Elements **22**
Sources of Information **24**
Books, Papers and Studies **24**
Writers, Columnists etc. Whose Material Was Used **28**
Websites and Online Newsletters or Publications **28**

For a Quick Review

This is a relatively long report and you may not want to have to wade through it all. In that case I have prepared an abbreviated version. If you received this report by email, the shorter version was attached to the same email as was this version. The abbreviated version includes much of the commentary, but very little of the extensive "Point/Counterpoint" presentation.

Background

The issue of finding the best health care philosophy and system has been around forever. While for years it seemed to be just background noise, fading in and out as other issues took top billing. Now, however, the costs and emotions surrounding the topic are more intense and don't seem to fade away any longer. The process of dealing with it is now solidly on the agenda, but that doesn't mean a final answer is near – it's involves too much of a long and polarizing debate to have any hope for fast action.

One of the biggest problems in health care reform is that parties to the debate have different viewpoints of the basic facts to be used in determining priorities and a solution.

There will be no workable reform without agreement on a set of basic facts about what needs to be reformed. The only thing that can be agreed on is there are problems with our health care system which need to be addressed. One side would say there needs to be more governmental involvement – that there is nothing better suited to our Federal government than providing health care. The other side would contend that the problems are the result of government involvement and departures from the free market system. And arguments exist at every point between those extremes.

Here are the rules I have attempted to follow in completing this report:

- I have tried to make my biases obvious.
- My disagreement does not result in excluding an opinion or assertion. Sometimes I disagree with the *"Point"* presented, a few times with the *"Counterpoint"*, and sometimes (not often) I disagree with both.
- The *"Points"* presented have been independently expressed by third parties and are not my invention. I have used paraphrasing in an attempt at brevity. Virtually all of these can be found, stated or strongly implied, in the independent/external sources listed at the end of the report.
- The "Points" presented are fairly common and the reader may be familiar with them. And remember that they may not reflect the majority opinion.
- The *"Counterpoints"* presented are summarized from the independent/external sources listed at the end of the report, and are not my invention.
- Neither the *"Points"* nor the *"Counterpoints"* should automatically be presumed correct, but I believe the credibility of the sources makes both positions and comments relevant for evaluating the issue.
- If a comment contains some of my personal opinion, I believe that will be obvious. Once again, all of the opinions and information originated separate from me – even if it's obvious I agree with some of them.
- And remember, neither the "point" nor the "counterpoint" will always tell the whole story – either individually or when considered together.

Definitions

Health Care Reform – Many equate health care reform with universal health care. It is not. Reform just means change. Universal care is just one type of reform.

Universal Health Care – This refers to a scenario where everyone is covered for basic health care services, and no one is denied care as long as they are legal (sometimes even illegal) residents in the geography covered. This concept is often equated to a single payer system but they are not necessarily the same.

Single Payer System – This type of system is one in which health care is paid for by only one entity. Many supporters of universal care, single payer, or even pure socialized medicine try to create clear distinctions between these three concepts. The differences are often just nuances and they are creating distinctions without real differences. For example, creation of a universal system generally leads to a single payer system, and in

100% of single payer systems, that payer is the government. And I think most would find that even in the least purely socialized of universal systems, perhaps Canada is an example, a significant portion of health care decisions are made bureaucratically, or by the government. Decisions made by the government; payments made by the government; and control of processes in the hands of the government; those characteristics come very close to characteristics of socialized medicine.

Socialized Medicine – This type of system goes a step farther than either universal or single payer systems. Under a socialized system, the government employs all health care personnel, and all providers of services are part of government. All decisions are made by government and the system is also both a universal and single payer system.

Benefit Mandate – This is a law (usually from a state) that commands a health plan to pay for, or at least offer, a specified treatment or type of provider, usually removing the benefit from negotiation between beneficiaries and health plans. Most of these mandates were legislated without formal review of costs and benefits. The Pacific Research Institute recently reported that each additional benefit mandate explains an increase in the number of uninsured of about 0.25%. Why? – because adding mandates cost money. Stated another way, these mandates require Americans to pay for coverage they don't need or prefer not to have. Some suggested reforms recognize this and propose having limited benefit plans (e.g. major medical or catastrophic coverage) more readily available, or perhaps a "shopping cart" of benefits that could be chosen individually. The proponents of limited plans make solid arguments that this would promote cost savings.

Commentary – Points and Counterpoints

World Health Organization (WHO) Study

Several years ago, the WHO published a study of medical care around the world with specific comparisons to the U.S. The study included information on 191 nations and in the rankings the U.S. finished 37th, behind nations like Morocco, Cyprus, and Costa Rica. Finishing first and second were France and Italy. Michael Moore makes much of this in his movie "Sicko". The New York Times declared "the disturbing truth … that … the United States is a laggard not a leader in providing good medical care". To evaluate the issue, we at least need to take a look at some of the issues and contrary arguments.

- *Point:* These are studies of relevant measurements of health care success.

  Counterpoint: There is less to these studies than meets the eye. They measure things other than the quality of medical care. Some of these are addressed below.

- *Point:* The WHO evaluated the quality of health care based on life expectancy.

  Counterpoint: Critics say that is not a good measurement if looked at in a vacuum. There are many things that cause premature death that have nothing to do with medical care. For example, we have proportionately more fatal

transportation accidents than other countries – no health care implications there. Similarly, our homicide rate is 10 times higher than the U.K., 8 times higher than France, and five times greater than Canada. Addressing the reason for these is a separate argument from health care. If the affect of homicide is factored in, the U.S. life expectancy is actually higher than each of the countries listed. Going one step farther, when "fatal injury" rates are adjusted for, U.S. life expectancy is actually higher than in nearly every other industrialized nation, and is the highest of the wealthy nations listed in the TCF section which follows.

- *Point:* The WHO judged the quality of health care on the "fairness" of distribution of services.

  Counterpoint: The critics would say that this had a socialistic bias. There was inadequate measurement of actual quality of health care. Some have demonstrated that using WHO's criterion, a country with high-quality care overall, but with some "unequal distribution" would rank below a country with lower quality average care but with equal distribution of the misery.

- *Point:* The number of people with medical insurance automatically improved or reduced the overall ranking for quality of health care.

  Counterpoint: Opponents of this report's state that many of America's "uninsured" are there by choice, ignorance, or because they are in the country illegally. This topic is taken up later in the ***Insurance*** section.

- *Point:* For all its problems, the WHO study gives the U.S. credit for quality of care and innovation by ranking them near the top for this category.

  Counterpoint: Some explain that the reason for this ranking is that development of life-saving drugs is included as a measurement. The other lower rankings are due to using subjective criterion which reward systems closer to socialized medicine. Refer to the later section, **Effectiveness of Care.**

The Commonwealth Fund (TCF) "Weighs In"

The TCF study looked just at wealthier nations – Australia, Canada, Germany, New Zealand, the United Kingdom and the U.S. In the TCF study, the U.S. ranked last or next to last on all but one criterion. So is that the final verdict? Let's take a closer look

- *Point:* The study states that despite having the most costly health system in the world the U.S. consistently underperforms.

  Counterpoint: Critics immediately point out that one of the most important considerations was, as the report states, that the U.S. is the only country in the study without universal health insurance, "partly accounting for its poor performance on access, equity, and health outcomes". While the lack of national

health insurance caused a low ranking in "access" et. al., the author's own words state that, if insured, "patients in the U.S. have rapid access". Also, it should be noted that while there are U.S. government programs that do guarantee basic medical care to the uninsured, no credit is given for that fact. As pointed out elsewhere herein, the uninsured simply aren't seeking available programs. We really have a different problem than access – rather, it's ignorance of the system.

- *Point:* All important performance factors were considered in the study.

  Counterpoint: Critics point out that the evaluation didn't consider that the U.S. is the center of medical innovation. When internists ranked the world's top 10 recent medical innovations, eight were developed from American innovations. Also, read the lengthy "counterpoint" in the later section, **Effectiveness of Care**.

- *Point:* The real U.S. problem is with the number of uninsured.

  Counterpoint: It is argued by opponents of universal care that the affect of this point is exaggerated. Refer to the discussion elsewhere herein about the characteristics of the American uninsured and also the fact that many of our uninsured simply don't seek the programs that are available to them. It should also be considered that many of these same citizens are only temporarily uninsured. Many do admit that this should be dealt with, but a national insurance or universal care is not the way to do it.

- *Point:* The U.S. scores at or near the bottom in most "quality" measurements.

  Counterpoint: The study divides "quality" into "right (effective) care", "safe care", "coordinated care" and "patient-centered care". The U.S. was rated 5th or 6th in the last three. It was first in "right (effective) care". Critics of TCF point out very convincingly that this is really the most important of the criteria. They also convincingly point out biases and problems with the other criteria including the fact that results were based on subjective telephone interviews with patients and doctors, not an objective study of data from records or about outcomes.

  It has been demonstrated that good ratings in the following categories or sub-categories could only be achieved if a universal health plan was in place – i.e. lack of such a plan automatically receives a low mark without regard to actual statistics: care management, coordinated care, patient-centered care, access, and equity. Once again I refer you to the later section, **Effectiveness of Care**.

- *Point:* The study's shortcomings are mitigated by the many factors considered.

  Counterpoint: Critics accuse the study of being designed to make the U.S. look bad. Characteristics common to universal health plans are given emphasis over outcome statistics. For example, the number of persons who pay amounts "out of pocket", even if low amounts, can penalize a country's rankings as much as low

reported infections can help. And also equally rated with these measures is the number of physicians who report the use of automated computer systems "to remind them to tell patients their test results". Another is that the level of administrative costs is rated heavier than the length of waits for surgery.

- *Point:* The British National Health Service rightfully is one of those systems held up as a highly rated system in almost all respects compared to the U.S.

  Counterpoint: Critics are quick to point out that the U.K.'s National Health Service recently made a promise to reduce wait times for hospital care to four months. One hospital was recently reported to have tried to save money by turning sheets over rather than changing them every day (no doubt an isolated example, but nevertheless true). More than 70,000 Brits have become "health tourists" by traveling long distances to other countries for major operations. It was recently reported that 750,000 Brits are awaiting hospital admission. Britain's National Health Services has tried to achieve an 18 week maximum wait from general practitioner to treatment, including all diagnostic tests.

- *Point:* Michael Moore's movie confirmed what was stipulated in the TCF study.

  Counterpoint: Many consider Michael Moore's movie as anything but objective. He accepts TCF assertions and then "reaches" for support. He praises Canada's system, but doesn't point out it ranked only 5th overall, ahead of only the U.S. and was evaluated by TCF as being worse than the U.S. in many ways.

- *Point:* The study's shortcomings are mitigated by the fact that the same telephone interview questions were asked of patients and physicians in all of the countries.

  Counterpoint: While its uniformity was commendable, critics point out that there was no attempt to make real objective measurements of outcomes, practices, etc. The fact that it was a telephone interview measuring impressions only is a weakness not a strength. It's an accumulation of "impressions", largely from patients. The report does nothing more than reveal which nation does the worst job of satisfying the subjective preferences of the people who conducted this study. Expectations do tend to be higher in the U.S., and not taking this into account biases the study against the U.S. health care system.

  Even the study recognizes inherent shortcoming in the following direct quote from its Summary: **"Any attempt to assess the relative performance of countries has inherent limitations. These rankings summarize evidence on measures of high performance based on national mortality data and the perceptions and experiences of patients and physicians. THEY DO NOT CAPTURE IMPORTANT DIMENSIONS OF EFFECTIVENESS OR EFFICIENCY THAT MIGHT BE OBTAINED FROM MEDICAL RECORDS OR ADMINISTRATIVE DATA. Patients' and physicians'**

assessments might be affected by their experiences and expectations, which could differ by country and culture".

Emphasis is added because this is a very important admission by the authors!

The real "rub" here is that the survey would automatically permit a country with a universal system to be rated higher than one with higher overall quality care but no universal coverage. The U.S. fails the survey simply and only because a high rating is dependent on a system's proximity to socialized medicine.

Michael Moore, "Sicko", and Cuba

"Sicko" is a 2007 documentary film by American filmmaker Michael Moore (MM). The film is represented as an investigation of the American health care system. The film compares the for-profit, non-universal U.S. system with the non-profit universal systems of Canada, Cuba, France and the U.K. While it opened to positive reviews, it also generated criticism and controversy. Critics say the positive reaction generally came from those who heard what they wanted to hear. But it now is generally agreed by all, that this project was anything but an objective gathering of data. It was, quite clearly, a project which set out to create film footage which would put the U.S. system in a bad light – a preconceived agenda by the filmmaker. Some objective, but still severe, critics of our U.S. health care system, have come to consider the film as having done their cause considerable damage. This has resulted from careful scrutiny of the filming process and the representations made in the film. It wasn't what it was first thought to be in terms of credibility and accuracy.

- *Point:* MM contends in the movie that "…if there's one thing they do right in Cuba, it's health care. There's very little debate about that." He took a group of 9/11 rescue workers to Cuba and asked Cuban officials to "give us the same exact care they give their fellow Cuban citizens. No more, no less. And that's what they did." He states that there is really no argument about this.

  Counterpoint: There is considerable argument available. In actuality they were sent to a special clinic that is specifically used for important citizens, tourists, and dignitaries – not at all representative of typical care. Cuban born Dr. Jose Carro, who interviews Cuban doctors who have moved to the U.S., contends that MM's movie lies. Dr. Darsi Ferrer, a human-rights advocate in Cuba, told John Stossel at ABC News that Americans should not believe the claims being made. He describes the Cuban people as "crazy with desperation" because of poor quality care. ABC News reported that, unlike "Moore's hospital", most hospitals in Cuba are dilapidated. And when Fidel Castro became ill in 2006, a Doctor from Spain was brought in to care for him.

- *Point:* MM claims Cubans live longer than Americans.

Counterpoint: It's true that a U.N. report claims that, but the U.N. didn't gather that data. Dr. Carro contends that "The United Nations simply reports whatever the government in Cuba reports, so we have no objective way to know what the real statistics are". It's very doubtful that this is even close to the truth. MM apparently would believe Cuban government representations before he would believe verifiable U.S. statistics.

- *Point:* Cuba has low infant mortality.

  Counterpoint: Once again, this is what the Cuban government reports. Doctors report that Cuban obstetricians tend to abort a fetus when they think there might be a problem. Dr. Julio Alfonso reported to John Stossel of ABC News that they used to do 70 to 80 abortions a day (presumably at his medical facility). There is another report from former Cuban doctors that is disturbing – Cuban doctors don't count an infant as ever having lived if he or she dies within a few hours of birth. It's obvious what this sort of counting would do to the reliability of these reports.

- *Point:* MM claims in a representation to ABC that "All the independent health organizations in the world, and even our own CIA, believe that the Cubans have a pretty good health system. And they do, in fact live longer than we do."

  Counterpoint: The CIA disagrees with this – their position is the opposite, and this is clearly stated in their "Fact Book": U.S. citizens live approximately a year longer than Cuban citizens.

- *Point:* It didn't take Mr. Moore long to discover the very favorable aspects about Cuba's health care system. The information had been there all along and the movie merely raised the visibility of the Cuban successes.

  Counterpoint: Long before Mr. Moore's 2007 movie, in the mid 1990s, anthropologist Dr. Katherine Hirschfeld became interested in Cuba after reading numerous laudatory books and articles describing Castro's achievements in health and medicine. She found that the research was not credible and few, if any, of the authors actually spent time in Cuba. She personally was hospitalized in a Cuban hospital that had no working phone and never saw a doctor during her hospitalization. She lived in the country and completed considerable research which was published in a book several years later.

More About the Canadian Health Care System

Many claims have been made by Michael Moore and others as to the superiority of the Canadian health care system. Critics acknowledge the greatness of our close neighbor and ally Canada, but nevertheless a complete and objective evaluation of their health care system must consider the many flaws that it contains. The U.S. system has its set of problems, but Canada has its share as well.

- *Point:* Mr. Moore "dares" supporters of the U.S. system to try to "challenge me on these things" – referring to the higher Canadian rating compared with the U.S.

  Counterpoint: Rationing of health care services does occur in Canada. In 2007, a lady in Canada was about to have a multiple delivery. She was discouraged from going to the nearby neonatal units because of crowding. She chose to travel to Montana to have the babies. Dr. David Gratzer, author of "The Cure" reported on ABC that he thought the Canadian system was great until he started treating patients. "The more time I spent in the Canadian system, the more I came across people waiting", he reported. He sites examples of people waiting 6 months to see a neurologist for headache diagnosis and treatment. MRIs take a similar time to get scheduled.

  The Vancouver, B.C. based Fraser Institute's annual publication, "Waiting Your Turn" reports that Canada's median waiting times from a patient's referral by a general practitioner to treatment by a specialist, depending on the procedure, averages from five to 40 weeks. The wait for diagnostics, such as MRI or CT, ranges between four and 28 weeks. The Cato Institute reports that one out of three Canadian physicians send a patient to the U.S. for treatment each year.

- *Point:* Canadians live longer lives because of their superior health care.

  Counterpoint: The life expectancy is slightly higher in Canada, but for a different reason. The comparison would show U.S. citizens living longer if the effect of traffic accidents and violence were factored out. The U.S. needs to deal with this problem in a way other than health care reform.

- *Point:* The Commonwealth Fund Study (TCF) cited above rates Canada higher than the U.S. in "access" to health care services.

  Counterpoint: The fact that the U.S. does not have a universal system automatically lowered the ranking dramatically – without regard to any other objective measurement or available statistics. For example, one thing that wasn't considered is that more than a million Canadians cannot find a regular family doctor – in spite of their universal system. One town actually holds a lottery to determine those who will have access to a family doctor – but their treatment is "free" when it occurs. Canadians stuck on waiting lists sometimes pay "medical travel agents" to get to America for treatment. And there are many examples of important surgery being classified as "elective". One veterinarian reported he can see a dog or cat the next day for a CT scan, but humans typically wait a month. Access to a waiting list is not access to health care.

- *Point:* The Canadian system is incorrectly identified as "socialized medicine". In socialized systems, the doctors work for the state. In Canada, and many countries with universal care, the state reimburses the doctors for the care they provide.

Counterpoint: Critics would say that's a distinction without a difference. What really distinguishes a socialized system is that the government makes all the decisions on care and pricing. This is different from a free market for health care, even if an insurance industry is superimposed on top.

- *Point:* Canadian physicians do make considerably less than in the U.S., but there are other, less measurable, more intangible benefits.

  Counterpoint: Critics would call this a "yes/but" argument. While escaping the problem of dealing with insurance companies and other distractions is a positive, there isn't the inherent motivation, focus and other advantages of a typical free market – even with all of the flaws of a free market system.

- *Point:* A recent report intended to defend the Canadian health system, and expunge the myths about it, stated that the claims that Canadian patients have horrendous wait times is partly true and partly false. "It depends on which province you live in, and what's wrong with you".

  Counterpoint: This would be described as a very weak "yes/but" argument – almost an admission of inferiority.

- *Point:* The report referred to in the prior item takes exception to the assertion that you have to wait forever to get a family doctor. But they admit this is the case for a percentage of Canadians. Again it depends on where you live, for the most part.

  Counterpoint: This is another admission disguised as a "yes/but" defense.

- *Point:* The claims that Canada has universal coverage for only the basics, and "you are on your own for anything else" is acknowledged as true by its defenders. It's not really a problem, they claim, because the basic coverage covers so much. Items not covered, according to the defenders, are things such as medical equipment, prescriptions, physical therapy, chiropractic care, dental, vision, private rooms, etc. This information is taken directly from the pro Canadian report referred to above which also points out that "filling the gap between the basics and the extras falls to the country's remaining private health insurers".

  Counterpoint: This is another "yes/but" defense which actually seems to close the definitional gap between the U.S. and Canadian systems – perhaps more than universal health proponents are comfortable with.

- *Point:* Canadian health care services are not rationed.

  Counterpoint: Many expert observers disagree. Claude Castontuay chaired a 1960s Canadian government committee studying health reform and recommended that his home province adopt government administered health care. All citizens would be covered through tax levies. He is considered by many as the architect of

the existing Canadian health care system – at least for the province of Quebec. His ideas for Quebec were implemented coast to coast.

Investors' Business Daily, reports that four decades later, as chairman of a government committee reviewing Quebec health care in 2008, he concluded that the system is in "crisis". He states, "We thought we could resolve the systems's problems by rationing services or injecting massive amounts of new money into it". And now he prescribes a radical overhaul: "We are proposing to give a greater role to the private sector so that people can exercise freedom of choice". He wants to contract services back out to the sector which had it originally.

What made him change his mind was a reluctant (probably) acknowledgement that the Canadian system is so overburdened that hundreds of thousands in need of attention wait for care, participate in lotteries for family doctor appointments, travel to the U.S. for certain problems, etc.

Quietly, the provincial governments of Canada have sent patients to the U.S. For example, in the last two years, Ontario has sent at least 164 patients to New York and Michigan for neurosurgery emergencies – defined as "broken necks, burst aneurysms and other types of bleeding in or around the brain".

Critics point out that you simply can't "centrally plan" your way to better care.

Insurance

- *Point:* Insurance is a savior and individuals should get all they can.

  Counterpoint: Some characterize insurance as a necessary evil. Some contend that we should invest in it only for the bigger financial risks. If everyone could do this it would be best for the system. Health insurance has become a payment system, rather than a risk management tool.

  Doctors spend approximately 14% of their revenue on insurance paperwork. We need to have more consumer control over what is paid and how much coverage is obtained. Furthermore, some feel that the current payment system is too invisible and that a better transparent system would be if the consumer paid the bills with reimbursement by the insurance company coming to the consumer. This should also be tied in with tax credits for the consumer.

- *Point:* Insurance is an efficient way to pay for health care.

  Counterpoint: Perhaps it is for major medical and catastrophies, but not what is referred to as "first dollar coverage". Therefore some believe the best way is to combine major/catastrophic coverage with a self insured savings plan for "first dollar coverage". One form of this is a health savings account (HSA). This gives an added benefit because consumers spend directly for this part of their coverage

which many believe is a more efficient method to provide wise decisions for amounts less than major medical coverage. But many states right now do not allow an insurance company to sell you that major medical coverage without all the add-ons that politicians and special interests have come up with. Mandated coverage is discussed further elsewhere in this report.

This philosophy opposes universal systems as being inefficient with poor choices for expenditures the result. Put the individual in charge. Care deteriorates under governmental control. Foolish pursuit of "free care" is the enemy of good care.

- *Point:* Based on census data from 2005, over 46 million people lack health care coverage because it's too expensive. The estimate is now over 47 million people.

  Counterpoint: Skeptics of the usefulness of this data provide the following analysis. Of the total 46 million, approximately 17 million made over $50,000 and simply chose not to obtain coverage – affordable coverage was available to them. The average uninsured American has above average income, and people living in poverty do have access to Medicaid. Another point is that almost half of the 46 million were in transition and not part of a long-term uninsured group. This occurred while between jobs and they chose not to have the Cobra continuation coverage available to them – again a matter of choice. Of the remaining, about 10 million are not citizens, including illegal immigrants.

  Critics point out that as many as 14 million of this uninsured are fully eligible for generous government assistance programs like Medicare, Medicaid, and SCHIP. A study in 2008 by the Georgetown University Health Policy Institute shows that 70% of uninsured children are eligible for either Medicaid, Schip, or both. They just are not enrolling in these programs – for adults and children.

  Skeptics also point out that, according to some estimates, the so-called "crisis" really applies to fewer than 10 million Americans who truly lack long term access to health care coverage. These are "falling through the cracks" and certainly should be part of the focus of any reform we institute.

- *Point:* People without health insurance have no access to care.

  Counterpoint: Among those with comparable incomes, the uninsured get about the same amount of health care as those with insurance once they seek care. Many of those not receiving care simply aren't seeking it.

- *Point:* Insuring people will eliminate uncompensated care.

  Counterpoint: The largest amounts of uncompensated care are generated by Medicare and Medicaid patients. This occurs because Medicaid and Medicare often pay providers less than cost. Eliminating the uninsured by putting them on Medicaid may actually increase the amount of uncompensated care by eliminating

the payments the uninsured make for their own care, increasing utilization and increasing administrative overhead. In the 1990s, Tennessee insured everyone in the state under the TennCare program. The program was supposed to eliminate uncompensated care, but by the late 1990s uncompensated care had increased.

- *Point:* Health insurance is unaffordable for individuals.

  Counterpoint: As one example, in Colorado, a 40 year-old woman can choose from a number of comprehensive health insurance policies that cost less than $100 a month. Adding two children costs about $50 to $100 a month more. The most this woman would have to pay for health insurance, regardless of health status, would be $425 a month under Cover Colorado, the state's risk pool, or insurance plan, for the uninsurable. These are rates available as of 2008. Most or all states have programs for making reasonably priced coverage available to all citizens.

- *Point:* Medicare has lower administrative costs than private insurance plans or private care providers. A government report stated that administrative costs for Medicare are 1.5% of total expenditures, while for private health care it is 25%.

  Counterpoint: Recent information suggests that Medicare administrative costs are similar to those in the private sector. Overhead is not completely a waste. For example, it includes case management for patients with chronic conditions, health education expenses, fraud detection and customer service, areas in which Medicare is notoriously weak.

  The government report is misleading and inaccurate. A study by the Council for Affordable Health Insurance (CAHI) found that Medicare administrative costs were 5.2% compared to private sector care that was approximately 8.9%. PriceWaterhouseCoopers found that only 6% of private health care premiums go to administrative costs and a full 86% of premiums go to providing actual medical care. In 2002, the Washington State Office of the Insurance Commissioner determined that administrative expenses for companies filing annual statements with the state averaged 12.6 percent of overall revenues.

  Part of the confusion here is that the government's official estimate didn't account for the hidden costs of Medicare, and actually hid other costs. For example, the government's official report doesn't include things like the salaries of managers and administrators, or the marketing costs associated with advertising new policies like Medicare Part D drug benefits. Private plans must, and do report all such costs. Additionally, Medicare passes off a great deal of its costs to private payers. And the low reimbursement rates of Medicare and Medicaid end up being subsidized by private plans – some estimate this to be as much as a 10% impact. CAHI found that when all of the hidden costs and certain related unfunded liabilities were included, Medicare and Medicaid administrative costs were significantly higher (26.9%) than the private sector (16.2%).

- *Point:* People are better off if their health insurance policies have lower deductibles and pay for routine care.

  Counterpoint: Buying insurance for predictable expenses is the most expensive way to purchase medical care. Lower deductibles come with higher premiums. Someone spending $10,000 on health insurance with a $500 deductible might be able to buy a policy with a $5,000 deductible for $5,000 a year and save the remaining $5,000 in a tax-free health savings account. The higher deductible makes this plan better if health expenses for the year are less than $5,000.

  The anecdotal evidence that I have read and heard about seems to indicate that if one opts for a high-deductible plan, and then due to health issues you pay most or all of the deductible, the total you expend for the year will be a bit less, but in the same magnitude, as if lower deductible insurance had been purchased. The horror stories come from the fact that the amounts saved on the monthly premiums were not set aside in a tax deductible medical savings account, but rather spent.

- *Point:* Insurance company profits increase the cost of care.

  Counterpoint: There is a great deal of evidence showing that for-profit entities minimize costs better than nonprofit entities. Competitive markets generally make price increases difficult. When that happens, the only certain way to generate profits is to cut costs. In some cases, the efficiencies created by the drive to minimize costs allow for-profit firms to provide services that are better and less expensive than their nonprofit competitors, even though the for-profit entities must pay higher taxes and shareholder dividends. There is no evidence that health insurers are making abnormal margins or profits.

- *Point:* Malpractice lawsuits are essential to protecting patients.

  Counterpoint: In fact, many believe it hurts many and generally reduces innovation and availability of care. One famous serious of lawsuits is held out as an example. Many suits claimed C-sections reduced the incidents of cerebral palsy, and large settlements were obtained. Many personal injury lawyers are still litigating these cases. But some research has shown that the increase of the use of C-sections hasn't reduced cerebral palsy. In spite of this, our friend John Edwards has not returned one cent of the $40 to 60 million he earned by bringing these suits. Fear of lawsuits introduces a "better safe than sorry" attitude which some believe leads to unnecessary procedures. Fear of suits also leads to secrecy.

Drugs and Drug Companies

- *Point:* Drug companies are evil and are price "gougers"

Counterpoint: Given all their "warts" and the many things drug companies do to give us "stomach acid", the business climate in the U.S. has made us the producer of almost 90% of the new drugs coming to market. But there is no doubt, capitalism, like free speech, brings some bad with a whole lot of good.

- *Point:* Drug companies spend more on advertising than on research.

  Counterpoint: Wrong. Investigators for network television reported that while huge sums are spent on advertising, over 12 times as much is spent on developing new drugs.

- *Point:* Expensive prescription drugs is one of the most important reasons for rising health care costs.

  Counterpoint: There is evidence that the real price of prescription drugs is actually decreasing. This is significantly due to the increased use of generic drugs. And drug spending is but a small slice of total health care spending – less than 11% of health care expenditures go to prescription drugs. Moreover, as will hopefully come out in the debate, drugs actually reduce health-care costs in the long run as newer drugs often obviate the need for expensive surgeries and long hospital stays. According to a recent study published by the National Bureau of Economic Research, each dollar spent on pharmaceutical drugs through Medicare saves the program $2.06. One of the most effective ways to lower overall health care costs is to control chronic disease – and drugs have proven to be one of the most effective ways of doing so.

- *Point:* Drug importation could be an important part of the solution to rising costs.

  Counterpoint: Americans are subsidizing the lower cost of drugs in other countries. How? The U.S. drug manufacturers face government controls in those countries and are able to sell into those controlled markets only because we pay the "full freight" here in the U.S. It doesn't seem right does it? Should they refuse to sell anywhere there are such controls? That attitude reminds me of the old movie title "The Ugly American". Also, some other countries have permitted their local manufacturers to undercut the U.S. patent protection laws by manufacturing generics soon after development in the U.S.

- *Point:* Drug companies shouldn't be allowed to charge high prices for new drugs.

  Counterpoint: The only reason we have many new drugs is because of the free market forces in the U.S. Since most experimental drugs fail in clinical trials, the average cost to bring a new drug successfully and safely to consumers is about $1.3 billion. Since Europe and Canada do very little drug R&D, they absorb few of these costs. Investors in the U.S. are willing to make such a risky investment because the rewards of developing a cure for diseases such as Non-Hodgkins Lymphoma, AIDS, or diabetes for example (all recent examples of successful

pharmaceutical research). Without the profit motive, investment and innovation would dry up and "miracle cures" from America would vanish. Thank God for U.S. innovation! Success isn't cheap or easy!

Overall Costs

- *Point:* Because the United States has the highest per capita health care spending, that must mean it "spends too much on health care".

  Counterpoint: Not all higher spending is waste. Wealthier people spend more on health in order to function better, just as they spend more on housing, transportation and entertainment. Countries with lower levels of health care spending have worse health outcomes than the United States along a variety of measures. Within the United States, vacationers admitted to emergency rooms in high-spending areas have lower mortality rates than similar visitors in lower spending areas.

  What is not generally reported is that the United States spends roughly the same percent of GDP on public health care as Canada. This does translate into a higher relative level of absolute spending since the U.S. economy has a higher level of per-capita output than Canada. So, in the U.S., various levels of government spent more per capita on its citizens than Canada - $3,073 vs. $2,590 for the recent period studied. That should surprise the socialist medicine advocates.

  And why, in this debate, is the discussion only about rapidly rising costs. That should be discussed, but what ever happened to a discussion about the dramatic increase in value we have received from our system. We should put things in perspective. According to readily available statistics, the typical American family directly spends just 5.4% of its income on health care, as opposed to 40.8% on housing, 18.3% on transportation, 18.2% on food, and 4.5% on clothing. But to be fair, remember that much of this typical family's health care expenditures, are not directly spent by them – rather, it's paid by their employer or the government.

- *Point:* The U.S. health system spends more money and has poorer outcomes than health systems in other countries.

  Counterpoint: Medical literature shows the opposite. A few examples: lower U.S. infant mortality rates, higher cancer survival rates, better population blood pressure control, lower mortality and morbidity from cardiac disease, better diabetes treatment, more preventive care, and better health and quality of life for spinal cord injury patients. Compared to the British National Health Service, U.S. medical care provides more services for roughly the same expenditures.

  Nevertheless, American does spend a lot on health care compared with most countries in the world. So what! We do it because we can, and most of them

can't – there's nothing wrong with that. Refer to the later section, **Effectiveness of Care.**

- *Point:* Much of the cost increases actually occurs in expanding health-care sectors and adoption of expensive new technologies – drugs, devices, tests, and procedures. Unfortunately, we have gone too far in this expansion because only a fraction of these technologies have proven to dramatically improve outcomes. (Isn't this Tom Daschle's contention)

  Counterpoint: What are our priorities? Do we want to be on the cutting edge of discoveries and advancements? It seems to me that with advances come only after much experimentation and failure. And leadership doesn't come cheaply.

- *Point:* The uninsured get their care at the emergency room, driving up costs for everyone.

  Counterpoint: There are extreme and shocking examples, but a recent look at a census of all frequent users of Massachusetts emergency rooms suggests that ER use by the uninsured is roughly the same as for the privately insured. The Urban Institute has concluded that the uninsured do not use emergency rooms at a higher rate than the insured.

- *Point:* More spending on the indigent will improve health outcomes.

  Counterpoint: Spending on the indigent has risen significantly and there is little evidence of positive effects. It may be time to study how money is spent rather than simply spending more. But surprisingly, disparities between health care access for the rich and poor are lower in the United States than in other countries.

- *Point:* While making a speech kicking off his health care reform, President Obama stated: "The cost of health care now causes a bankruptcy in America every 30 seconds". The figures come from a 2005 Harvard University study.

  Counterpoint: The "fact checkers" went to work on this one – both in 2005 and now after the president once again quoted from the study. First of all, if you add up all bankruptcies in a year, from all causes, you still don't have one occurring every 30 seconds. A more recent study indicates that in 2007 about eight-tenths of one percent of Americans lived in families that filed for bankruptcy as a result of medical costs. That rings a bit more true.

  Also, looking at the Harvard study, those surveyed were asked if medical costs were "a reason" for the bankruptcy i.e. potentially one of many reasons. They weren't asked if medical costs were "the reason". Further, the Harvard researchers "chose" to add into the statistics any bankruptcy filers who had at least $1,000 in unreimbursed medical expenses in the previous two years. Given deductibles and co-pays, that's a huge percentage of those surveyed.

Additionally, they added into the "medical bankruptcies", filings for individuals with gambling problems (an illness I guess). Another example is that if a bankruptcy was caused by the sudden death of a "main wage earning" spouse, that was included as a medical bankruptcy. One of the researchers claim that in his mind, any death is a medical event for purposes of this study. I also found that the lead Harvard researcher is a co-founder of Physicians for a National Health Program, created to promote a government run single payer health system.

Bias in, bias out. Garbage in, garbage out.

Effectiveness of Care

I SINCERELY BELIEVE THE FACTS POINTED OUT IN THIS SECTION ARE EXTREMELY IMPORTANT!

The *"Point"* made in many of the items discussed previously sought derision of the U.S. health care system, often merely on the basis of the U.S. not having a universal care system. The negative results come from "studies" made by the World Health Organization, The Commonwealth Fund, Michael Moore and others. But what happens when medical "outcomes" or results are the specific focus of a study? One good *"Counterpoint"* is presented by the recently published report by the National Center for Policy Analysis (NCPA). Citations for this information are presented on its website.

NCPA came up with the following list of ten "facts" about our health care system which should be considered in any truly objective evaluation of America's health care system:

- Fact One – Americans have better survival rates than Europeans for common cancers. Breast cancer mortality is 52% higher in Germany than in the U.S., and 88% higher in the U.K. Prostate cancer mortality is 604% higher in the U.K. and 457% higher in Norway. The mortality rate for colorectal cancer among British men and women is about 40% higher.
- Fact Two – Americans have lower cancer mortality rates than Canadians. In Canada, breast cancer mortality is 9% higher, prostate cancer is 184% higher and colon cancer mortality among men is about 10% higher than in the U.S.
- Fact Three – Americans have better access to treatment for chronic diseases than patients in other developed countries. Some 56% of Americans who could benefit are taking statins, which reduce cholesterol and protect against heart disease. By comparison, of those patients who could benefit from these drugs, only 36% of the Dutch, 29% of the Swiss, 26% of Germans, 23% of Britons and 17% of Italians receive them.
- Fact Four – Americans have better access to preventive cancer screening than Canadians. Take the proportion of the appropriate-age population groups who have received recommended tests for breast, cervical, prostate and colon cancer: 89% of middle-aged American women have had a mammogram, compared to 72% of Canadians; 96% of American women have had a pap smear, compared to less than 90% of Canadians; 54% of American men have had a PSA test,

compared to 16% of Canadians; 30% of Americans have had a colonoscopy, compared with less the 5% of Canadians.

- Fact Five – Lower income Americans are in better health than comparable Canadians. Twice as many American seniors with below-median incomes self-report "excellent" health compared to Canadian seniors (11.7% versus 5.8%). Conversely, Canadian young adults with below-median incomes are 20% more likely than lower income Americans to describe their health as "fair or poor".
- Fact Six – Americans spend less time waiting for care than patients in Canada and the U.K. Canadian and British patients wait about twice as long to see a specialist, to have elective surgery like hip replacements, or to get radiation treatment for cancer.
- Fact Seven – People in countries with more government control of health care are highly dissatisfied and believe reform is needed. More than 70% of German, Canadian, Australian, New Zealand and British adults say their health system needs either "fundamental change" or "complete rebuilding".
- Fact Eight – Americans are more satisfied with the care they receive than Canadians. When asked about their own health care instead of the "health care system", over 51% of Americans are very satisfied with their health care services, compared to only 41.5% of Canadians; 6.8% of Americans are dissatisfied compared with 8.5% of Canadians.
- Fact Nine – Americans have much better access to important new technologies like medical imaging than patients in Canada or the U.K. An overwhelming majority of leading American physicians identified CT and MRI procedures as the most important medical innovations for improving patient care during the previous decade. The U.S. has several times the number of these machines, per capita, than either Canada or the U.K. Why? The number of these machines has been maligned as waste by economists and policymakers who are naïve about actual medical practices.
- Fact Ten – Americans are responsible for the vast majority of all health care innovations. The top five U.S. hospitals conduct more clinical trials than all the hospitals in any other single developed country. Nobel Prize awards follow a similar pattern.

Despite the serious challenges in our current system of health care, such as escalating costs and uninsured citizens, the U.S. system compares very, very favorably with any other country chosen for comparison.

Young Get "Help"; Old Get the Shaft; We All Get Government

So what's our government been up to lately? Let's start with what Mark Steyn has referred to as the "real war on children". He was referring to the State Children's Health Insurance Program (SCHIP), and feels it's passage would begin turning "free-born citizens into enervated wards of the Nanny State….in Europe its killing their future. Don't make the same mistake here."

SCHIP's original purpose, when enacted in 1997 by a Republican controlled Congress, was to subsidize state governments as they subsidize health care for families too affluent to be eligible for Medicaid but not affluent enough to afford health insurance. It was said to be for "poor children" or children of the "working poor". In 2007, after President Bush proposed a $5 billion increase in SCHIP, the House voted for a $50 billion increase which was then reduced to $35 billion by the Senate's proposal. Bush successfully vetoed this measure because it would have provided assistance to households with income up to $83,000 for a family of four. That's $30,000 above the median household income and 400% of the poverty line. More recently, since Obama came on the job the House passed proposed legislation which would double the funding for SCHIP and make it much easier for states to expand SCHIP eligibility up to almost $85,000. And with the ability to subtract certain rent, mortgage, heating, food, transportation, or some combination thereof, this proposed legislation could possibly benefit some families with incomes over $100,000. The bill also covered illegal immigrants. The overall increase was almost $33 million. The House and Senate finally agreed on a final version and President Obama signed it into law.

Why all this fuss by the liberals to reach so far to provide assistance to middle and even upper income families? For Grace-Marie Turner, a student of health care policies, it makes all the sense in the world if your goal is to quickly get as many people on public health coverage as possible and to have children even from higher income families grow up thinking that it is normal for them to get their health insurance from the government. That's really the unspoken goal. Score one for the supporters of universal health care.

Tom Daschle may have withdrawn as nominee to head the Health and Human Services Department, but his fingerprints are all over the health care provisions of the president's so called "stimulus" (spell that S-P-E-N-D-I-N-G) bill. It includes provisions whereby medical treatments will be tracked electronically by a federal system. And there's a new bureaucracy, the National Coordinator of Health Information Technology, which will monitor treatments to make sure the doctor is doing what the federal government deems appropriate and cost effective. These provisions are almost identical to what Daschle wrote in his 2008 book about the "health care crisis". What else did that book say? Perhaps we should look into it to see what to expect in future health care legislation.

In his book, Daschle proposed an appointed body with vast powers to make the "tough decisions elected politicians won't make". The stimulus bill calls this function the Federal Coordinating Council for Comparative Effectiveness Research. Mr. Daschle explains the goal as to slow the development and use of new medications and technologies because they are driving up costs. He praises Europeans for being more willing to accept "hopeless diagnoses" and "forgo experimental treatments", and he chastises Americans for expecting too much from the health care system. What? Be like Europe and relinquish our enviable and proud position as medical technology leader in the world. Is it so bad that Americans expect miracles? Is it better to be like Europe and expect mediocrity? He doesn't want us on the cutting edge! How can acceptance of mediocrity be so easily swallowed?

Daschle explains that reform "will not be pain free" – especially for senior citizens. His position is that seniors should be more accepting of the conditions that come with age instead of treating them. That means the elderly will bear the brunt of cost savings, apparently. According to Betsy McCaughey (former New York lieutenant governor and now with the Hudson Institute), the now legislated Federal decision making council "is modeled after a U.K. board discuss discussed in Daschle's book. This board approves or rejects treatments using a formula that divides the cost of the treatment by the number of years the patient is likely to benefit. Treatments for younger patients are therefore more often approved than treatments for diseases that affect the elderly, such as osteoporosis". Remember the movie "Solient Green" – scary! Ms McCaughey goes on to say: "the bill treats health care the way European governments do – as a cost problem rather than a growth industry". I have trouble believing this – but I do believe it!

I love Charles Krauthammer's commentary. He always expresses things simply and with great insight. He took a slightly different approach when he recently wrote: "Obama wants to be to universal health care what Lyndon Johnson was to Medicare". But Charles doesn't think Obama will try to do this directly. Rather, while the president has publicly abandoned pushing hard for a single payer system like Canada and Great Britain, he will create a middle step, like the above legislation, that will ultimately and inevitable lead to a universal/single payer system. Charles predicts that Obama will merely create a government-run plan that is relatively attractive in price and benefits, while leaving the private insurance sector intact – hence Obama's "public/private" partnership approach. But his government plan will, in the short run, be so attractive as to starve the private side of the partnership – people will slowly migrate to the government plan. The ultimate and inevitable result is socialized medicine – but it will take a while – slow and insidious – with Obama recognized as its father long after he leaves office.

My Opinion on Reform

Commentary

First of all I am completely satisfied with the evidence I have found and presented debunking the "oft' quoted" projects by the World Health Organization, The Commonwealth Fund, and everyone's "hero", Michael Moore. Their points were addressed earlier and shouldn't be part of finding real improvements to our health care system. We have a system we can be proud of in many, many ways. Yet it is flawed and can be improved.

The work done by the National Center for Policy Analysis (NCPA) has been most helpful to me. Their report, *State Health Care Reform: Key Questions and Answers*, was very helpful in developing my position. I also reviewed other NCPA reports, most recently their summary of ten "facts" about the U.S. health care system. Perhaps the most instructive source I used was the recent book published by the Pacific Research Institute, *The Top Ten Myths of American Health Care* by Sally C. Pipes. This report doesn't just attempt to clarify distorted facts; it deals with how to reform/improve a fine, but flawed,

U.S. health care system. And no one should skip over the Heritage Foundation as an excellent source of information about important issues like this.

I think it's important to note that the health care reform debate is NOT mainly about access to medical treatment since a level of access is already guaranteed to all by federal law. Specifically, *The Emergency Medical Treatment and Active Labor Act* (EMTALA), a federal law enacted in 1986, requires hospital emergency departments to treat emergency conditions regardless of a patient's ability to pay. That's just one aspect. As we all know, basic care is also available under Medicaid benefits. Any reform must deal effectively with those who are chronically uninsured for two years or more – those that have truly "slipped through the cracks". Most Americans agree that everyone should have access to affordable health insurance coverage. But the debate really is centered on who will pay the costs of medical care and by what arrangement.

Sally C. Pipes of PRI, a well-known expert and writer on health care reform, categorizes reform proposals into two competing visions: one focuses on government, mandates and taxes; the other focuses on markets, consumer free will, and innovation. The first promotes universal coverage, the second promotes universal choice (a new term).

The key elements of sound health care reform are competition, consumer control, and free market influences. Many of our problems, of which some are serious, stem from departures from free market principles, tax manipulations in the system, costly insurance mandates, and bureaucratic interference. Well over 50% of all health care expenditures are made by government. Also problematic is a lack of spending "consciousness" by consumers resulting from 6 of 7 dollars being spent by third party reimbursers. The central focus of any serious reform effort should be a vibrant and competitive free market for private health care, with a wide choice of physicians and treatments and a variety of ways to pay for them. There should also be a competitive market for private health insurance, one that offers a wide choice of health plans.

Consumer-directed health care initiatives, under which individuals manage some of their own health care dollars through systems such as Health Savings Accounts (HSA), are superior to traditional first dollar coverage, especially under insurance programs designed and controlled by government. There is considerable evidence that consumer-directed programs reduce costs. When the cost of health care drops, health insurance premiums drop, and paying cash for care becomes easier. Paying cash for some services further reduces costs by eliminating the overhead costs of third-party payment systems. There is no evidence that expansion of government health programs decreases costs. In fact, there is evidence that such programs actually increase costs.

But will there be further incursion of European/universal style health system influence in our own country? Maybe not in the long term. One large company which is a major consultant to U.S. health care facilities actually detects a slow movement of the world's health systems toward more of a U.S. style system. We shall see if that comes about, considering the Obama administrations strong bias in favor of a universal system.

While America's current health system has clear strengths, it also has significant things to correct. For all the success at helping people live longer and healthier lives, America's system seems too costly, confusing, inefficient, and uneven in its results, and it leaves too many people without adequate access to its benefits. Correcting those faults while maintaining the history of innovation and creativity is what we must achieve.

Summary of Reform Elements

Ultimately, I have to offer suggestions, not just criticize. Here is a summary of my ideas for a workable plan for health care reform:

- Individuals should be the key decision makers in a reformed system. Individuals, not employers or government, should buy and own their own health coverage.
- Individuals should have periodic opportunities to change health coverage.
- Prices for coverage, services, or products should be transparent to the individual.
- We must maintain a free market system of providers, insurers, technology development, pharmaceutical development, manufacturing of equipment and drugs, and marketing of all these products and services. This must occur!
- We should change the tax code to allow all medical related expenditures, up to a generous maximum, to be deductible (not limited by a percentage of income). Or we could consider a refundable tax credit. This should include encouraging vehicles such as HSA through the tax code and permit the consumer/owner of the HSA to build a tax deductible/tax sheltered "next egg" to be used in future years and during periods of unemployment.
- Any new tax incentives or health care policies should encourage what I consider the reform most likely to make a difference – the widespread use of HSAs in tandem with an inexpensive, qualified, high-deductible insurance policy designed to cover major medical or catastrophic costs. All of this should be encouraged through a combination of generous tax deductibility and refundable tax credits.
- We should consider the prudent implementation of limited direct tax credits for certain other expenditures. Since taking care of children is such a "hot button" (witness SCHIPS), we could implement limited tax credits for health care expenditures for persons under 21 in families below the median U.S. income.
- How should we deal directly with our approximately 47 million uninsured?
    1. We should aggressively deal with the chronically long-term (e.g. over two years) uninsured through a system like Medicaid and fund adequately – recipients would pay only nominally. We should onsider the creative use of vouchers for an insurance pool set up for just this purpose. This would encompass at least 10 million people – the most important 10 million!
    2. We should deal with transitional uninsured (between jobs or temporarily unemployed) with a system like Medicare, and fund it adequately. Payments would be made by the insured with generous tax credit provisions. There should be a time limit for coverage under this plan.
    3. There is an element that, for various reasons, chooses to roll the dice and not spend for health care coverage – even though they could afford it. The approach I suggest should convince many that these provisions make

coverage cheaper, more attractive and they would buy it. This is where use of HSAs, unbundled major medical coverage, tax deductions and credits, price transparency, etc. would make a difference in the number of uninsured. But you can't mandate "smarts".

4. We should agree to disagree, at least for now, and limit illegal immigrants to taxpayer paid coverage provided in hospital emergency rooms or at walk-in centers only. Any person residing in the U.S., however, could purchase their own coverage on the open market.

I believe this would deal with those currently uninsured in a "smart" way.

- Government (usually state) mandates for insurance coverage should be eliminated and we should move closer to a "shopping cart" approach to buying insurance. This will allow insurers to offer a range of plans – from basic/lower cost to comprehensive/higher cost coverage – which will meet a variety of individual needs and preference while making access much more affordable. This will effectively reduce costs. Mandates are estimated to increase the cost of health care for a typical individual by 50%.
- Individuals should be allowed to buy insurance across state lines. State borders now act as unnecessary regulatory walls. This will permit shopping among a robust variety of insurers. They all currently exist, we just can't access them outside of our state of residence.
- We should prevent ridiculous and inequitable "out of network" provisions used by many insurers today.
- Tort reform should occur by eliminating abusive and unnecessary lawsuits and settlements. This should include a cap on non-economic damage awards.
- Health care providers should be allowed and encouraged to offer affordable care at convenient locations such as retail clinics at malls, walk-in centers, etc.
- All persons using emergency rooms or walk-in centers would, as part of their treatment be directed to the parts of our system which they could benefit from but about which they are uninformed.

Sources of Information

This is not intended to be a bibliography or list of notes and references which would be adequate for publication or other wide use of this report. I have given specific attribution to very few quotes and statistics. Therefore, this report is in a state of "technical plagiarism". The following lists are intended to relay the nature, extent, and sincerity of my effort to become personally more knowledgeable. I hope they lend some measure of credibility to the information provided. The items below are listed in no particular order.

Books, Papers and Studies (and one Documentary Movie) (Approximately 60% were obtained and reviewed entirely. For the balance I reviewed summaries or excerpts)

The World Health Reports – Published by the World Health Organization

U.S. Health System Performance: A National Scorecard by Karen Davis, Ph.D. et. al. – Published by The Commonwealth Fund

Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care by Karen Davis, Ph.D. et. al. – Published by The Commonwealth Fund

The Top Ten Myths of American Health Care – A Citizen's Guide by Sally C. Pipes, Forward by Steve Forbes – Published by Pacific Research Institute

Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market by Edmund F. Haislmaier – Published by The Heritage Foundation

Americans at Risk: One in Three Uninsured – Published by Families USA

A Framework for Medicare Reform by John C. Goodman, Ph.D. – Published by National Center for Policy Analysis

Critical: What We Can Do About The Health-Care Crisis by Tom Daschle

Critical Error: Tom Dashle's Blurred Health Care Vision by John R. Graham – Published by Pacific Research Institute

Reforming the U.S. Health Care System – Published by National Center for Policy Analysis

10 Surprising Facts about American Health Care by Scott Atlas – Published by National Center for Policy Analysis

Ranking Health Care in the States: The Most important Input is the Patient by John R. Graham – Published by Pacific Research Institute

Health Care Reform: Do Other Countries Have the Answers? by John C. Goodman, Linda Gorman, Devon Herrick, and Robert M. Sade, MD – Published by National Center for Policy Analysis

Single Payer: It's Time to Have Hope by Sara Rogers

What Government Does Better: Health Care by Howard A. Green, MD, FACP, FAAD, FACMS – Published by Physicians for a National Health Program

Ten Ways to Trim Your Health Care Costs by Devon Herrick, PH.D. – Published by National Center for Policy Analysis

Why the American Health Care System Needs Reform
Understanding Health Care Reform – Rethinking the Business of How Americans Receive Their Health Care

What is Universal Health Care Coverage? – It's Not the Same as Single Payer Healthcare
What is a Single Payer Healthcare System?
What is the Difference Between Universal Healthcare and a Single Payer System?

These 6 items were all written by Trisha Torrey for About.com, a patient empowerment organization and website.

U.S. Cancer Care is Number One by Betsy McCaughey – Published by National Center for Policy Analysis

Medical Malpractice Reform – Published by National Center for Policy Analysis

Health, Politics and Revolution in Cuba Since 1898 by Katherine Hirschfield

10 Myths About Canadian Health Care, Busted by Sara Robinson – Published by Physicians for a National Health Program

Mythbusting Canadian Health Care, Part II: Debunking the Free Marketeers by Sara Robinson – Published by OurFuture.org

Sicko (documentary movie) – with Michael Moore as writer, director, producer and star

How to Fix Health Care Delivery in the United States by Tor Dahl

From Heart Transplants to Hairpieces – The Questionable Benefits of State Benefit Mandates for Health Insurance by John R. Graham – Published by Pacific Research Institute

Medicare Spending Across the Map by Amy Hopson and Andrew J. Rettenmaier – Published by National Center for Policy Analysis

American Health Care: Government, Market Processes, and the Public Interest – Edited by Roger D. Feldman

California's Newest Chronic Disease: "Preventionitis" by John R. Graham – Published by Pacific Research Institute

The Stealth Mental Health Parity Act: An Attack on Innovation and Choice in Health Care by John R. Graham – Published by Pacific Research Institute

Escaping From Unhealthy Health Care Dependency: Lessons From Down Under by Diana M. Ernst – Published by Pacific Research Institute

Health Care Policy and Freedom – Published by The Heartland Institute

SCHIP Bill: Top 10 Changes for Congress to Consider by Dennis G. Smith – Published by The Heritage Foundation

The New SCHIP Bill: The Senate Must Protect Private Coverage by Paul L. Winfree and Greg D'Angelo – Published by the Heritage Foundation

Pharmaceutical Price Regulation by Joseph H. Golec and John A. Vernon – Published by American Enterprise Institute

State Health Care Reform: Key Questions and Answers by Linda Gorman and R. Allan Jensen – Published by National Center for Policy Analysis

Ensuring Access to Affordable Health Insurance by Stuart M. Butler, Ph.D., and Nina Owcharenko

Crisis of the Uninsured (several annual reports) by Devon Herrick – Published by National Center for Policy Analysis

The Doubt of the Benefit: Why State Benefit Mandates are a poor Prescription for Health Insurance by John R. Graham – Published by Pacific Research Institute

Understanding the Tax Implications of Single-Payer Health Care by Jason Clemens and Adam Frey – Published by Pacific Research Institute

Is Health Care Spending Out of Control? by Eugene Steuerle, Ph.D. – Published by Pacific Research Institute.

Medical Bankruptcies: A Data-Check – ABC News Blog

Who Should Pay for Health Care? by Sally C. Pipes – Published by Clare Boothe Luce Policy Institute.

Miracle Cure: How to Solve America's Health Care Crisis and Why Canada Isn't the Answer by Sally C. Pipes – Published by Pacific Research Institute

Calls to Inaction? Three New Books on Health Reform by Diana M. Ernst – Published by Pacific Research Institute

Next Steps for Health Savings Accounts by Diana M. Ernst – Published by Pacific Research Institute

Canadian Health Care We so Envy Lies in Ruins, Its Architect Admits by David Gratzer – Published by Investors' Business Daily

Ruin Your Health With the Obama Stimulus Plan by Betsy McCaughey – Published by Boomberg.com

Writers, Columnists, Commentators, Educators, Scientists, Reporters and Editorial Sources From Which Material Was Used (often multiple items for each, most relatively brief - some are experts but most are not):

Thomas Sowell	Walter Williams	David Brooks
Betsy McCaughey	David Gratzer	Linda Chavez
Wesley Pruden	Mark Steyn	John Stossel
Michael Moore	George Will	Erica Werner
Charles Krauthammer	Ricardo Alonzo Zaldivar	Steve and Cokie Roberts
Michael Arnold Glueck	Andrew Taylor	Tom Purcell
Kevin Freking	Philip Elliot	Andrew Sullivan
Mona Charen	David Broder	Nina Owcharenko

Websites and Online Newsletters or Publications - Most Monitored Regularly / Some Specific to This Project Only

Pacific Research Institute	The Heartland Institute	The Economist
The Heritage Foundation	ABC News	The Spectator
New York Times	Politico	Wall Street Journal
Conservative Book Service	The Commonwealth Fund	The Weekly Standard
American Enterprise Institute	National Review	Jewish World Review
American Enterprise Institute	World Health Organization	Real Clear Politics
Bloomberg.com	Associated Press	City Journal
The American Spectator	The Progressive Magazine	The Nation

Council for Affordable Health Insurance
National Center for Policy Analysis