Chapter 12

Proposal for Reduced Cost Medical Care

Preface

Health care is not a right. As such it is neither protected as an enumerated nor inferred right under our Constitution. Still, health care is a necessity. The preamble to the US Constitution states that among the purposes of establishing the Constitution is: "*to promote the General Welfare*." But, regardless of how you might want to interpret the words, in its historical context, promoting the General Welfare was in no way ever intended to imply that the Federal Government should be responsible for the health care of the American people.

But, a healthier population does promote the General Welfare. And, it can be argued that a healthier population leads to a more prosperous and happier nation. A healthier population is also a stronger population. High cost and frequent geographical scarcity of facilities produces an inaccessibility to health care for many citizens. It is incumbent upon the central government in conjunction with the states to investigate some manner of underwriting health care; which to a certain degree it already does. Government on all levels underwrites healthcare through municipal and state clinics, on-demand emergency care, Medicare, Medicaid, TRICARE and other government reimbursed insurance programs - and in the case of military hospitals, actually provides the care. The aim then is to aid in developing geographically accessible health care underwritten in some form for all qualified U.S. citizens, in a much more efficient and much less costly manner than is currently done.

This proposal on medical care might be considered radical because it provides government funded medical care for all citizens who want it. The important

distinguishing characteristic of this plan from other government run proposals is that the delivery of medical care in this instance is not government "managed."

The single flaw in this system, as in any large system, is that it is susceptible to fraud - but, even private insurance is susceptible to fraud. An awareness of the propensity of certain people to raid the candy dish, demands that adequate prevention and oversight be created. The fraud that would be most possible, just like the fraud in private insurance programs, is doctor initiated fraud. Oversight of this aspect of the system could be accomplished without direct intervention in the actual medical treatment of particular individuals.

The design of the system does not allow for any direct connection, medical or otherwise, between the individual citizen and the government via a vis the delivery of health care. All medical decisions are left to the attending doctor. And, even within the context of the guidelines of allowed procedures, doctors have the last word on medical care and are free to do whatever they feel is best for the patient. Any revelation of medical information could only be made public by the patient, if for some reason they felt it necessary. Case numbers for medical treatment reimbursement to the local counties will not contain the patient's name. All personal information will remain with the doctor and the medical office and / or institution.

The program effectively removes an entire layer of government bureaucracy in the delivery of Health Care, and the savings yielded because of the reduction in overhead costs would be passed on to the underwriting of actual medical care. This proposal, admittedly controversial, was constructed with the intention of making available the delivery of health care services to all citizens, taking into consideration the unaffordable cost of many health care procedures - and looking at the benefits to the overall health of the nation by making medical care as ubiquitous as possible. The benefits of improved health care were also looked at in terms of reducing lost productivity due to preventable medical conditions;

especially degenerative conditions that could be prevented with earlier intervention. A large part of the cost savings is the result of the mentioned reduction of bureaucracy and middlemen in the delivery of health care. The removal of wasted spending on clerical work and the elimination of bloated profit would yield more available health care with less cost than we have today.

As an example of the extravagances in the delivery of health care, the following is one example of what exists throughout the entire system. During the research for this proposal, a cost difference was discovered in the consumer price of a 'prescription only' dental mouthwash. The wholesale cost to the dentist was $17.00. His selling price was $30.00. The cost at a chain pharmacy was $87.00. The cost at a competing chain store with a pharmacy was $4.00 - a cost difference of $83.00. Yet, only recently I discovered that through Doctor Josh Umbehr's Atlas MD, the same 'prescription only' mouthwash was sold to their patients for $2.75.

Doctor Umbehr has been able to negotiate with pharmaceutical companies and has been able to purchase drugs at a cost reduction of as much as 95% below general retail market prices. This includes sophisticated life saving drugs, which many people usually find cost prohibitive. One could only imagine the buying power of a group with 300,000,000 members. Additionally, Doctor Umbehr feels that 90% of all medical procedures do not require insurance coverage, and he has established a medical care program that is extremely reasonable and allows for multiple visits and provides for basic medical procedures. He says he is "...*able to shrug off the burdens and restrictions of government and insurance regulation so he can focus solely on his patients and their needs."* He has assisted many other doctors establish similar groups throughout the country. It is this type of creative approach to savings in medical care that would make a government reimbursed doctor managed delivery of medical care system very cost effective.

Incomprehensible cost differentials in service, equipment, appliances and drugs are not uncommon throughout all aspects of the health care system, and much of the costs are mandated and driven by the Federal Government's current health care systems in conjunction with insurance companies' medical insurance programs.

While the Founders never intended the Federal government to underwrite the delivery of health care to the entire country, the health care proposal is very much in agreement with the intentions of the Founding Fathers, who when scripting the Constitution, very clearly stated:

> *"No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken."* [*]

The Founders didn't want the sheriff coming around to collect taxes - which is exactly what we have now. Most people complain about the IRS and its inordinate invasiveness and authority. This proposal, like the More Fair - Fair Tax, effectively eliminates any requirement for government agents to come into direct contact with the individual citizen pursuant to the operation of the program.

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This proposal will be met with some approval by those who believe that health care should, in one form or another, be the responsibility of “the government”.

This proposal will be met with severe disapproval by those who believe that health care should in no way be a concern of the central government - and that the cost, management and consequential information gathering associated with health care is a dangerous expansion of the central government and an additional and dangerous intrusion into the lives of the individual.

The structure of the proposal guarantees the availability of health care to all citizens without an expansion of the central government's power over the individual, and without imposing upon the individual undue government scrutiny or control. It also produces no constraints upon the medical practitioners, and in fact allows them more latitude in providing the most necessary and least wasteful care than what exists today under Medicare and other programs. In this proposal there is extremely limited, if any, intrusion into the people's liberty. The total outlay from the treasuries of the Federal Government and the states will be relatively little more than what is being allocated for the broken system we now have. There is also the possibility that when all unnecessary medical cost generators are reduced or removed. government's bill for medical care nationwide will be reduced. And, most beneficial, the end result will be a better delivery of healthcare, and healthier and happier citizens.

Obtaining health care is not a concern for everyone. Among the citizenry there are those who can afford health care, either by paying directly or through insurance coverage. Under this proposal, those individuals or families who can afford to do so, will still have the option to purchase the most comprehensive private insurance coverage they want, yielding them, if they want to pay for it, a luxurious delivery of care at the level they want. For the rest of us, a good doctor, a good nurse and a clean bed in an airy room would be enough. Currently, there are those that have insurance policies through their employment. Depending upon their size, companies who currently underwrite insurance as a benefit will decide either to continue the insurance, or to cover only supplemental costs or possibly eliminate insurance coverage altogether. Insurance through employment should be an employer incentive as part of a benefits package and not a mandated requirement.

As regards the cost of health care to the nation - like it or not we are all paying for health care in one form or another. We either pay for it directly out of pocket, at a

higher rate than those paying for the same services under a health insurance policy, or as Federal and state taxes to cover the payments made to Medicare, Medicaid, the VA, TRICARE or other government sponsored federal employee programs. We pay for it through higher costs of goods and services because of employer contributions to an employee's health care insurance. We pay for it with lost production hours because of untreated illnesses due to the inability of many citizens to pay for medical attention. We pay for it as a direct result of the massive fraud that festers in the reimbursement systems of the current Federally managed health care programs, and from what can only be described as 'profiteering' from elements in the medical care delivery system from the bottom to the top. We also pay for it as the result of elevated end of life medical costs due to chronic conditions that needed to be addressed much earlier.

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There are American citizens for whom the expense of paying for medical care or the expense of purchasing medical insurance is an inconsequential matter. There are others who can afford the cost of substantial medical insurance, and although it is a relatively large consideration relative to their earnings, they can manage to have all their medical costs covered, even in some situations where drastic or extensive medical care is required. There are many who cannot easily afford decent medical care, and the cost of medical insurance is a heavy burden; and what they spend on insurance is a severe drain on their income and acts as a deterrent to their ability to invest in improving their life and the lives of their children - and in the event of a catastrophic event requiring expensive services, they are unable to cover their medical obligation; and the ensuing debt will force them to severely alter their lifestyle, not just the purchase of non-essential amenities but basics such as food and housing - and may even force them into unmanageable debt and bankruptcy. There are those who flat out cannot afford medical insurance, and in the event of any illness they go without anything other than lifesaving emergency care, which may be provided by some institution, but the payment of those lifesaving services may remain unpaid and uncollectible

and will eventually be written off by the medical facility and physicians who provided the services. In turn, under the current system, these unpaid medical bills raise the cost of medical care for everyone else.

In the United States there are citizens whose medical care is either partially or fully covered by government programs such as Medicare, Medicaid, and the Veteran's Administration. The VA basically covers veterans. TRICARE is for retired military personnel and military families, and TRICARE for Life is supplemental to Medicare for those retirees over 65, covering medications and co-pays. But in this case, eye and ear related problems are left unaddressed.

There is the problem of the many foreigners here illegally who have received emergency medical care, which all hospitals are required to provide, regardless of a person's ability to pay. Some hospitals devise ways to avoid accepting some emergency care by sending them up the road. There are also those foreigners who have learned how to scam the system, or who have been invited by certain states to receive, free ongoing non-emergency medical care - at great cost to the American citizen taxpayer. This has become a politicized blind cost hidden in the burgeoning maze of state and national debt. The cost to state-federal health insurance programs for the poor is about $2 billion a year for emergency treatment, for a group of patients who, according to hospitals, mostly comprise the class of immigrants who have learned to scam the system. Added to this is the cost to hospitals for what is termed "permanent patients," illegal aliens who have no relatives, insurance or an established address where they can go once released, and so they wind up in long term care in a hospital. [1]

Any proposed 'single payer' plan adds large bureaucratically driven systems for the payment of medical care, and does nothing to reduce the cost of that care, much in the same way that Medicare has not kept down the cost of medical care, which it might be able to do to some degree if doctor's and hospitals did not have to deal with insurance companies. It is undeniable that hospital costs are

egregiously high. In fact even pre - Affordable Care Act medical care demanded costly billing personnel to be added to a doctor's office and increased the doctor payment departments in insurance agencies. Billing management of Medicare and private insurance programs created a large expense for doctors. General Practitioners who preferred to opt out of accepting medical insurance found it very difficult to do, and almost all doctors had to enlarge their office staff to deal with the insurance paperwork, or join a medical practice group with a shared billing staff. The winner in all these schemes that utilize medical insurance as the means of providing health care is the middle man, the insurance company. It is unconscionable that under the ACA, scores of US citizens who cannot afford health insurance and are not eligible for a government subsidy are penalized for not having enough money. Talk about insult to injury. This is about to change. But, the overall change in any program adopted, will still be focused on making insurance affordable, not dealing with the underlying cost of medical care.

The fact is that many people in this country cannot afford insurance that would guarantee basic medical services, let alone the cost of major surgical procedures and hospitalization. Go to any county court when collections are being handled for unpaid debt. There is a frightening large number of people being sued by hospitals for nonpayment of bills. These collections do not come free, and the legal costs, collection costs and write-offs for medical service providers add up. At its core, insurance coverage is an added layer of costs in providing medical care. On the other hand, any single payer system, as currently conceived, would add greatly to the already costly Federal health care bureaucracy and create more government intrusion into the life of the individual citizen.

In general, along with finding an alternative cost efficient and practical way of delivering heath care, the major focus of any reform to the health care system must be to find a way to bring down the cost of health care. That goal must be kept in mind when reviewing the health care solution that I am proposing.

Free is when someone else pays for what you get

Currently in the United States medical care is extremely expensive. There is a need for less expensive care for basic medical services such as: emergency services that save lives; general care which cures existing illnesses or prevents future illnesses; surgical care to mend or correct wounds due to injuries or unforeseeable medical conditions; and care for the general array of debilitating physical maladies that constitute the human condition. I also include as part of medical cures and preventatives, certain dental procedures and mental health counseling that promotes wellness.

The Affordable Care Act does very little if anything to address the cost of medical care. It is a medical insurance scheme, designed to buy insurance, not to reduce the cost of that insurance - except when it provides certain individuals with taxpayer subsidies from the general coffers; administered by an expensive bureaucracy. In fact, the mandated requirements under the law have increased the price of insurance by mandating that everyone underwrite the cost of procedures for everyone else, even for procedures that will never be necessary for large groups of people. For example the ACA program requires , a young single male to underwrite the cost of maternity care, among other things he doesn't need or won't need for many years down the road. Whatever program is eventually adopted by the new Congress will still saddle the American people with high medical care costs. Little creativity has thus far been shown in proposed changes to the delivery of health care.

In many instances, doctors are culpable of prescribing too many tests, anti-biotics, and drugs in general. The number of drug reactive related secondary illnesses is untold, and the number of deaths is somewhere around one hundred thousand a year. Besides being a somewhat nauseating statistic, the medical attention these unfortunate victims require on their way out is very costly. Add to

that the cost of lawsuits for these drug reactions, and it adds to the overall mess of medical care in the U.S.. In an environment in which a doctor in a medical group is expected to generate billing income like a lawyer in a law firm, turning a set number of patients each hour, giving each patient something like 10 minutes, it is easier and more cost effective to prescribe symptom relieving drugs and prescribe a test rather than do a hands on diagnosis. There are few if any real diagnosticians any longer. The day of the visit to a GP with an internist background may long be gone. The test result reader has replaced them.

The time worn alternative proposal to any private insurance based system is a Federal Government operated Single Payer Plan.

Some of the conclusions presented herein are based on information derived from discussions with doctors, nurses and hospital workers, personal experience, and several published sources, including an Aetna Insurance Company study originally compiled by Aetna subsidiary Schaller Anderson. And, while the study potentially may be biased, many of its conclusions are interesting, and they are reflected in this section. Although, some explanation for the high cost of health care has been presented, the essence of this offering is not a dissertation on health care costs, more so it is a preface to the health care proposal hat has been put together. That is to say - we all know health care is very expensive - and the prefatory comments are merely setting the stage for the proposal by trying to bring some elements of the cost of health care into focus for the sake of the discussion. For a more in depth look at what is driving up health care costs, some of the sources in the citations below make for some very interesting and informative reading.

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Driving up the cost of Health Care in the U.S.

Before looking at what drives up the cost of health care, we really should consider exactly what constitutes health care. Many things have changed since

the beginning of our republic. What has not changed is the tug of power between people, and people and their government. Since time immemorial some people have been honest. Some have been cheats, and some have been out and out crooks. Government s composed of people and is heir to the same morality, immorality, honesty, dishonesty, altruism and corruption as exists in society in general. It is so, was so, and always will be so, regardless of the utopian dream peddlers preying upon our expectations, stealing our will and our initiative, and putting us into debt. The grab for power and profit by those with access to government was well understood by those that had just shaken off the yoke of the English king after the Revolution. At the time of the creation of the expanded, more powerful second central government, it was felt that the less intrusion into the individual citizen's life that the government could perpetrate, the better it was for the citizen. In fact, this philosophy is the fountain of the American creed of individual responsibility, and is the soul of the liberty that was so cherished in putting together our country's structure.

What has not changed are people's needs, but what will satisfy those needs has changed.

People who are ill want to be cured of their illness. And, although many illnesses have not changed, their diagnosis and an understanding of their pathologies have changed; and having a clearer picture of what ails us, we inherently have a greater expectation of being cured. As recently as the 1920's, before the advent of Penicillin and other antibiotics, illnesses such as pneumonia and many infections, were usually fatal. It was not a matter of the cost of a drug that prevented someone from getting the drug, it was that there were no drugs to be gotten. Well, drugs cures don't come free, and the more cures we have, the more opportunity there is to spend money on them. On the other hand, some illnesses that are rampant today were hardly noticeable in the course of one's life even just one hundred years ago. In fact, because of the many new cures and live saving procedures, we tend to live longer, and with that comes increased odds of

encountering illnesses in our old age that might not have been encountered by the shorter life of our progenitors.

In a fascinating novel, "*A tree grows in Brooklyn*", there is a wonderful view into a world we have just recently left behind. Through the story we experience the lives of a poor family at the turn of the 20th century, and as part of the story there are illnesses and a need for medical attention. This Brooklyn family, has very limited expectations of receiving any form of sophisticated medical assistance, neither a cure for the loving but drunken husband who eventually succumbs to alcoholism and pneumonia, nor help for the widowed wife who will give birth at home, with only the help of a sister and her young daughter. The only outside help they get is from a friend or two and a helpful policeman who befriends the family in an unofficial capacity. Their lot is to do without. There is no government to step in and magically help them. Today, the state would have the children removed from the home and the mother whisked off by ambulance to a hospital for maternity care. Somehow, the family survives, and the daughter grows up to write about her experience. The characters understand their economic position and look to themselves for whatever help and joy they can garner. We observe the frugalness that the mother employs in trying to meet their obligations; and in spite of a continuing veil of poverty and desperation that hangs over them they live their lives hoping for and achieving happiness.

Again, trying to gain a perspective of where we recently were and where we are now, I would like to revisit the past for a while longer, relating a time, several years ago, when I took my wife to visit my old 'block' in the South Bronx. My old apartment house was still there on Longfellow Avenue. The building was seedier. The outside doors had metal security screens over the windows and the hallways were dirtier than they were when Tony Matteola was the super, and there was a mix of first generation American families living in the building. The brown paint on the apartment doors seemed to have been applied heavily with little care for the brass hardware. I took a chance seeing if I could show my wife the apartment

that we lived in. We were invited into the apartment, which was occupied by a Puerto Rican lady and her nephew. The lady was very congenial and pleasant. It turned out she didn't have a job, and spent her time taking care of the boy, living on government assistance. The boy had medical conditions. He was on mood controlling drugs and from what I understood they both spent much of the day in front of a 40 inch TV screen with cable hookup, substantially different from the 10 inch Admiral that my folks bought in 1950, which was mostly used when I came home from school to watch Howdy Doody, and on Tuesday night when the entire building came into our apartment to watch Milton Berle. I pointed to the spot where the armchair and the folding chair was located when we watched Bobby Thompson hit his 9th inning home run to beat the Dodgers for the 1951 Pennant. I could almost still hear the screams. The city had enlarged the apartment and there were now two bedrooms instead of the one that my sister and I shared. My folks slept on a fold out couch in the living room. I tried talking to the kid about karate and exercise and proper diet - anything holistic that I thought was appropriate. I don't know how much good it did. I assume the behavior problems he was having are today still being controlled by expensive anti-psychotics or some such.

As we exited the building I stood by the stoop and tried to picture Henry Applebaum who owned the corner 'candy store' and greeted me lovingly with a big "Hello Yussel" when I came in for an egg cream or a lemon and lime soda - both made in a two cent paper cone cup ensconced in a stainless cup holder, and always with a long mixing spoon stirring the mix as he artfully added the seltzer from the counter soda dispenser. My eyes watered a bit with the remembrance of that time, which while we were somewhere between poor and working class, was very warm and wonderful. My mother had contracted polio when she was a child, and it left her face disfigured for life. She sadly and regrettably left junior high when she was sixteen and went to work. My father started working when he was twelve. Neither had the free college that Bernie and Barack and even my own governor are demanding for everyone. My mother

stopped working and raised the kids. My father worked long hours at everything from pushing a clothing rack in the garment center to hacking in New York. By the end of his life he was a business owner and well off, and retired to a condominium in Florida along with many of his business partners

The life of the average citizen has changed dramatically from what it was only fifty years ago. And while the poor, as a class, exists today, their lives are different. In many ways lives today should be healthier, but in many ways lives today have become much less healthy. The simple home cooked diet of the working poor, and of many Americans in general, has been replaced with less healthy processed food, costing more, but yielding less nutrition. The difference in the nutritional value is the salary of the food processor and the profits for the processing company. There is a cost to processing, packaging and advertising food. And, like the insurer in health care, the middle man in food processing has a payroll to meet. I am not against private enterprise or progress, but when the convenience and cost savings of a particular form of progress winds up reducing the quality of life and ends up costing more, then maybe progress is not the correct word for what is occurring.

Life was tougher back then. Work occupied much more of one's day. Working conditions were dirtier, less healthy and less safe. In rural America and in big and small cities, medical care was the local doctor, making his rounds. Most people were treated at home for many of the ailments that are now only treated in a doctor's office or in a clinic or a hospital. Many ailments that were once incurable are now curable or treatable to a degree that it takes longer for a patient to succumb to them. In most larger cities there were clinics and charity hospitals - and almost everywhere there were county run hospitals. Everybody I know - be it in Los Angeles, or New York or East Tennessee, was born in a county hospital or even, as was the editor of this chapter, born at home.

Doctors' offices and hospital furnishings and equipment back then were rather simple. The range of treatments and medicines was rather limited. Even as recently 40 years ago, there were no long three page forms and liability releases to fill out when going to the doctor's office. Mostly, a hospital asked for a consent form to be signed, if anything. Studying to become a doctor or dentist was difficult and not inexpensive, but no where near the cost of what it is today. Today it is not unusual for a young surgeon or GP to have an outstanding student loan of a quarter million dollars. Today's health care office is many times more expensive to open than it was fifty years ago. Liability insurance coverage for doctors is exorbitant. Today, hospitals are big business. They are rarely independent, usually part of a health care corporation.

The doctor who, in the 1950's, treated me for three days in my house out of his black bag may exist somewhere, but I haven't heard about him. The surgeon who, in the 1960's, examined me in the parlor office of his home and then performed surgery on me in a Catholic run hospital and made an extended bedside visit after the operation, no longer exists. Many years ago in the early 80's I hurt my hand in Karate class and needed to see if there was a broken bone. I looked up the address of an X-ray facility and went there. The X-ray technician took the image and then read the X-ray. The cost was $25.00 More recently I wounded my foot and again I wanted an X-ray to check the damage. Tennessee, as well as many other states, now requires a doctor's prescription for an X-ray. So - I was forced to go to a local hospital, part of a medical corporation. A doctor took my blood pressure, which was as it has been for years, at around 110 over 75. She sent me down the hall and an X-ray technician took the image and then read the X-ray. The doctor looked at the report and told me that there was a hairline fracture and that it just needed rest and to continue using the crutches, as I was already doing. The bill was over $750.00. The single aspirin was $5.00. The tongue compressor was $1.00, etc. I wrote a letter and complained and had the bill lowered, even though I was paying out of pocket, I wanted the insurance rate and the cost of the aspirin reduced to 25¢. I figured I

deserved a cash discount. Today any hospital emergency room visit is a minimum of $500.00. As I recall, the hospitals I visited in my youth were less social, more clinical, preferred to do less rather than more, had smaller lobbies and the upstairs consisted of a single corridor and nurses station, with rooms of all sorts in each wing. Today we mostly have sizeable medical centers that are a challenge to navigate and costly to manage.

There are still many poor people in America, but few have the perspective of families from our recent past. There is today a continuing diatribe that the poor are victims and deserve to be compensated merely for their not having. We have ignored the truth that for most of modern civilization, poverty was and still is the general condition. It is in the Western World and in America in particular, that a great rise in the average standard of living occurred. Recently we have begun a slide downhill as we look to false ideals and false prophets, promising societal perfection. In the past, survival required personal discipline. Today survival is described as a function of the government - and to a degree that is true, in the sense that government on all levels has taken control of so much of our lives, that much of the struggle to survive requires getting something back.

Today, for many, survival appears to consist of finagling handouts - both at the top and the bottom. However one wants to look at a program like Quantitative Easing, it is a handout. The handouts need to stop, and the tax system must be changed. The top, mostly large companies, get the big handouts, and their top personnel have ways to avoid a certain amount of taxes. But, it is the bottom that is having the most significant effect on the treasury. The welfare system is abused by far too many, and the issue of generational welfare, both at the top and bottom should finally be discussed seriously.

As regards the delivery of medical care, there are choices that must be made regarding priorities and allocations. For example, on the most basic level, should a laggard, a drunk or a drug or food addict be given the same medical care and

government funded social support as someone who maintains a disciplined lifestyle and diet? That, again is a question we must ask. It is generally accepted that some help should always be given to see if those with emotional problems leading to addiction can be helped. For those who are determined to kill themselves through degenerative habits, it is questionable to assume that it is society's responsibility to sustain addicts in comfort of any sort. Neither should the state purchase drugs or alcohol for addicts or allow non-essential, truly unhealthy foods to be purchased on food assistance programs. Some questions may appear silly, but all aspects of someone's behavior and lifestyle are emblematic of larger issues. Should someone's tax subsidized diet include a shopping cart filled with bottles of soda and potato chips? If someone wants to kill themselves, is it inappropriate to ask if they should do it without the taxpayers' assistance. In the specific case of drugs, if drugs were de-illegalized, they would be available without requiring crime as the method of obtaining them, instead of spending billions in the replacement of stolen merchandise, higher insurance rates, drug interdiction, apprehension, adjudication, incarceration and ineffective rehabilitation.

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What has truly changed is technology, and in turn technology has changed many aspects of our lives.

So, what do we have today? We have a much more formal, much more complex, much more labor intensive, test demanding, specialist oriented, pharmaceutical oriented, TORT driven medical system. Although the dollar is worth only a fraction of the value it had fifty or one hundred years ago, the $5.00 or $10.00 dollar doctor's visit is relatively much more expensive today, and today's pharmaceutical, that didn't exist 100 years ago, that in many cases will only ameliorate the symptoms of an ailment, are very costly - and as mentioned,

many cause side effects that then have to be treated - with more visits to the doctor and possibly requiring the use of more drugs.

What is also much higher today, are our expectations. Years ago we had both the local GP and the Park Avenue doctor. We had the county hospital and we had the major medical center, often associated with a university medical school.

In my own life, as a result of my lifestyle and my learning, I treat illnesses and wounds very differently from many people. Although I do not exercise the way I did twenty years ago, mostly a result of the lack of time, not due to being older, I still have a very decent routine. My diet may include the occasional deliciously greasy hamburger with fries and ketchup, but I consume many greens and vegetables. I cure my ills as much as I can by myself. Still, over the past several years I had two hernia surgeries. I was diagnosed with a Deep Vein Thrombosis in my leg and required blood thinning medicines. Fortunately, these maladies are the extent of what needed attention by medical professionals. I did visit a dermatologist who removed some very small pre - cancerous spots. Still, I have had no serious medical attention other than the two surgeries, the DVT and the skin treatment. I saw the dentist, had a filling and passed on a root canal, and will probably lose a tooth in the future. When I twisted my back a while ago and once again inflamed my sciatic nerve, I pulled out my never too far away crutches and used them for a week, until my sciatica calmed down. Most people my age are on prescription medications and see the doctor for all sorts of ailments.

It is what we consider health care that concerns me. If we were to place ourselves 100 years in the past, some thirty years before I was born, the world would be very different. People tended to their own ills much more than people do today. Today we have a pill for everything. Sniffles and allergies require medication. Every illness requires medication. The television and paper and web based advertising budget for pharmaceuticals is quite massive. It is budgeted at just shy of 25% of the 325 billion dollars in sales / over 80 billion dollars annually,

not counting promotions to doctors. We look less and less to diet for cures. I often compare the contents of my shopping cart to others in the super market and I am astounded at the sweets, the sodas, the basic array of illness producing garbage that will lead to everything from hyper tension to diabetes - all to be cured by medical treatment and pills. I ask myself, if these people needed medical attention attributable to poor diet and lifestyle, was the road to their illness paved with government money and their 'cure' paid for by government supported medical care?

If we someday consider a government subsidized medical system, are we supposed to pay for the ills caused by terrible unhealthy lifestyles and garbage based diets? Like it or not, we must all ask ourselves these questions. Are we supposed to pay for other people's slovenliness? It may be an uncomfortable question, but that is what will define affordable health care, and how much it will cost us, and how much we can afford for other illnesses.

Recently my heavy duty utility trailer was stolen, and subsequently an expensive ladder and an expensive air compressor were stolen. My insurance does not cover most of the loss, and at the time of this writing, time I cannot afford to replace these items. The people who stole these tools are thieves. They robbed from me something that came as the result of my hard work at a time when I could do the hard work. The thieves are selfish leeches, living off the work of others. I no more wanted to reward those thieves with my trailer bought with my hard earned money than I want to reward lazy leeches with health care paid for with public money. I will not establish the criteria to answer the question about how we define justifiable health care within the confines of this book, but I will say that if we are to establish a health care system supported by public funds, then we must, at some point, ask the question - exactly what is health care?

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Although no particular European system is being promoted as a model for access to health care - looking at some European countries served as a comparison of medical treatment under an alternative system. For example, in spite of a generally improved standard of living in the United States, because of the way our health care system has developed since the end of World War Two, cost is the primary reason people give for problems accessing health care. Americans with below-average incomes are much more likely than their counterparts in other countries to report not visiting a physician when sick, or not getting a recommended test, or treatment, or follow-up care, or filling a prescription or having dental work done. Six out of ten physicians in the U.S. say that their patients have difficulty paying for care. In a recent study, three of ten uninsured adults reported either not getting or delaying medical care because of cost. This number compares to five in a hundred privately insured adults who forego treatment. The rate is lowest for those receiving government assistance in paying hospital and doctor bills, which indicates very clearly that money is the key factor in getting health care.

While there is no agreement as to the single cause of rising U.S. health care costs, three contributing factors can be identified.

The first factor is the availability of new technologies and prescription drugs themselves. They are an incentive for expensive development, because they create demand for more intense, costly services, even if they are not necessarily cost-effective. The U.S. spends almost a $1,000.00 per capita on pharmaceuticals and other non-durable medical care, more than double the average of other industrialized countries.

Another factor for increased costs is 'the rise of chronic diseases, including obesity and Diabetes. Nationally, health care costs for chronic diseases consume huge proportions of health care costs, particularly during end of life care. Patients with chronic illness in their last two years of life account for about 32% of total

Medicare spending, much of it going toward physician and hospital fees associated with repeated hospitalizations.' [2] The National Academy of Sciences found that among other high-income nations the U.S. has a higher rate of chronic illness and a lower overall life expectancy. Their findings suggest that this holds true even when controlling for socio-economic disparity. [3] Experts are focusing more on preventative care in an effort to improve health and reduce the financial burdens associated with chronic disease. [4] One positive provision of the Patient Protection and Affordable Care Act, stipulates additional Medicaid funding for states providing low cost access to preventative care. [5] This though is done through Medicaid, which limits its dissemination to the public at large, although Medicare now pays for a yearly wellness exam - a step in the right direction.

In a personal observation, during my mother's final days, although I repeatedly tried to have her remain in her own home, even with the agreement of her surgeon, who had arranged for a nurse to visit once a day, which would have been as medically prudent as a return to the hospital merely because of an insignificant level of dehydration; and although she literally begged to remain in her house, the State of Florida Children and Family Services intervened and she was literally ripped out of her bed and returned to a hospital for additional unnecessary repetitive and costly tests. In spite of her improved medical condition after a surgery, the stress of the two transfers from facility to facility and the imposition of the repetitive tests, observably depressed her and observably brought about her death. From the reams of medical records I obtained, I estimate that between doctors’ bills, testing, hospitalization, transportation and pharmaceuticals, more than $100,000 was wasted on what became the last two weeks of her life. For the short two month period of time beginning with my mother's heart by-pass surgery, she had become a half million dollar cash cow for the system.

Ironically - if you are willing to call asinine behavior on the part of an administrator 'ironic' - the Medicare system was prepared to house my mother in

a continuing "rehabilitation" situation for additional time. It was the early removal from that depressing facility that led a staff member of that facility to surreptitiously call CFS and complain that my mother was in danger - despite what her attending physician stated - that led to my mother being recycled into the system. It appears that everyone on the health care payroll was protecting their turf and justifying their job. The true irony here is that one of the problems with health care is that Medicare generally limits rehabilitation time after hospitalization, and that the cost of long term care is exorbitant. In this instance, one way to extend rehabilitation was to reinstitute the hospitalization process, starting the clock over again.

Lastly, high administrative costs are a contributing factor to the inflated costs of U.S. health care. The U.S. leads all other industrialized countries in the share of national health care expenditures devoted to insurance administration. It is difficult to determine the exact differences between public and private administrative costs, in part because the definition of “administrative” varies widely. Further, the government out-sources some of its administrative needs to private firms. [6] In fact, the federally mandated requirement for electronic record keeping and exchange does not fully work. Many doctor groups outsource the patient portion of their records to different firms who do not necessarily work together, and data is often unreadable across different software platforms. Additionally the extra data entry is burdensome and many doctors limit their entries to one year of information or refuse to do it completely. In some instances valued older doctors who are not computer comfortable have retired.

What is clear is that larger firms spend a smaller percentage of their total expenditures on administration, while nationwide estimates suggest that as much as half of the $361 billion spent annually on administrative costs is wasteful. [7] In January 2013, a national pilot program implemented under the Affordable Care Act began, which had the goal of improving administrative efficiency by allowing

doctors and hospitals to bundle billing for an episode of care rather than the current ad hoc method. [8]

This last item, bundling of billing, as insignificant as it may appear, is suggestive of a cornerstone element of my proposal; that being - to allow doctors to treat patients as they see fit, rather than having to fit the patient to an allowable closely monitored treatment program, wherein costs are individual procedure oriented rather looking at the patient's needs holistically.

In July 2011a NIHCM (National Institute of Health Care Management) Foundation Data Brief identified which patients were availing medical care, and noted that rising costs were most attributable to a rising cost per unit of service rather than a rising rate of service utilization. As I mentioned earlier, those groups associated with addictive behavior, with related medical conditions, disproportionately utilize care, while it would be politically difficult to have them prohibited from receiving full medical attention; some adjustment in how to prevent the need for repetitive care and how to more cost effectively address the needs of those groups most utilizing care, needs to be made. Again - the overall cost of medical care needs to be addressed, rather than just guaranteeing insurance coverage, which I see as no more than politically and corruptly bandaging a festering wound. As can be seen from the results stated in the summary below, one can observe that the ACA severely and disproportionately taxes and penalizes the smallest group of those utilizing medical service to pay for those most utilizing medical care. That would be the younger working citizens versus the older retired citizens. It is hoped that under my group of proposals, especially the tariff and tax proposals, the working population would not bear the burden of producing money to fund the Federal government, dis-proportionate to their financial capabilities.

Below is the Summary of Key Points from the NIHCM Foundation Data Brief:

- U.S. spending for health care has been on a relentless upward path – reaching 2.5 trillion in the aggregate, / $8,100 per person, and 17.6 percent of GDP in 2009.

- Spending is highly concentrated among a relatively small portion of high-cost users, with just five percent of the population responsible for almost 50 percent of all spending. At the other end, half of the population accounts for just three percent of spending.

- As more people are being diagnosed with and treated for chronic conditions, including many linked to rising obesity rates, high health spending has spread to a larger segment of the population. The spending distribution remains highly concentrated, however.

- Higher spending for hospital care and physician and clinical services accounted for half of the increase in total national health spending between 2005 and 2009 and more than 80 percent of the increase in private insurance premiums over the period.

- Rising prices per unit of service have played a larger role than rising utilization rates as a determinant of recent expenditure growth.

- Key drivers of rising unit prices and higher utilization include advances in medical technology, rising prevalence rates for chronic diseases, and increased provider consolidation and market power.

Statement

I realize that the expectation of the elimination of waste and fraud in any system might be looked at as pie in the sky dreaming, acknowledging that even during the terrible days of the American Revolution, when soldiers were going hungry,

there was profiteering being committed by food suppliers. I will, though, work with the premise that somehow almost all citizens might someday look at their government as something other than just another entity ripe for profit or plunder; which admittedly might be impossible considering that half the population now looks at the Federal Government as Santa's toyshop and a small segment of the other half are allowed to act as if they own the toyshop. As regards existing Medicare, one might want to increase the penalties for Medicare fraud, considering that often the fraud is difficult to see. For example, hospitals usually file their Medicare claims automatically every 30 days, which in many instances leads to a double or triple payment of the claim. And, while the overpayment may be seen as administrative error, the cost of adjusting the claims' payments is an additional expense.

Going back to pie in the sky dreaming again, and assuming that waste and corruption were removed from national and state budgets, and the national debt were eliminated, * thereby eliminating the interest payments on the debt, and the systems of taxation and import controls that I lay out in this book were achieved, and more Americans were gainfully employed, leaving them more disposable income, and the bloated costs associated with today's medical care, as described below, were reduced - funding a health care system would not present the insurmountable problem it is presented as being. There is no reason that the country could not afford health care in an honest system.

* (*As Thomas Jefferson wanted from the very beginning - seeing the debt as a great danger*)

Waste

Wasteful spending likely accounts for between one-third and one-half of all U.S. health care spending. PricewaterhouseCoopers calculates that up to $1.2 trillion, or half of all health care spending, is the result of waste. [4] An Institute of Medicine (IOM) report estimated unnecessary health spending totaled $750 billion in 2009 alone. [5] The biggest area of excess is 'defensive medicine',

including redundant, inappropriate or unnecessary tests and procedures. Other factors that contribute to wasteful spending include non-adherence to medical advice and prescriptions, alcohol abuse, smoking and obesity.

Unhealthy lifestyles

The growing burden of chronic diseases adds significantly to escalating health care costs. Researchers predict a 42 percent increase in chronic disease cases by 2023, adding $4.2 trillion in treatment costs and lost economic output. [6] Much of this cost is preventable, since many chronic conditions are linked to unhealthy lifestyles. For example, obesity accounts for an estimated 12 percent of the health spending growth in recent years. [7]

An Alternative Method of Delivering Health Care

Health care, like everything else, can be provided with different service levels; the different fees charged by different doctors and nurse practitioners, the amenities provided by one hospital over another, the choice of a clinic versus a doctor with an expensive address, the type of room in a health care facility, the length of stay, etc. For some, four in a hospital room is fine, for some a semi private room is fine, and for some a private room is required, and for others only a luxury room or a luxury room with accommodations for a family member will do.

This proposed plan would assume that minimal but sufficient hospital care would put the patient in a hospital or clinic room with four to six people or a semi-private room would be provided if needed. The goal is to provide decent basic medical care that is financially sustainable; with the assumption that those who want and can afford more luxurious or more costly specialized care will purchase private insurance that provides that level of care for which they are willing to pay, or the level of care they can pay for out of pocket. It might be said that increasing the room occupancy to several people in a room potentially exposes the patients to

infections like Mersa, and Staph. But, with proper procedures, that surely doesn't have to be the case. The VA hospitals, among others, usually have four patients in a room, which seems to work well. Today much monitoring is done electronically, through cameras. While more in a room might appear to make patient monitoring more difficult, in today's age of advanced electronics, some system would surely be able to be developed that would satisfy the situation. Also, where possible even in a 'ward situation', construction and design could be such that there is ample patient separation, and a reclining chair could be provided for a patient's friend or family member; and the presence of that person would reduce the cost of nurse monitoring. We are presently so conditioned to accept only authority personnel at every level that we feel separated from what was once common practice, tending to the sick by family members.

Irony in the Health Care World

In spite of the difficulty for many people to obtain heath care, hospitals are shutting down at a growing rate, especially in rural areas, exacerbating the accessibility problem for many.[9] This is largely due to the inability of the residents in a hospital's service area to pay for hospital services without government assistance, or on occasion, even with it. Currently, medical care is by and large a business, which in the larger sense, it should be. But, I see no reason why the profits of medical care should not be collected by the medical professionals who service the patient community. I see no conflict in reducing health care costs on the one hand and still having sufficient financial incentives for the development of new drugs and medical tests and procedures, and sufficient pay as an incentive to attract health care processionals - which should be driven by the needs in the consumer market and not who in particular pays. It has been suggested that much use of tests involving CT scans and MRI's is based on the machinery's ownership by doctor's groups, and a need to amortize the high cost of the machinery. Again, we have to refer back to the demand on a

doctor's schedule for a maximized number of appointments per day, and the lack of true internists / diagnosticians.

In earlier days most working class people utilized county hospitals, and they had the ability to meet the costs for the services provided. Today, most county hospitals have closed and have been replaced by private medical institutions. The combination of 'for profit' corporate hospitals and insurance companies as intermediaries is a major factor decreasing availability to health care.

PROPOSAL

Preface

The proposal is simple in concept and execution.

The underlying assumption made:

The elimination of the multi-layered health care service approval and payment systems and the re-establishment of the more traditional chain of providing services and handling billing will guide health care money more directly to those people and institutions most closely associated with the delivery of services, and will in of itself create a less wasteful system. That is to say, by eliminating as much as possible the middle man in the medical care delivery system for those not able or wanting to purchase private medical insurance eliminates an entire layer of bureaucracy and lowers the cost of providing medical services. I am not specifically referring to the cost of administration of private health care insurance, which is about 3.75 percent of overall national spending on health care, but to the government nexus of health care administration and profit driven medical care and insurance provided care - as opposed to a balanced system

allowing for a choice between publicly funded medical care and private insurance covered medical care.

-The current cost for medical care in the US is $4 trillion annually, of which the Federal taxpayer underwrote $831 billion in 2014 and states contributed $215 billion in 2012. While we don't have more current numbers, anecdotally there were increases in costs across the board under the ACA system

-A 2011 study by the 34-nation Organization for Economic Cooperation and Development (OECD), among other things concluded that:

-The cost of healthcare in the United States is 62 percent higher than that in Switzerland, which has a similar per capita income and also relies substantially on private health insurance.

-Meanwhile, Americans receive comparatively little actual care, despite sky-high prices driven by expensive tests and procedures. They also spend more tax money on healthcare than most other countries,

-An "underdeveloped" U.S. primary care system is plagued by shortages of family doctors and high rates of avoidable hospital admissions for people with asthma, lung disease, diabetes, hypertension and other common illnesses.

-Mark Pearson of the OECD said researchers believe national mortality rates increasingly reflect the quality of healthcare, though more than half of the equation is still believed to lie with other indicators including lifestyle and diet.

-Americans have fewer doctors and hospital beds, make fewer doctor visits, go to the hospital less often and stay for shorter lengths of time than about three-quarters of the other OECD countries.

-But the United States is at the front of the pack when it comes to costly medical procedures including knee replacements, MRI and CT scans and tonsillectomies.

-And, it is consistently at the top of the cost chart for a number of procedures including caesarean sections, which are almost twice as expensive in the United States as in Germany.

-Pharmaceuticals also cost about 60 percent more than in a range of European countries.

-Pearson said one reason prices are higher in the United States is that the healthcare system lacks what other countries have: an effective government mechanism that acts to keep prices down.

Eliminating Medicare, Medicaid, TRICARE, other government insurance programs and the non-combat related services provided by the VA hospitals into a general medical service system, will eliminate layers of redundant administrative costs, and will save taxpayers' money. The VA Hospitals will still provide the more specialized care that returning and wounded servicemen require, and as a consequence of the reorganization, the VA can focus on veterans with special needs, and with this change the VA should provide faster and better care.

People who have the financial capability to pay for more luxurious medical service would have the choice to do so, either through private insurance or paying for it on their own directly.

Program

Rather than establish a centralized medical payments system, money for health care would come from a central government fund and funds in each state to establish and support county hospitals and associated clinics proportionate to the population and needs of each county in the U.S.. Initially, many existing health care facilities can be converted to county use. Eventually, all facilities should be standardized so that equipment purchase and maintenance of the facilities and the purchase of repair materials will be less costly This program is intended to

service United States Citizens, and will not be available to people who have entered the US illegally. Those here on legal visas will be required to purchase insurance for the length of their stay in the U.S.. Possibly some reciprocal reimbursement arrangement can be made with foreign governments that have their own nationalized medical system. If we can be creative enough to intentionally negotiate bad trade deals that harm Americans, we can certainly intentionally negotiate good agreements for health care that will help Americans.

Payment for the cost of the services provided in these facilities will be between the patient and the hospital billing office, or the private physician. A sliding scale deductible could be devised, but that would inevitably lead to some direct contact with the Federal Government and the establishment of a bureaucracy to service it. Quite possibly there will have to be a deductible established for all services, or no deductible at all. It is once again the cost of health care that is the stumbling block for many citizens.

As I would like to see the current income tax replaced with a progressive retail sales tax, I am loathe to see the creation of any new medical bureaucracy being established for this program, especially after eliminating Medicare. Realistically, in today's America, even deductibles can be daunting for many people, as much of present day America is basically "paycheck to paycheck broke". Even those who can now afford health insurance, find it puts a terrible strain on their budget. At the moment, medical care may have to be provided on a no fee basis, with no deductible for those who utilize the county system, until such time that America can pull itself up again. In any event, however the program is arranged, a bill for services rendered will be sent to the patient, and the patient or the patient's family will pay what can be paid. Any money received by the facility or the doctor will be credited to the facility's general account.

All billing for health care will be on the county level. It is the county that will communicate with the state, and the state with the central government when it

comes to reimbursement payments. Just as a tradesman sends a bill to his client for payment, the doctor working out of his own office and treating a patient without private insurance, will send his bill not only to the patient, but to the county medical care hub, and monthly reimbursement payments will be sent out from there - or transferred electronically to the doctor's account. A general agreement on fees in each county would have to be established, as the overhead and cost of doing business in different areas of the country vary greatly. In the case of a doctor, or a nurse practitioner working through the county hospital or county health care facility as an independent contractor, using the county facility, they would bill the hospital or facility directly. No billing for particular services rendered will be sent from the county to the state or from the state to the central government. For the sake of monitoring services rendered and what illnesses are being encountered, a separate filing detailing services rendered and for what would be sent to the office of the U.S. Surgeon General for analysis.

All Federal employees and office holders from the Legislative, Judicial and executive Branches will utilize the county hospital and care system unless they choose not to. But, aside from specialized care for military veterans who will remain in the VA system, no special medical care program will be established for any Federal or state employee - from the bottom to the top, including all elected and appointed persons. I say the following with all sincerity. Unless the President of the United States is willing to pay for their own doctor or medical services, their doctor will not be a private / personal physician. I understand that whoever services the President may have to make house calls and if the President requires hospitalization, they should be quartered in a private room for security reasons, but that is very different from the President having a doctor at their side at the taxpayer's expense. As I mentioned earlier in this book, I am for cutting whatever expenses we can to get this government out of debt, and keep it out of debt. If we are to stop the Presidency from becoming an imperial institution then we must stop treating the President like a king. The Presidency is a great job, but for heaven's sake let's cut out a bit of the pomp and ceremony. The

President is a person, and their electoral victory does not promote them to royalty. It's enough they get a decent salary and have a great place to live, and have servants - but guys, let's get a handle on it. Money is money. Enough said.

The only involvement the Federal Government will have with individual county hospitals and care centers is to guarantee that they are sufficiently funded to provide the services required and oversee the total expenditures to gauge how money is being spent and on what services. An audit of the county health care facilities will be performed by the state governments with oversight by the US General Accounting Office, office of the Inspector General. The quality and availability of care should be analyzed by the Surgeon General who should make his report to the US Congress whenever the Surgeon General feels it necessary or when called before Congress.

Caveat

The initial editor of this proposal expressed an opinion to me, and I feel I should relay it to you the reader, and although I somewhat touched upon it previously, I would like to expand upon it. The editor was born in the region in which he currently resides, but as a young man he left the area, and as part of his lengthy service in the United States Army, he lived in several different places, both in and out of the U.S.. His service as an officer in the Army, gave him a certain perspective about bureaucracies. He told me that he had always felt that as much as could be handled by local government should be handled at the local level. He is a politically astute person, and upon returning home he became aware of the great corruption that existed in his city, and county and state governments. His fear about this program as I envision it, is that any system that involves so many levels of government would be very susceptible to fraud - taking into account the fraud that is currently being committed by doctors and other medical service providers with Medicare. His feeling is that a single payer plan managed by the Federal government would be the best solution, not withstanding the problems he and his wife have had with the health care system

as retirees. Obviously, he is aware that I am opposed to a traditional single payer plan or any plan that is run from the top down.

On a personal note, this week I witnessed some very uncomfortable dealings with an associate's warehouse landlord. The second such experience they have had in the past three years. Basically the landlord had made more lucrative arrangements with a new tenant, which are at the expense of the renter's ability to easily access the facility. The renter cannot afford the $15,000.00 cost to move once again, for what would be the third time in four years. Why this is of some note is that during the same week, a very honorable mechanic whom I patronize, was ripped off by a new customer who made a claim to his credit card company that the work he was charged for was never done. The mechanic is among those people whom I know to be honorable. He was very upset, as upset as the storage renter. In the case of the mechanic, it is not the $80.00 that bothers him. In the past I have seen him write off many charges. It is the fact that an amorphous credit card company was challenging his integrity and treating him like dirt, taking the word of a disreputable card holder. As an honorable person the mechanic doesn't enjoy being called a cheat. The warehouse landlord and the mechanic's customer appear to have no conscience. They use whatever leverage they can to get a leg up on someone.

The particulars of the above two incidents are not important. What is important is that as I get older, it seems I have become aware of the inherent state of dishonesty, greed, avarice, lack of respect and general lousy business etiquette that exists throughout the world. That is not to say that there are not good and honest people around. I believe, in fact, that there are many good people out there, but there are also just too many crooks to allow me to have much trust - and I don't place trust where it is not necessary. This is the same concern that the editor had, and I brought up these instances, because they are symptomatic of the frequent cheating and generally scurrilous behavior that we all witness.

So, it can be assumed that any system that includes reimbursements from a government bureaucracy is subject to fraud on every level that exists, and the more levels, the more potential for fraud. Therefore wrapped into this proposal is my expectation that will be efficient oversight arrangements and crime investigation and punishment will be swift enough to prevent major loss to the public at the hands of citizen crooks.

This proposal is not for a single payer system.

This is a system wherein every US citizen with or without health care insurance is able to receive basic medical and dental care at a county facility, not much different from the way it was seventy years ago, and even more recently in some areas of the country.

This will be a system of Federal / state funded county run hospitals that will have outreach clinics and other health care facilities as part of their mandate. Among services provided will be basic dental care, as dental issues result in both diminished overall general health and a loss in employment potential.

Doctors and dentists who want to participate in this program and have their own private or group practice may sign up and their office will be considered as part of the county outreach system, and be subject to the same requirements and payments as if they were physically located in a county facility. The billing would have to be set up in such a way that it is in line with and part of the county system and not a continuation of the Medicare / Medicaid reimbursement system.

For the sake of fraud prevention through double billing and to prevent pill scamming by individuals, each citizen would have to apply for a medical care account, which would identify that individual as the person receiving the care. For the sake of general services provided audits, only the patient's account number and chronological age data would be accessible from the account.

The medical care provided will be for emergency medical treatment, maternity care and for surgeries such as the repair of broken bones, hernias, degenerated joint repair, gall bladder and appendix removal, etc. The surgeries offered will not include cosmetic surgeries other than for procedures that result from serious deformation either at birth or as a result of a disfiguring accident. Elective procedures used for weight reduction, and other surgeries of this type will not be offered on the state sponsored program.

Someone who wants a certain procedure not offered on the schedule of procedures, but would prefer the surgery take place at the county hospital and is willing to pre-pay or have their insurance company pay for the entire procedure would be allowed to have their doctor utilize the facility at whatever cost is eventually decided upon.

There will be an emphasis on preventive medical care and a focus on proper nutrition, exercise and lifestyle. Hopefully, intervention at an early age will result in healthier citizens, and a reduced incidence of lifestyle caused illnesses later on. This in no way is to infer that the US Government will monitor the lifestyle or dietary habits of any child or adult. The most we can hope for is to make preventative exams available and have facilities available for those who decide to utilize them. As I am writing, I am thinking of the cooking class I took in grammar school in the 1950's. It did not make a chef out of me, and it wasn't until many years later when I was living on my own that I began serious cooking, but having had that class made it easier for me to begin cooking.

All children attending public schools will be offered yearly medical and dental exams. Children being home schooled or in private schools will have the same access to the yearly exam.

The cost of medical care at county facilities will be reduced through the elimination of the health insurer middleman for the larger portion of the population, the reduction of CYA tests and the use of fewer and less expensive drugs, and the utilization of more physician assistants and nurse practitioners. The hospital will be run on a not-for-profit basis, and administrative salaries will be kept within a modest range, commensurate with the local cost of living index.

The need for a particular medical test will be determined by the attending medical doctor, and the patient will not have access to a tort suit for mal practice if a certain test is not performed and at a later date if it is subsequently speculated that something might have been discovered through a certain test. Patients will be informed which tests are and are not being performed, and what and what not is being done on their behalf - and will always have the option to prepay for a test or have a test done elsewhere. In the event that a test is on the 'not available list', but it is deemed necessary by the physician, the physician will have the last word on ordering the test. As regards TORT suits, whether or not higher caps should be applied when criminal behavior can be proven is something to consider.

Only Federal and State Inspectors will have access to the complete detailed invoice in their random or targeted examination for fraudulent billing as part of their oversight and cost evaluation function.

Some county hospitals will also serve as training hospitals, but the level of care will be of the highest and most professional care available, subject to the restrictions noted regarding the services offered.

All facilities themselves will be simple in design and designed for easy and inexpensive maintenance. Equipment will be limited to the most cost effective and least maintenance requiring available. The hospital rooms will house a minimum of four patients, possibly as many as six. There will be private and semi-private rooms available for those instances when it is required. The rooms

will be spacious and bright and airy and designed so that they will be easily maintained for the most cleanliness possible. Walls will be painted white without intricate detailing so that they may be cleaned and repainted easily and inexpensively.

The existence of this ubiquitous county based hospital system will not preclude the existence of whatever private medical institutions choose to enter the health care market, and whatever private medical insurance programs are offered.

If someone has medical insurance and their doctor chooses to utilize the county hospital, the insurance provider will be presented the full invoice representing the same cost presented to the non-insured patient. No longer will insured and non-insured patients be charged differently.

In essence this will be a Federal / state / county supported government medical program operating side by side with other privately operated medical facilities. While this is a funded program it is not in any sense the single payer system that currently exists under Medicare. This system is intentionally designed to replace the Medicare and Medicaid systems. This system will also reduce most of the patient load in VA hospitals, allowing those hospitals to focus on the serious combat traumas or types of services required by returning vets and not covered by the county facilities. Hopefully all medical systems will develop a synergy that should provide more available health care at a reduced cost.

Citations:

* - Article 1, Section 9, - 4. No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken.7

Amended 1911 and ratified 1913:

Article XVI. The Congress shall have power to lay and collect taxes on incomes, from whatever source derived, without apportionment among the several States, and without regard to any census or enumeration.

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