Towards a "Free Market" Medical System

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Does the medical system in the US operate in a free market environment or does it operate as a highly regulated and price controlled industry? The discussion surrounding health care reform centers on this principal idea; is private insurance or public insurance the key to improving health care in the US? Debates over the universality and funding of a revised health care system have focused primarily on government and private company controls while ignoring the consumers themselves as having a controlling interest in the matter. This paper discusses issues surrounding the current US health care system and proposes a free market approach to health care that restores control of the personal medical process to the consumer.

INTRODUCTION

Does the medical system in the US operate in a free market environment or does it operate as a highly regulated and price controlled industry? The discussion surrounding health care reform currently centers on this principal idea: Is private insurance or public insurance the key to improving health care in the US? Stuart M. Butler, Ph.D. (Vice President, Domestic and Economic Policy Studies, The Heritage Foundation, 2008) proposed that health care reform be achieved through comprehensive reform in the insurance industry at both the state and federal level [Butler 2008].

"The goals that we virtually all share – such as reducing the number of uninsured Americans – could, in principle, be reached through a comprehensive federal reform of the health insurance system for working families. And some argue for a system designed in Washington. According to this view, health reform could come through a national restructuring of the insurance market. But I believe that strategy is inherently flawed. To be sure, it is important to set broad goals at the national level and to lay down parameters within which our values as a nation are preserved – such as our commitment to the disabled and the chronically sick. As almost all health economists agree, it is also important to fix the tax treatment of health care at the federal level to achieve greater equity. But in the case of insurance systems, and generally the organization of health systems, the best approach to achieve our goals is through a "bottom-up evolution" not a "top-down revolution."

Butler [2008] maintains that a federally based insurance system is not the way to go and argues that a state based insurance system is preferred over a federal system for three reasons. He maintains that:

1) **The regulation of insurance in the private sector has primarily been, and should remain, a state function.**

   Some argue that a national exchange, or set of national exchanges, is better or more practical than state-level exchanges. Indeed, states do vary in their capacity to develop and implement innovative proposals. But any attempt to create a national exchange, or to introduce federally designed exchanges at the state level, would immediately be sidetracked into a debate over the federal preemption of state insurance laws and the form and structure of the new federal regulations that would be applied to plans sold through a national exchange. Also federalizing regulations—such as benefit mandates— would exacerbate problems that currently exist. For instance, while some states have driven up the cost of health insurance with costly benefit mandates, that problem will only become more pervasive if regulation were centralized in Washington. Instead of focusing on fifty state capitols, industry lobbyists would have to make just one short ride from K Street to get a legislature to force Americans to use their industry's services. Congress's history in designing the benefits for the Medicare program is instructive in this regard.

2) **National reform designs and federal regulatory structures would be inflexible and incapable of adequately addressing diverse local conditions.**

   Americans who would benefit most from insurance market reforms or the creation of an exchange are typically those employed in small or medium-size firms. The circumstances and even values of those Americans differ in given geographic locations. A federal exchange, or system of federally designed exchanges, could not easily accommodate complex variations among, and even within, states. A state-based reform design would provide needed flexibility and is best able to practically address local conditions. Although certain general characteristics of an exchange are indeed essential if it is to achieve the goals of reform, there are many different ways to design the details to accommodate different local considerations. While the ease of a national approach to health insurance market reform might on the surface seem appealing, it clearly trivializes these very intricate and complex nuances of design.

3) **State experimentation with insurance market reform should continue because it is an important instrument to facilitate policy improvement.**

   Nobody, including me, can say with certainty what is the best way of organizing health insurance. It is such a complex system, where unintended consequences seem to be the norm after any change, that we cannot possibly imagine constructing an arrangement that would work from downtown Brooklyn to rural Alabama. And even if, conceivably, we could do that, innovations and changing conditions would immediately begin to render ineffective in parts of the country. Consequently, it makes sense to set only broad parameters and goals in Washington. Allow the states to propose and implement the best ways they think instance should be arranged in an exchange system, and let us learn from the strengths and weaknesses as we compare their initiatives.

Debates over the universality and funding of a revised health care system have focused primarily on government and private company controls while ignoring the consumers themselves as having a controlling interest in the matter. Models from both conservative and liberal think tanks agree that the complexity of a 'one system fits all' solution has previously proven impossible because of the myriads of players and legalities involved.

This paper discusses issues surrounding the current US health care system and proposes a free market approach to health care that restores control of the personal medical process to the consumer. This suggestion pushes the control of medical expenses back to the focal point of the transaction: the consumer. No model exists to date that pushes total expenditure control to this level. In a free market environment, free-floating prices and freedom to choose at the consumer level removes the complexity of the market balancing transactions so often sought at the government or corporate sector level.

WHAT IS A FREE AND PERFECT MARKET?

A perfect market is one in which there are numerous small firms and customers, there are so many buyers and sellers that each has a negligible effect on the whole, and their decisions on price have no effect on the market (this rules out any collusion or attempts by firms to fix prices). Perfect competition exists when the product of all the firms is homogeneous , firms are free to enter and leave the industry, no barriers to entry or exit exist, and when each firm and each customer is well informed about conditions in the industry.

While many of the conditions of a free and perfect market appear unattainable, we could argue that removal of all entities other than the consumer and supplier would enhance and simplify the free market interaction for medical services. In this simple and perfect market, competition reigns supreme. The free market consumer chooses medical services based on price, location, and preference. The free market medical service provider competes for consumers by meeting price, location and preference considering their own profitability. In essence, competition will drive supply.

Friedrich Engels [The Poverty of Philosophy, 1847], a friend and co-author of Karl Marx describes competition and its effect on the market as follows: “Competition…brings about the only…arrangement of social production which is possible…[Otherwise] what guarantee [do] we have that the necessary quantity and not more of each product will be produced, that we shall not go hungry in regard to corn and meat while we are choked in beet sugar and drowned in potato spirit, that we shall not lack trousers to cover our nakedness while buttons flood us in millions?

Milton Friedman [2003], one of the last century’s proponents of freedom and free markets maintained: "The most important single central fact about a free market is that no exchange takes place unless both parties benefit."

Friedman talks of two entities, not three or four, trying to decide what is best for a single transaction (one supplier, the medical professional, and one consumer, the patient). The imposition of additional parties into the exchange process creates complexities that confuse the basic market transaction. Both the consumer and the medical provider are disenfranchised when a third and fourth party enter the negotiations and act on behalf of many rather than one.

Another of Friedman’s [2003] arguments for free markets was his belief that: "Nobody spends somebody else's money as carefully as he spends his own. Nobody uses somebody else's resources as carefully as he uses his own. So if you want efficiency and effectiveness, if you want knowledge to be properly utilized, you have to do it through the means of private property."

Friedman maintains that when you spend your own money you are extremely careful. Ownership of these funds is important. The consumer who spends his or her own money behaves differently than when he or she spends someone else’s money. Given this tenet, any suggested model needs to force ownership of funds to the lowest level of the transaction to ensure true free market choice occurs. The same holds true for medical suppliers where resources that are available to be sold to the market are best valued by the resource owner, not a third party provider intent on leveling prices outside of the free market transaction process.

Butler’s discussion on market complexity in the medical arena is simplified considerably with the removal of both government and private insurers from the medical transaction. Friedman is inherently distrustful of government intervention in any market transaction.

"Governments never learn. Only people learn." [Friedman 2003]

The basis for a free market is freedom for suppliers and consumers to choose product, price, and location. "The only way that has ever been discovered to have a lot of people cooperate together voluntarily is through the free market. And that's why it's so essential to preserving individual freedom." [Friedman 2003]

THE MEDICAL CRISIS

Approximately 45.7 million people, 15.3% of the US population, were without health insurance in 2007 [DeNavas-Walt et al, 2008]. The uninsured rate for Blacks in 2007 was 19.5% and for Hispanics 32.1%, while among white non-Hispanics it was 10.4%. 24.5% of people in households with annual incomes below $25,000 were uninsured, compared with 7.8% of households with annual incomes over $75,000.

Their research led Cutler and Gelber [2009] to state, "Our results portend difficulties if private coverage continues to decline and is not offset by further expansions of public insurance." Yet, the US currently spends 7% of its GDP on public health insurance, more than the average 6.5% of the 30 industrialized nations belonging to the Organization for Economic Cooperation and Development [OECD, 2009].

According to Bernard and Banthin [2009], "Total [2006] expenditures on health care services were highest among families with public coverage and lowest among uninsured families." Out-of-pocket expenditures, on the other hand, were significantly higher among families with private coverage (Table 1).

TABLE 1
2006 FAMILY LEVEL EXPENDITURES ON HEALTH CARE SERVICES*

Level of Coverage	Mean Total Expenditures	Out of Pocket Expenditures
Public Insurance	$8,831	$643
Private Insurance	$6,785	$1,410
Uninsured	$1,425	$663

* Families are defined as all civilian non-institutionalized nonelderly families in the US.

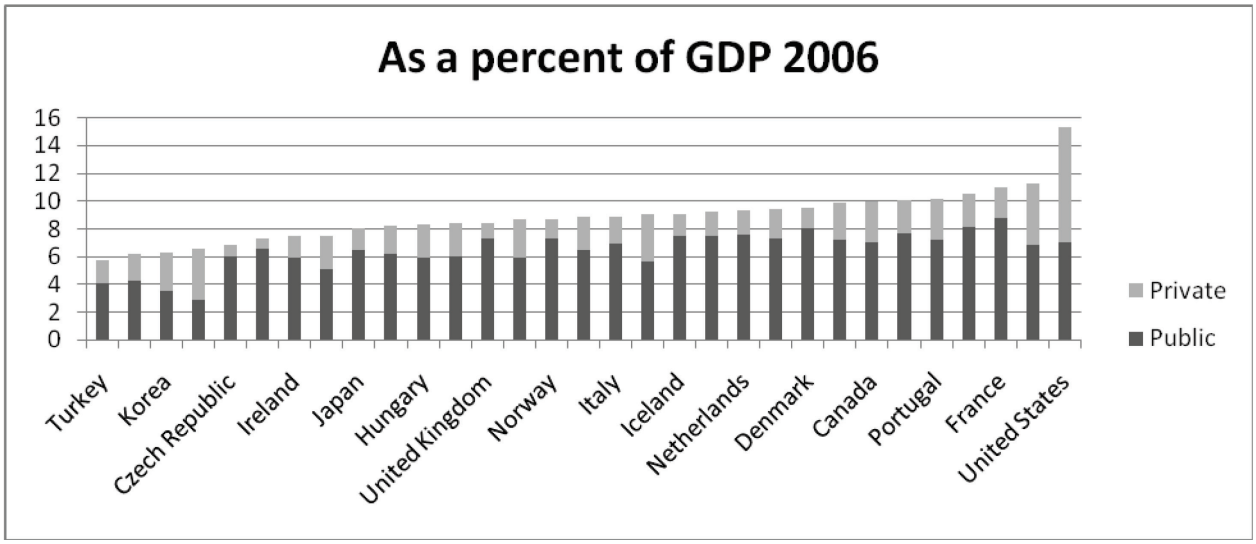
In addition, families with private insurance incur out-of-pocket expenditures for health insurance premiums. Average 2006 out-of-pocket premiums for one-person families were $1,002; $2,490 for two-person families; and $2,846 for three or more person families [Bernard and Banthin, 2009].

In the individual health insurance market (coverage that people buy directly from health insurers), average premiums "increased by 44% from $2,159 in 1996 to $3,111 in 2002… [Adjusted for inflation using the Consumer Price Index (CPI)], average premiums increased by 28.2% in real terms from 1996 to 2002" [Bernard, 2005].

Not all uninsured people are uninsured by circumstances such as unemployment or a preexisting condition. Some people in the US are uninsured by choice. According to Cohen [2007, "In 2004, 10.7% of adults agreed with the statement 'I'm healthy enough that I really don't need health insurance,' and 24.1% of adults agreed with the statement 'Health insurance is not worth the money it costs.'" These percentages increased when uninsured adults (age 18-64) responded to the same questions. 19.7% of uninsured adults agreed that they are healthy and do not need health insurance. 36.3% of uninsured adults agreed that health insurance is not worth the cost [Cohen, 2007].

OECD comparisons show that total health expenditures as a percent of GDP are highest in the USA as compared to other countries with nationalized health care systems. The fact that the US spends 15% of its GDP on medical expenditures and yet consumers remain dissatisfied with the current system indicates that a problem exists within the system.

FIGURE 1- EXPENDITURE ON HEALTH



Source: OECD Factbook 2009: Economic, Environmental and Social Statistics - ISBN 92-64-05604-1 - © OECD 2009 – Refer Appendix A for numeric data.

Fogoros [2007 maintains that four circumstances have converged to create the crises we now face in health care:

1. As long as we have a system in which we create centralized pools of money (some controlled by the government, others by private insurers) from which virtually all health care expenditures must be paid, rationing is necessary…
2. Because the very notion of rationing health care is taboo in American society, the unavoidable rationing must be done covertly. That is, we need to develop (and have developed) a system whereby the necessary rationing is done without acknowledging that any rationing is occurring…Those we have deputized to covertly ration our health care (the government and private insurers) have only one viable method for doing so. They must apply coercive pressure to the focal point of all health care spending, namely, to the physician-consumer encounter. Thus, the final common pathway for all covert rationing must be - can only be - the systematic destruction of the doctor-consumer relationship…
3. Without the classic doctor-consumer relationship, consumers are entirely on their own, groping their way through an (at best) unsympathetic health care system, and at a time when they are least able to defend themselves…
4. The key to protecting yourself within a health care system where you have been systematically marginalized is to discover, create, invent, or induce the development of methods for self-empowerment.

Resolving the issues of rising costs and limited supply currently plaguing our health system lies not with government or private enterprise but with empowering consumers, enabling them to make free market choices, and allowing the market mechanism of supply and demand to resolve service supply issues. Removal of market constraints imposed by government regulation and insurance companies frees new suppliers to enter the market, increasing competition and reducing prices.

MESSING WITH THE MARKET

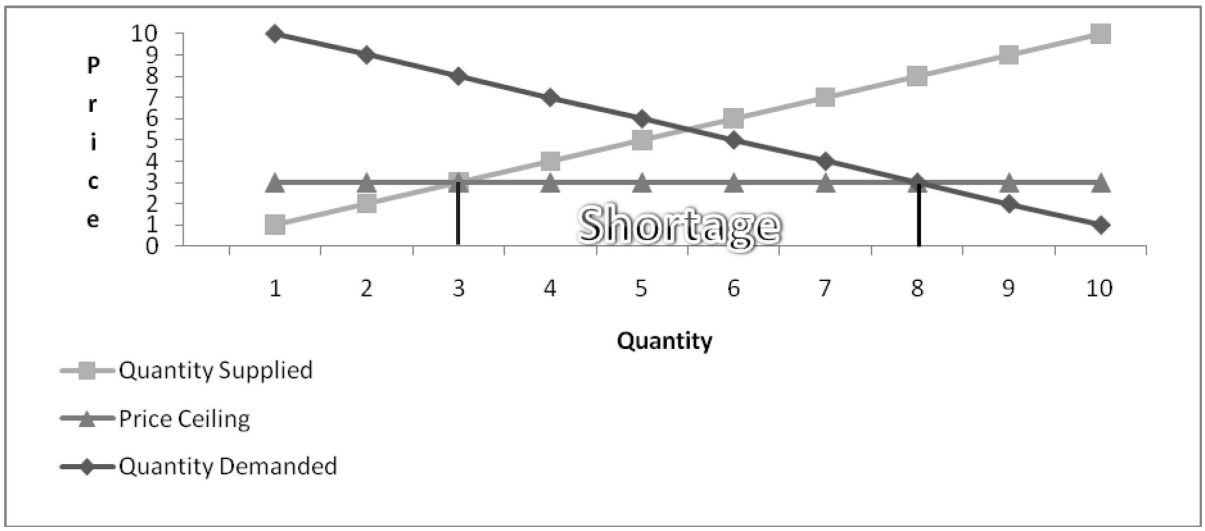
Price fixing in any industry is illegal and monitored closely by regulatory agencies. The manipulation of the market by means other than free market forces causes an imbalance in supply and demand.

Antitrust laws are specifically designed to prevent price collusion and price fixing in many industries. However, the health care industry has been excluded from these regulations, allowing insurance companies to fix prices for services.

"The reason antitrust laws have not been applied to health care practices in the past is not because they failed to meet the statutory definition of prohibited practices, but because several established legal defenses protected health care providers. The most important is the fact that Federal Antitrust laws were written to specifically apply to "trade or commerce," and the practice of the learned professions were not considered "trade or commerce." [Christoffel, 1981]

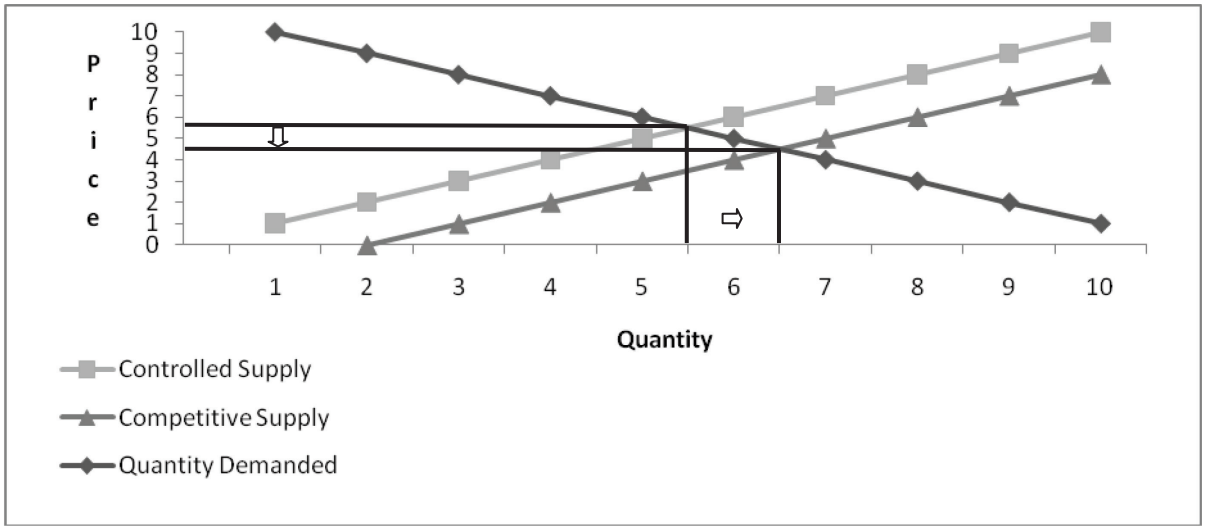
The imposition of fixed charges for fixed services (often designated by insurance companies) impedes the interaction of consumer demand for and medical profession supply of needed services. These "fixed prices" operate as price floors or price ceilings (Figure 2 - which artificially controls the supply for services); price ceilings, in effect, ration services to the marketplace.

FIGURE 2 – PRICE CEILING



Were these artificial price ceilings removed (Figure 3), free market pressures would take over, i.e., prices would rise, encouraging the increased supply of needed services in rationed areas. In the long-term, increased prices would provide economic profit and encourage the entry of new suppliers into the medical supply marketplace. This shifts the supply curve to the right lowering prices, thus, as more suppliers enter the marketplace, the cost of services begins to drop.

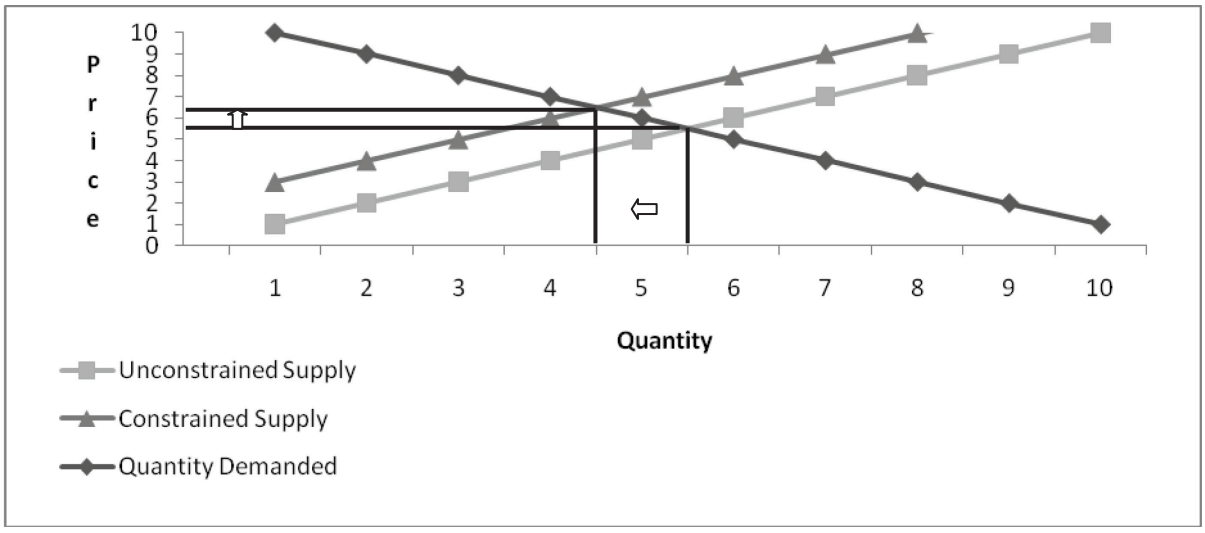
FIGURE 3 – PRICE CEILING REMOVED



RESTRAINT OF TRADE

Government regulations restrain trade in the medical field [Wlodkowski, 1983]. While licensing and accreditation issues are fundamental to the quality of services provided, it is important to note that by limiting the number of entrants into the supply side of medicine we are, in fact, constraining supply. Constrained supply causes prices to rise. See Figure 4 for a graph example of constrained supply.

FIGURE 4 – CONSTRAINED SUPPLY



Strict licensing laws - in place to ensure quality care - have historically limited the supply of medical services. Recent licensing trends in the medical profession indicate that the medical profession is stratifying to allow for different levels of medical training, e.g., Medical Doctor, Doctor of Osteopathy,

Physician's Assistant, Nurse Practitioner, Nurse, and Nurses Aid. This stratification changes the cost structure within service levels and reduces training time for various levels of medical care. Current trends will allow medical service providers to be more cost efficient through the focused use of stratified medical practitioners causing competitive service opportunities to increase, allowing service providers the opportunity to differentiate on service as well as price.

INSURANCE OVERREGULATION

Insurance regulation affects the supply of insurance. Universal coverage requires that coverage be available to all consumers. The application of universal coverage imposes increased costs on the majority of consumers. Couples in their fifties pay increased medical premiums to cover the in vitro fertilization costs incurred by younger couples. Young couples pay increased premiums to cover the catastrophic medical care for end-of-life consumers. Consumers have little or no say over the type of coverage they need. Regulations drive up the market price of coverage as the costs of universal coverage are forced on all users in the market.

OWNERSHIP

The presence of insurance changes a consumer's desire to control medical expenses. Consumers are adept at containing costs when spending their own funds. They are less likely to be concerned about high prices when protected from the personal impact of those high prices by insurance policies. Without personal exposure to the high cost of medical procedures, consumers fail to control the overuse or fraudulent billing of medical procedures. When consumers spend their own money on medical procedures, they are cautious in their expenditures. Spending someone else's money, however, makes them less than cautious in their spending.

Fraudulent billing under a government - or insurance controlled system requires agents of the government or insurance company to monitor and research - overbilling and fraudulent acts. Monitoring adds significant cost to the provision of the medical service through increased insurance premiums or government taxes to provide the investigative services to resolve these issues.

MARKET LOCATION

Medical insurance impedes free market interaction between the consumer and medical provider. Freedom to decide on price, location, and quality of the market transaction does not reside with the consumer. Insurance ties a consumer to fixed supply agreements. These agreements may not be convenient to the consumer. The consumer must use only certain suppliers who have agreed on fixed prices for services with the insurance company. The ability to shop around and select the best service at the best price in an agreeable location does not reside with the consumer.

Service agreements cause great inefficiency in locating services for consumers. Examples of these inefficiencies are found in insured consumers or military veterans traveling three to six hours to receive specialized services that might be found locally. The inconvenience for the consumer caused by these agreements is never taken into account when costing medical services. What is best and least expensive for the insurance company or government provider overrides consumer convenience.

MEDICAL SERVICE FUNDING

Medical services today are:

1. Self funded: Consumers pay out of pocket for medical services. These payments may be partial co-payments or full payments for all services.
2. Corporate funded: Consumers work for corporations that offer benefits that often include medical coverage discounted fully or partially to the employee and/or his family.

3. Insurance funded: Consumers or corporations pay insurance companies to fund or manage their health care.
4. Government funded: Corporate and individual consumer taxes fund Medicaid, Medicare, and VA coverage.
5. Benevolent funded: These funds are often sourced through medical system write-offs for uncollectible debts and gifting from benevolent entities or individuals.

THE MODELING QUESTION

Is there a model that empowers the consumer, minimizes costs, encourages free market practices, and stimulates self-management of health care and health care costs for all people? We propose that a free-market medical model will empower consumers, reduce regulations, minimize expenses, encourage market pricing, and stimulate financial growth in the economy. We propose that in the long term this free-market model will improve the level of medical care for all people within the United States of America.

THE MODEL HYPOTHESIS

In the long-term, free markets empower consumers, minimize expenses, encourage market pricing, maximize services, and stimulate financial growth, thus providing a better medical experience for the consumer.

SUGGESTED MODEL

The free market model is founded on the following tenets:

1. Freedom of Choice

The basis of this model is the freedom to choose. Each consumer has the choice of doctor, level of care, location of care, cost of care, and quality of care. A basic assumption of this suggestion is the need for perfect information. Thus, the model assumes that each consumer understands that his/her choices are based on free market information and that the medical profession competes for consumers based on price and quality of service.

Information must be freely available to all consumers on the type, quality, cost, and location of all medical services. The use of the internet in this process will be important to ensure that competitive forces give the consumer the ability to stratify the market based on his/her desire for services.

This tenet in no way suggests that the quality of service falls below government regulated standards (i.e., service by non-qualified medical practitioners). It does, however, encourage the medical profession to compete for consumers (who are free to move to any provider) based on information presented to the consumer.

Consumers who choose basic service know exactly where to go for the cheapest and best basic service; consumers who want a more specialized experience pay a higher premium price (which they are willing to do for this differentiated service) to obtain the level of care they desire, e.g., home visits, hotel-style hospital accommodation, personal service, etc. Low cost providers will enter the market specializing in basic services. Companies such as Walmart (who have ventured in to pharmacy and eye care) may offer basic medical services as an expansion of their service options.

As the number of providers increase, competition within the medical system will inspire innovative marketing deals for medical procedures to help differentiate doctors and their services. Three examples of innovative marketing are: medical procedure warranties (e.g., a facelift tune-up guarantee if the work fails to maintain a certain standard); no-cost re-dos if a medical

procedure fails to resolve a medical condition; and team service that provides 24/7 access to medical teams with little or no wait time.

The ability to change providers with each procedure requires perfect information for the providing doctors as well as the consumers. The use of online electronic health records that are accessible from any location is a requirement of the proposed system.

2. Insurance Deregulation

The second tenet of the model is the need to remove health care insurance regulations requiring universal care for all individuals. The tenet does not suggest the removal of medical insurance completely. It does, however, allow the consumer to insure for specific situations (for which he/she is willing to pay). For example, consumers whose family histories have significant heart problems could buy catastrophic coverage for heart problems only. This insurance would exist only as a last resort, after a minimum expenditure has been reached, and after all other payment options are exhausted.

3. Government-Created Personal Health Fund Debit System

Under our model the government would create a new debit system assigned to each citizen at birth. This debit system links a medical account with a market fund that exists in each consumer's medical portfolio. At birth, the government funds the account with a seed fund sufficient to cover early medical costs for the newborn. This account grows at the market rate as unused funds are invested in market securities.

The government also has the right to seed the health fund at certain significant life events that are linked to events, milestones or life goals. An example of this is a retirement gift or a balance-above-a-certain-level gift, which encourages the frugal use of medical funds throughout life. The government can also fund for service in the military (replacing the VA program).

This fund exists as a tax-free benefit for each consumer. The funds are usable by the consumer and can be gifted to other consumers with no tax burden. Unused funds at the end of life can be bequeathed to new consumers tax-free for their use. Consumers can opt to pay into their own medical account on a tax-free basis. Parents and family can gift tax-free to anyone should the need arise.

This tax-free fund can be used as an incentive account by employers. New employees might be given regular deposits to their health care account as part of compensation packages throughout their terms of employment. These corporate payments can be part of individually negotiated payments or payments negotiated under union contracts.

Medical portfolios may be invested in any market fund. Individuals can move funds to diversify risk. As consumers near end-of-life, the funds can be moved to less volatile areas of the market (just as we do in retirement nowadays).

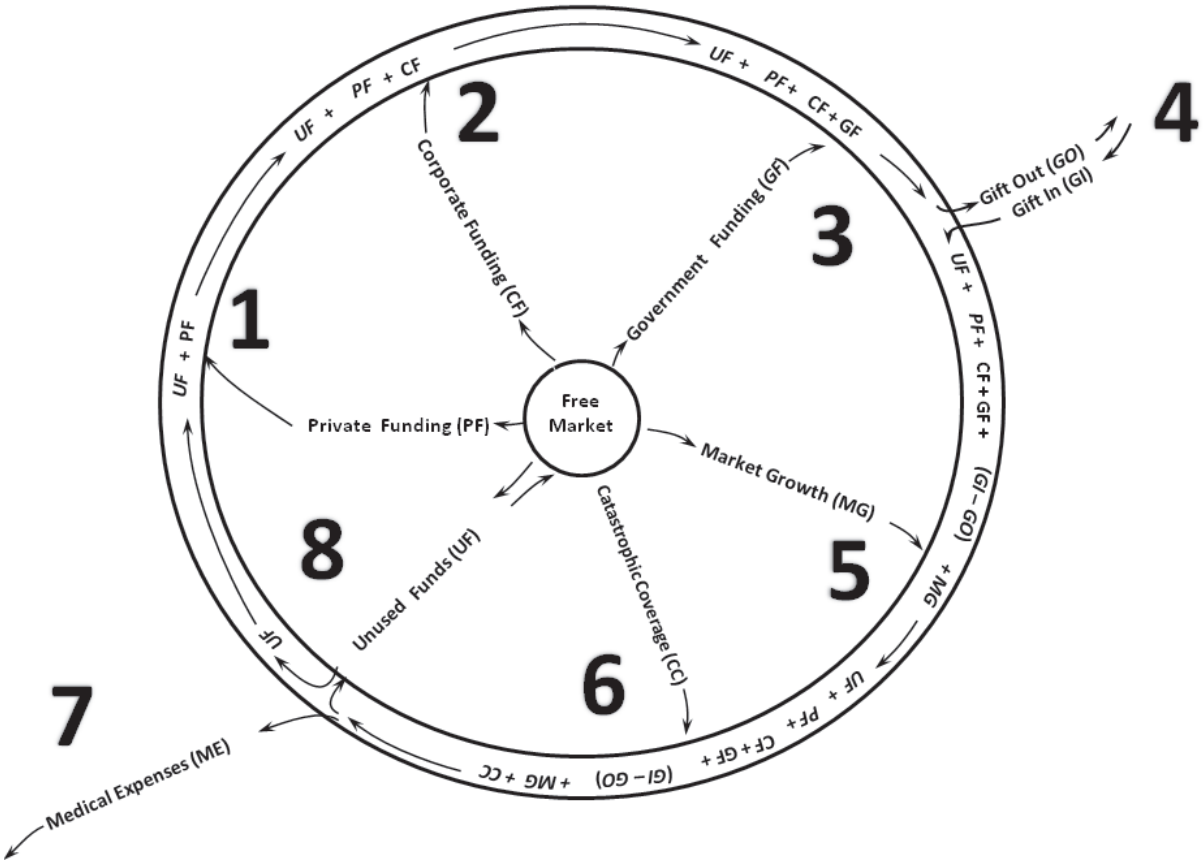
The fund transfers from a "medical only fund" at retirement to a fund that can be used for living expenses, extending retirement payments. This transfer incentive encourages frugality during pre-retirement years to gain reward at retirement.

MODEL VARIABLES

1. Unused Funds (UF) - At birth, this fund has a zero balance. Each year, unused funds are recycled through the market to grow at market rates.
2. Private Funding (PF) – Individuals can deposit pre-tax dollars into the fund for personal coverage.
3. Corporate Funding (CF) – Individuals negotiate with corporations as part of employment contracts to mutually agree on corporate funds deposited to their accounts.
4. Government Funding (GF) – A seed amount is determined and added at significant life events, e.g., birth amount, savings goal amount, or retirement amount.

5. Gift Out (GO) – Consumers can gift any amount to another individual tax-free.
6. Gift In (GI) – Consumers can accept gifts of any amount from another individual tax-free.
7. Market Growth (MG) – Unused funds are invested in the market and grow at market rates.
8. Catastrophic Coverage (CC) – Catastrophic coverage is offered to handle extreme emergencies with high deductibles, e.g., $100,000 minimum.
9. Medical Expenses (ME) – Medical expenses are those costs incurred by the consumer and paid for out of Unused Funds.

FIGURE 5
CIRCULAR FLOW MODEL FOR FREE MARKET MEDICINE



Model: PF + CF + GF + (GI – GO) + MG + CC = ME + UF

This model ignores all free market interactions outside of the funding for consumers. Once freedom of choice in medical care has been established, the free market mechanisms of supply and demand will equilibrate the supply and demand for services in mutually agreeable locations at mutually agreeable prices.

A simple example of the mathematical dynamics of the model shown in Figure 5 are presented in Table 1. This table contains simple examples of probable events in a medical consumer's lifetime. This table is not meant to be inclusive of all probable medical events, just to present the mathematics of the model. The table skips years for the sake of brevity.

TABLE 1
AN UNREMARKABLE EXAMPLE OF THE MODEL

Year	*Gift In or Gift Out (GI or GO)*	*Private Funding (PF)*	*Corporate Funding (CF)*	*Government Funding (GF)*	*Market Growth (MG)*	*Fund Growth*	*Medical Expense (ME)*	*Catastrophic Coverage (CC - Over $100 k)*	*Unused Funds (UF)*	*Notes*
Birth	***$ 7,500***	$ -	$ -	***$ 20,000***	3.00%	$ 28,325	$ 7,500	$ -	$ 20,825	birth costs
1	$ -	$ -	$ -	$ -	3.00%	$ 21,450	$ 1,000	$ -	$ 20,450	regular medical
14	$ -	$ -	$ -	$ -	3.00%	$ 15,413	***$ 4,000***	$ -	$ 11,413	regular medical orthodontia
16	$ -	$ -	$ -	$ -	3.00%	$ 7,988	$ 1,000	$ -	$ 6,988	regular medical
17	***$ 15,000***	$ -	$ -	$ -	3.00%	$ 22,648	***$ 15,000***	$ -	$ 7,648	regular medical, injury ER
22	$ -	***$ 1,200***	***$ 4,800***	$ -	3.00%	$ 10,737	$ 1,000	$ -	$ 9,737	regular medical
23	$ -	$ 1,236	$ 4,944	$ -	3.00%	$ 16,395	$ 1,000	$ -	$ 15,395	regular medical
50	$ -	$ 2,746	$ 10,982	$ -	3.00%	$ 350,582	***$ 150,000***	***$ 50,000***	$ 250,582	heart attack
55	***$ 20,000***	$ 3,183	$ 12,731	$ -	3.00%	$ 388,741	$ 1,000	$ -	$ 387,741	regular medical
56	$ -	$ 3,278	$ 13,113	$ -	3.00%	$ 416,257	$ 1,000	$ -	$ 415,257	regular medical
75	$ -	$ -	$ -	$ -	3.00%	$ 970,481	***$ 40,000***	$ -	$ 930,481	nursing home
76	$ -	$ -	$ -	$ -	3.00%	$ 958,395	$ 40,000	$ -	$ 918,395	nursing home
77	$ -	$ -	$ -	$ -	3.00%	$ 945,947	***$ 95,000***	$ -	$ 850,947	death
78	***($850,947)***	$ -	$ -	$ -	0.00%	$ -	$ -	$ -	$ -	gift to family

MODEL CONCERNS AND QUESTIONS?

1. ***Who Should Manage these Medical Funds?***

   Investment fund management can be conducted by free market merchants investing in free market securities. At birth parents are given a choice of fund managers. Post birth investments are moved just as we move retirement investments accounts today. Fund reporting on a quarterly basis should allow the consumers to manage their accounts. Funding for management fees are reviewed and approved by authorities so that individuals do not directly bear the cost of management fees. These fees are paid out of the medical account as are most retirement account fees today.

2. ***Should We Impose Middle Class Values on the Less Fortunate?***

   Is it fair to impose middle class (and upper class) values on the lower class consumer? Individuals that have no income or ability to save should not be forced to save. First, individuals are not forced to contribute personally to any medical account. The option of personal and company contributions (as well as gifting and bequeathments) are available to these consumers on a voluntary basis. Second, we should not disregard the model if it works for the forgotten man, that ninety percent of the population that understands the model and uses it wisely to manage their future legacy.

3. ***Where is the Motivation to Encourage Fund Growth?***

   What motivation is there for consumers to let the medical fund grow? This is a valid concern. Individuals often lack the necessary self-control to delay gratification. One could argue that a face-lift today is more important than the possibility of a heart attack later in life. So how do we motivate the frugal use of the fund during life with a hope to fully funding any medical event later in life?

   One suggestion is to vest the user in the medical fund at retirement. Funds saved in the medical account could be used tax-free for retirement as well as medical funding. This has a twofold effect. One, this creates incentive to 'save,' since funds can be used for non-medical events after retirement; and, two, it instigates a long term view on available funds. A consumer might reason; "I would rather travel when I reach 65 years of age than have a facelift now and waste my medical funds".

4. ***What about Bad Debt and Other Medical Business Concerns?***

This model does not remove the common practice within business to accrue for and manage bad debts. The model does not remove the need to serve individuals on an as needed basis. Medical services cannot and should not be withheld based on the ability to pay. Profitable companies today operate with bad debt losses. Post model changes do not change this requirement. Accruing for bad debt is important to any company's profitability.

5. ***Where are the Angels that care for us today?***

All arguments against the model must be reviewed in light of the current situation. Does the model contain any situations that do not already occur? For instance, one could argue that homeless or destitute individuals that have no family or friends to gift funds could suffer! True, but these individuals face this situation now. There are no miraculous events that will suddenly make "everything all right" for all participants. There are currently no Angels sweeping down to save the sick and dispossessed. There will still be homeless, disenfranchised, and self-satisficing individuals who will push the limits of our medical system and lack the funds to pay for all the services that they need.

One must remember that economics is a two-edged sword. While we still have an imperfect model on the consumer demand side, we must enforce free market principles on the supply side. Free market principles will drive down costs and improve the supply of medical services, allowing the marginalized and disenfranchised access to better and more affordable health care in the long term.

CONCLUDING THOUGHTS AND QUESTIONS

This paper discusses issues surrounding the current US health care system and proposes a free market approach to health care that restores control of the personal medical process to the consumer. This suggestion pushes the control of medical expenses back to the focal point of the transaction, the consumer. No model exists to date that pushes total expenditure control to this level. In a free market environment, free-floating prices and freedom to choose at the consumer level removes the complexity of the market balancing transactions so often sought at the government or corporate sector level.

The basis of this model is freedom of choice. Each consumer has the choice of doctor, level of care, location of care, cost of care, and quality of care. A basic assumption of this suggestion is the need for perfect information. Thus, the model assumes that each consumer understands that his/her choices are based on free market information and that the medical profession competes for consumers based on price and quality of service. The ability to change providers with each procedure requires perfect information for the providing doctors as well as the consumers. The use of online electronic health records that are accessible from any location is a requirement of the proposed system.

This model does not suggest that the quality of service fall below government regulated standards (i.e., service by non-qualified medical practitioners). It does suggest that the medical profession compete for consumers (who are free to move to any provider) based on information presented to the consumer). As competition within the medical system increases, that competition will inspire innovative marketing deals for medical procedures to help differentiate doctors and their services.

The model requires:

1. ***Freedom of Choice with Perfect Information for consumers and medical practitioners***
2. ***Insurance Deregulation and***
3. ***Government-Created Personal Health Fund Debit System invested in the market.***

The intent of the suggested model is to stimulate thought on current medical market interactions and move the medical system towards a free market model. Such an option has not been previously discussed.

APPENDIX A

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Expenditure on health as a percentage of GDP, 2006 or latest year

Country	*Public*	*Private*
Turkey	4.1	1.6
Poland	4.3	1.9
Korea	3.5	2.8
Mexico	2.9	3.7
Czech Republic	6.0	0.8
Luxembourg	6.6	0.7
Ireland	5.9	1.6
Slovak Republic	5.1	2.4
Japan	6.5	1.5
Finland	6.2	2.0
Hungary	5.9	2.4
Spain	6.0	2.4
United Kingdom	7.3	1.1
Australia	5.9	2.8
Norway	7.3	1.4
OECD average	6.5	2.4
Italy	6.9	2.0
Greece	5.6	3.5
Iceland	7.5	1.6
Sweden	7.5	1.7
Netherlands	7.6	1.7
New Zealand	7.3	2.1
Denmark	8.0	1.5
Belgium	7.2	2.7
Canada	7.0	3.0
Austria	7.7	2.4
Portugal	7.2	3.0
Germany	8.1	2.4
France	8.8	2.2
Switzerland	6.8	4.5
United States	7.0	8.3

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