The Health Economy

Contributed by David Cundiff, MD
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David Cundiff emerges as the man of the hour for anyone interested in the connection of health, medical costs, and the socioeconomic basis of the U.S.'s spiraling affliction of many interrelated crises. To achieve this, his new book The Health Economy:
Changing the Culture of Waste and Preventable Disease proposes bold, sensible restructuring of government spending and taxing to bring about greater citizen control over health, community and the direction that the nation is going in. - editor

A century ago, the U.S. was transitioning from an agricultural economy to an industrial/manufacturing economy with millions of workers moving from farms to jobs in factories, oil fields, and mines. Over the last half century, U.S. workers have continued to abandon the agricultural sector but also steadily left the manufacturing sector to find service economy jobs, many taking higher paying jobs in health care, financial services, education, law, and government. Others have taken low paying jobs in occupations not requiring higher education like food services, landscaping, housecleaning, nursing aids, childcare, and general labor.

With 80% of jobs in the service sector with its striking pay inequalities, the U.S. is now moving toward Third World nation status. Causes include trickle-down Wall Street casino-capitalism, globalization, and increased job outsourcing to lower paying countries.

America has arrived at a crossroads: letting the failing service economy fall into an abyss, or embracing a healthy economic paradigm. The latter requires sweeping change, but does not have to be frightening when it need not involve either unsustainable deficits or draconian public services cuts.

It is increasingly accepted that the era of cheap oil that allowed the U.S. economy to boom in the 20th century is behind us. The sought-after energy alternatives for continuing our expansion and boom are not within our grasp, even if they did truly substitute for the unique properties and advantages of cheap oil. Regardless of energy issues, given current fiscal and Main Street realities, no amount of entrepreneurial innovation will revive the past expansion rate of the gross domestic product (GDP) in either our imminent economic abyss or any new economic paradigm.

Fortunately, despite or because of the U.S.'s current dire economic situation, we can rapidly evolve from our sinking service economy to the “Health Economy,” with the creation of tens of millions of high value, if not high-paying jobs.

As my new book The Health Economy shows, we can restructure the U.S. financial and economic system as a “steady state economy” (i.e., 0% GDP growth), steadily advancing in quality of life instead of expanding material consumption. A steady state economy with the right structural reforms in health care, welfare, and other sectors can improve public health, strengthen communities, and lift ecological health. It does this by replacing institutionalized waste and inefficiencies in the public and private sectors with valuable human activities.

The Health Economy would be free-market oriented but less money-driven and afflicted by greed, with more importance given to volunteerism and mutual aid. As the book demonstrates with figures and charts, our $14.7 trillion economy carries at least $3 trillion in identifiable waste, including at least $1.1 trillion of the $2.6 trillion in health related expenditures. The complexities of how public and private funds can be re-allocated are made simple and appealing.

Medical controversies have always and will always be with us. For example, experts don't agree about whether screening mammograms or prostate tests save lives. Despite the fact that controversy is inherent in medical practice, government and insurance company-designated "evidence-based" treatment guidelines increasingly define what is and is not covered by public and private insurance. These top-down guidelines -- often influenced by biased researchers, special interest lobbying, or economic considerations -- change with remarkable rapidity.

Because the effectiveness and value of medical interventions are so frequently in dispute, the determination of which medical tests and treatments are covered by insurance should not be vested in government agencies (e.g., Food and Drug Administration, Center for Medicare and Medicaid Services, etc) or insurance companies. It should be decentralized and vested with the health care workers caring for patients in their communities -- health care workers hired by the patients they serve. The government should cease interference in health care and instead facilitate quality medical treatment, mostly by getting out of the way. Protecting the public from physicians prescribing bad treatments or from failing to use good therapies can be dealt with best on the community level rather than by committee decisions and edicts issued from Washington, D.C.

The Patient Protection and Affordable Care law (i.e., "Obamacare") strongly incentivizes "accountable care organizations" (ACOs), providing comprehensive prepaid care. Both Democrats and Republicans endorse ACOs as evidenced by Medicare's beginning to pay 10% more for prepaid, coordinated private health plans than uncoordinated fee-for-service care. Examples are the Mayo Clinic, the Cleveland Clinic, and Kaiser Permanente – but they can be much smaller, individualized to the health care preferences of different populations, and even more effective.

Physician Managed Care -- the health care component of the Health Economy -- would feature the use of ACOs as the primary health care delivery system. However, Physician Managed Care ACOs would be owned cooperatively by the enrollees and run as accountable care cooperatives (ACCs). These ACCs would be constituted as nonprofit cooperatives as defined by the International Co-operative Alliance's Statement on the Co-operative Identity: "autonomous associations of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through jointly owned and democratically controlled enterprises."

Most funding for ACCs would come from age-adjusted insurance premiums paid by individuals, with subsidies for low-income people. Federal government funding to ACCs would be with consist of patient risk-adjusted allocations (i.e., the government gives ACCs more money for older, sicker patients than younger healthier patients).

Government health care regulation would be replaced by private, competing ACCs determining their own medical guidelines and benefit packages. Deregulation of insurance funding decisions in this consumer-driven health care system would over time dramatically reduce the waste and increase the range of services and the value of the health services provided. For instance, one ACC might not cover the cost of screening mammograms or prostate tests for enrollees while another ACC might cover these controversial tests. Money saved by not covering mammograms might be used to expand other health services.

Paradoxically, health outcomes (longevity, infant mortality, etc.) depend relatively little on the quality of medical treatment provided and much more on social indicators of health (e.g., educational opportunities, income, race, nutrition, social network, etc.). Consequently, the funding and responsibility for welfare services (e.g., food assistance, housing aid, unemployment and disability allocations, etc.), totaling $772 billion in 2010, would be shifted from the government to thousands of individual ACCs, to efficiently coordinate and integrate health and welfare services.

While fixing the health care and welfare sectors of the economy is sorely needed, doing this in isolation would still be similar to rearranging the deck chairs on the Titanic. In our current unprecedented economic crisis, waste and inefficiency must be greatly reduced in the other sectors of the economy -- at least $2 trillion per year is currently squandered -- to avert rising destitution and to optimize health.

The Health Economy plan is to extend the involvement of ACCs even beyond health and welfare services to jobs creation, Social Security, prepaid financial and legal services, and even aspects of national defense (e.g., sustainable development aid projects in Third World countries to build good will towards Americans).

With ACCs receiving patient health insurance premiums ($1.3 trillion beginning in 2011) and Social Security contributions ($600 billion), supplemented by federal government allocations for health, welfare, jobs creation, Social Security, and education system enhancements ($2.0 trillion), ACCs would control about $3.9 trillion per year to provide for the health care, welfare, and financial security needs of enrollees. ACCs would join society's three economic sectors -- government, private, and nonprofit (also called "social," "voluntary," "civic," or "community" sector) -- as the fourth major sector of the economy.

ACCs would be neither encumbered by excessive government bureaucracy nor beholden to elite Wall Street investors and bankers or powerful corporations. Government and corporate power over our lives would be hamstrung permanently, as the power of community and self-reliance is unleashed. In particular, ACC funding would create over 14 million new jobs and pay up to 50 million more people who are now parenting their children or caring for disabled and elderly relatives and friends. With a autonomous and empowered ACCs, we would see (1) an increase in enrollees' value for money for health care and welfare services, (2) downsizing of government spending by nearly $1.6 trillion per year, and (3) a massive decrease in waste and inefficiency in legal and financial services, energy, and the military, and (4) free-market non-megacorporate capitalism in health care and other sectors rather than obtrusive government regulation.

To pay for the federal government's component of personal health care costs, a "health fee" on fossil fuel and nuclear energy (equating to $2.08 per gallon of gasoline, raising $683 billion per year) would be levied. This would also reduce our dependence on foreign oil, decrease environmental pollution, foster conservation and renewable energy technologies, and improve our foreign trade imbalance. Even with the new $683 billion "health fee" on non-renewable energy considered a tax, the Health Economy would reduce taxes by the federal, state, and local governments by $367 billion relative to 2007.

Our current severe problems in health care and the economy will not yield to more government deficit spending or purely market solutions, but they can be addressed by ACCs creating jobs and improving unhealthy lifestyles ($1.7 trillion per year is spent today in chronic disease treatment costs). Moreover, such a shift to local-based decision making, as the Health Economy provides, would coordinate initiatives addressing the social indicators of health, eliminate unnecessary torts and litigation, foster financial literacy, conserve energy, reform immigration policy, strengthen Social Security, end deficit spending and shift our national defense strategy from military adventuring to aiding Third World people with sustainable development.

The Health Economy can serve as an alternative to the current dead-end options of more deficit spending versus increasingly draconian austerity measures. The Health Economy provides common ground in a model that can be embraced not only by mainstream taxpayers but those marginalized in economic and political discourse like Greens and Libertarians. In the process, communities, with the aid of ACCs, will retrieve much of the lost self-reliance and local decision making that formerly characterized the Jeffersonian democracy that founded this nation.

For additional details about the Health Economy plan, see Culture Change's upcoming publishing of Chapter One of David's book. Get the book as soon as it is announced for sale. For pre-sale orders, contact the author via email: dkcundiff3 "at" verizon.net

Please take a survey about your views concerning the Health Economy plan. Your input is needed toward generating public discourse on ACCs and other aspects of the Health Economy. Please pass along this article and encourage any

readers to take the survey.

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David K. Cundiff, MD is the author of previous books such as The Right Medicine: How to Make Health Care Reform Work Today, co-written with Mary Ellen McCarthy, Humana Press (1994), and
Money Driven Medicine – Tests and Treatments That Don't Work, by David Cundiff, MD, published by Cundiff (2006). He was employed in the 1990s at Los Angeles County - USC Medical Center Hospital in oncology and internal medicine for hospice patients. David's work quantifying the astronomical health and financial cost of car dependence and use of fossil fuels appeared in the Auto-Free Times magazine in the mid-1990s.

Culture Change's Jan Lundberg has been serving as editor of David Cundiff's book The Health Economy.