A Conversation about Canadian and American Health Care with Lee Kurisko, M.D.

Interviewed by Peter J. Nelson

CENTER OF THE AMERICAN EXPERIMENT

Center of the American Experiment is a nonpartisan, tax-exempt, public policy and educational institution that brings conservative and free market ideas to bear on the hardest problems facing Minnesota and the nation.

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Mitch Pearlstein, Founder & President, Center of the American Experiment: In contrasting health care in the United States and Canada, critics often have nicer things to say about how it's delivered north of the border rather than south of it. By "critics," in this instance, I'm referring mostly to those in this country. Personally, I must admit there have been moments when I've been so incensed and frustrated by the extraordinary complexity and weirdness of America's non-system, that a *seemingly* simpler arrangement such as Canada's, or perhaps Great Britain's, has held a certain appeal. I trust I'm not alone in this confession. Though I hasten to add, with a good night's sleep and the return of comparative calm, I've fully recognized that any health care system that's run by a national (or provincial) government is highly unlikely to be less maddening, especially in times of crisis when lives are very much at stake.

With that as prologue, I invite you to read this keenly important conversation with Dr. Lee Kurisko, as it's the most concise explanation I've ever read or heard why this is true specifically in Canada and by virtual definition elsewhere.

Lee Kurisko is a Canadian radiologist who formerly practiced in Thunder Bay, Ontario, as director of diagnostic imaging for Thunder Bay Regional Hospital. For most of his life, as he has written, he was a "staunch believer in the moral superiority of Canada's system of universal health care." But upon "confronting the obstacles to delivering quality care under such a system," he came to realize the "profound economic, logistical and even moral limitation of providing health care in a government-run, one-party-payer, universal health care system." So while already in his 40s (this was a half-dozen years ago), he moved to Minnesota, where he serves on the Board of Directors of Consulting Radiologists Ltd., based in Minneapolis. He works primarily out of St. Francis Regional Center in Shakopee, but also practices at Abbott-Northwestern Hospital in Minneapolis and the New Ulm Medical Center in New Ulm.

He's a graduate of the medical school at the University of Ottawa and did a two-year residency in family medicine at Ottawa Civic Hospital as well as a four-year residency in radiology at the University of Manitoba. He and his wife Laraine, a clinical depth psychologist, have two children.

Dr. Kurisko's on-target interlocutor for this publication was Peter Nelson, an American Experiment policy fellow and the Center's lead authority on health care. An Edina native and

University of Minnesota-trained lawyer, he is the author of Center publications such as *Affording Boomer Long-Term Care in Minnesota and the Nation: What Do Demographics and Health Trends Tell Us?"*

As a matter of public policy, health care reform is not only the elephant in the room, it's a whole herd. As such, American Experiment has significantly expanded our work in this area in recent years, and without question, the conversation that follows is one of our largest contributions. My great thanks to Lee and Peter, as well as editor Kent Kaiser, and as with everything the Center does, I welcome your comments.

Peter Nelson: A lot of Americans aren't very satisfied with their health care system. Surveys tend to show that Canadians are, in fact, more satisfied than Americans. If Canada's health care system has so many problems, why do Canadians seem so satisfied? At one point, you were quite satisfied with the Canadian system, weren't you?

Lee Kurisko: Every so often you hear of these surveys, and they're talked about regularly in the Canadian press, about how the majority of Canadians are happy with their health care. Yet those surveys are skewed, because, at any one time, most people are healthy. I think most Canadians are happy that they are not consciously paying out money for premiums (although they are paying covertly through the nose with their taxes).

There's a lot of propaganda in the Canadian press about the evil American health care system, where people are going bankrupt from paying for their health care bills and what not. Consequently, Canadians are very much biased against what they perceive as the evils of the free market American health care system.

When they're generally healthy, I think most Canadians are probably happy with the idea they're not necessarily paying for health care, and they *think* they have access to it. On the other hand, I suspect that their tune changes when they actually have a problem and realize that they may have to wait literally years to have the problem addressed, whether it is a hip replacement, diagnostic imaging, a consultation with a specialist, or whatever.

PN: Satisfaction surveys may be good for showing trends within a country, but are they really that good for comparing Canadians to Americans?

LK: In Canada there's a false perception, which I actually held for many years, that if you don't have health insurance in the United States, you literally do not get care. There's a perception in Canada that in the United States if you don't have insurance and you have a problem, you're going to get turned away and that people are just dying in the streets for lack of health care.

I've been in America for almost six years, and I've yet to see anybody who's been turned away for health care—at least in Minnesota. Whereas, the reality is that Canadians *are* turned away for health care in many different ways—through waiting lists for access. There are also huge inequities in the availability of health care throughout Canada. For example, in Newfoundland they have a waiting list of two-and-a-half years for a diagnostic MRI (Magnetic Resonance Imaging). In some places in the country the waiting list could conceivably be as low as six weeks. If you live in the Yukon Territory or the Northwest Territories, you're not going to have immediate access to a neurosurgeon. Your level of access is going to be far greater if you happen to live in a place like Toronto.

PN: What was it in the Canadian system then that prompted you to uproot your family and your career and move from Canada to Minnesota?

LK: It was a really big deal to change countries like that. When I finished all my medical training and specialist training, I had absolutely no inclination whatsoever to move to the United States. It was the farthest thing from my mind. Yet when I took my job as radiologist at Thunder Bay Regional Hospital, fairly quickly I became director of the department and was faced with the realities of trying to deliver high quality care. I was confronted with things like budget shortages, shortages of manpower, decrepit equipment, and to some degree incompetence on the part of people that normally in a marketplace would have been culled out.

I saw what was happening in Canadian health care and realized that, as director of the department, I really had little power to make things better. I was very much under the government's thumb. I just came to realize that socialism doesn't work. Central planning doesn't work. So it was a huge philosophical change for me. Eventually, I realized if I wanted to be happy in my work and deliver the standard of care that I wanted to give I had to emigrate to the United States.

I had a long period of denial where I thought that by just staying—if I just put up with this—eventually, I'll make things work. Eventually, I realized it was far bigger than I. If I wanted to participate in the level of care that I wanted to give, I had to move to the United States. It was a big deal, and it was definitely the right thing to do.

PN: A lot of people strongly criticize the American system as being unethical or immoral, especially in regards to the disparities that you might see in the system, disparities in care. It's true that someone with a low income tends to have less access to care compared to someone with a high income. Can you speak some more on any inequities that might be in the Canadian system that we in America might not hear about?

LK: I've seen more inequity and disparity in Canada than the United States, as far as access to care. As I mentioned, we had huge waiting lists. Our MRI waiting list was 13 months long. Our CT scan waiting list was seven months long. People in that system really were just left to suffer to a much greater degree than they are here in the United States.

One thing that you see that is not talked about very much is that Canadians with influence or connections tend to get medical attention more quickly. I would get telephone calls from various doctors requesting that their patients be moved up on the waiting list. If they made a reasonable case, I would do so, whereas there were other doctors who just referred people for imaging tests, and I *never* heard specific requests from those doctors. Their patients would just go to the end of the waiting list because they didn't have the same level of advocacy. The other thing—and it's kind of a deep, dark secret—is if you are connected to somebody in the medical system, you're much more likely to get your medical intervention done more quickly, whether by knowing a doctor, knowing somebody in the hospital administration, or whatever.

On the other hand, here in the United States, hospitals give an awful lot of free care, and nobody waits for it at all. Therefore, I would say that the inequities are far greater in Canada than they are in the United States—at least that's my perception on the ground, in the trenches, delivering health care from day to day.

PN: You worked in Thunder Bay, which is a decent-sized city, but it's isolated. Winnipeg, the closest large Canadian city, is pretty far away. When you left Thunder Bay, how easy or difficult was it for the Canadian system to adjust to the fact that you had left?

LK: The entire Canadian system is quite fragile. To a large degree, it's understaffed. We had serious manpower shortages in Canada when I left. We had only three radiologists providing services to 250,000 people; the Ministry of Health had determined that for us to be adequately staffed, we would need 13, so my resignation was very significant.

I think there's a lot of fragility because the Canadian system is purposely planned to be based on shortages. About 20 years ago, there was a conscious government decision—this is no secret—to create a rate-limiting step in the delivery of health care in Canada because health care inflation was out of control. The government determined that one way to control health care inflation was to reduce the number doctors they trained, so they started training fewer doctors. At the same time, there were good cures and good treatments for heart disease and cancer developing, so people were being kept alive longer with their conditions. The bottom line is that there was actually an increase in the need for doctors, and there was a conscious effort to cut the number of doctors. Thus, a single doctor leaving became very significant.

PN: Government-run systems are often criticized for lacking innovation. In your own field, tele-imaging has begun to improve access for rural America. What sort of timeframe do you think you would be looking at—the lag time between the market system in America saying, "Hey, we can serve rural communities through the Internet" and Canada catching on, it's whole central planning process notwithstanding?

LK: I've got some great experiences to share. When I was in Thunder Bay, there was a federal initiative in Northwestern Ontario—six million dollars put forth from the federal government for telemedicine services. It was like two or three years and nothing happened; I mean, the money was earmarked for it, but nothing really got produced as far as providing teleradiology services. On the other hand, working here in Minnesota with Consulting Radiologists, we are *actively* evolving our teleradiology service all the time. We have people on staff—information technology experts—working on our teleradiology services all the time. We're expanding them. We're moving forward—adding customers in North Dakota, South Dakota, Iowa, and Nebraska. In a period of months, I can see far more movement than I saw in a period of years in Canada.

Something interesting was that this federal money was earmarked for telemedicine in Canada, and I read in the newspaper about how, in short order, women would be able to get their mammograms in Kenora, which is a few hundred miles from Thunder Bay. Before they even left the doctor's office, they would have an interpretation from a radiologist in Thunder Bay. I'm thinking, "Hmmm, that's interesting. I'm one of only three radiologists in Thunder Bay, and I didn't hear anything about this whatsoever." Clearly, we didn't have the manpower to provide that instantaneous kind of turnaround. It probably never got off the ground anyway even after I left.

The point is, government can spend the public's money hand over fist irresponsibly and produce no results. On the other hand, as a private organization, Consulting Radiologists, where we have shareholders to whom we answer, has to produce in an efficient manner.

Now, the real motivator and the reason why what I'm seeing in the United States is working with teleradiology is that it's based on a free exchange of dollars. In other words, we can profit if we do it right, so we are motivated to do it. We can make money, and patients get the service they want. The doctors get the service they want. In fact, we strive

for a 30-minute turnaround. Compare that to Canada: My father had an MRI done several months ago. The only reason he didn't have to wait a long time is because he was connected to me. They got him in fairly quickly. He had the MRI done in late June. He was told he would get the report in October—that's just to get the report once the scan is done. Compare that to us really working hard to get a 30-minute turnaround here in Minnesota. That's the free market versus government planning.

Let me give you another example. When I was working in Canada, we had this personnel meltdown when we had only three radiologists for 250,000 people. I was director of the department at the time, and I said to the hospital administration, "We need a rolloscope." A rolloscope is a device where the X-rays and CT scans are set up on the scope, and you can push a button and go from case to case to case. It really expedites your ability to read the cases promptly. I was reading about 40,000 cases a year at that time, which is just an enormous number, especially if you're reading without a rolloscope. The hospital said, "Well, you know, what? There's no money in the budget for us to buy your rolloscope. Perhaps, you could plead the case to the Ministry of Health. Perhaps, they can make a special dispensation of dollars so that you can get this rolloscope." The radiologists in Thunder Bay eventually got the rolloscope three years later, but there was no money to hire a clerk to load the films, so it just sat and collected dust for another year.

When I moved to Minnesota, I worked at St. Francis Medical Center in Shakopee, and we were seeing increasing volumes and just getting busier, and busier, and busier. My partner and I approached our organization, Consulting Radiologists Limited, and said, "We need a rolloscope. We've got these increasing volumes." They looked and said, "Hey, you guys are phenomenally productive. We want to *facilitate* your productivity. Here's your rolloscope." We had the rolloscope in a month, and we had someone to load it, too. That's the free market versus central planning.

Let me give you another great example. A few years ago, my brother was sick with a really bad cancer. He'd been working for months to try to get it addressed. When he explained his symptoms, I said, "You really need to have an MRI of your head and neck." He just couldn't get one. On Christmas Day three years ago, he was in great pain. He presented himself to the emergency department—not in his own town of Guelph, because there was no MRI machine for people in that community of 70,000 although there is a scanner available for pets—but in Kitchener, which is about 15 miles away and where there is an MRI machine for humans in the hospital. Because it was Christmas, they said, "Nope, the MRI scanner is closed. You can't have an MRI. You can only have it on a business day, during regular working hours." My parents happened to be there visiting, and they just raised the roof. He got his MRI on Boxing Day, which is the day after Christmas. It's still a holiday in Canada, but he got the MRI. It was not read properly. I had to actually go to Canada and look at the MRI, and I diagnosed my brother's nasopharyngeal cancer.

It was very interesting visiting my brother in the hospital. They've got this kiosk in the lobby for Tim Horton's, which is a very popular restaurant chain in Canada, and it was open, basically, 24/7. You could go, sit down in the lobby of this hospital and get a nice sandwich, cup of coffee, and doughnut, 24/7, because it was a free market thing. Yet at the same time, you could not get the health care that you needed, because it's delivered under a socialist model.

PN: A lot of people are put off by the fact that doctors make money healing people. They believe

that, as a profession, it should be something a little bit different than any other profession because it's "the healing profession." Do you see a difference in America versus Canada in how doctors view their jobs as far as whether it's just about money here in America versus it being about serving your community?

LK: When I first went into medical school, I was truly not motivated to become wealthy. I saw economic security there, but it was not the primary thing that motivated me. I wanted to be in the profession.

I make pretty good money doing what I do, but it's because I provide value that people are willing to pay for. There was a time many years ago where I would have thought there was something wrong or shameful about making a profit from people's illnesses, but I don't see that anymore. I make a profit, but I don't gouge. I receive only what people are willing to pay. I don't think there's any kind of abuse or exploitation whatsoever in that relationship where I can make a profit off people's illnesses. Would it be wrong to say that people should not be able to make a profit selling food? Food is even more vital to our lives than health care. We would never say to Cub Foods, "It's wrong for you to make a profit."

PN: Do you think that most Canadians, today, have that sense that it's wrong and shameful to make a profit?

LK: Oh, yes! The buzz words "No profit in health care" are bandied about in the press all the time. If you were to set up an MRI center in Canada where people would pay out of their own pocket, there's a good chance you'd have people picketing. Not to mention, it would actually be against the law under the Federal Canada Health Act to set up such a business although recently, in some parts of the country, people are circumventing the law and opening private clinics and imaging centers. I suspect that the federal government is turning a blind-eye because they implicitly recognize government's inability to meet people's needs.

Yet, if you can't make a profit at what you do, why would you move capital into providing that service? Why would you ever expect somebody to invest money to feed you, to house you, to care for your medical problems if he cannot get something in return? I think that somebody should get a return for providing what people want. That's a major change in my view. Ten years ago, I would have thought profit in health care is a bad thing, but my eyes were opened to the reality that you have to have a potential for profit. Profit is the signal of where capital should go to provide what people want. Making a profit is actually a highly moral thing because it indicates that you are meeting people's wants and needs through mutually beneficial, non-coercive voluntary transactions. Such relationships form the basis of a peaceful, productive and happy society. History has demonstrated clearly what can happen when society is based upon the coercive iron fist of government with the goal of achieving some nebulous "greater good."

PN: We've talked about profit in America and how America decides where to put resources and investments. What about Canada? How are resources allocated differently in Canada?

LK: When I was there, I was, to some degree, involved in trying to influence where resources went. What I came to realize is that it was not about any objective information about where people are willing to spend their dollars. It was about how you could get your hands on the levers of power to influence others in power to get them to give you the money. It was not a voluntary relationship between you and the ultimate source of the money.

Let me give another example. When I was in Canada, I did a lot of intravascular work, and I was doing a cerebral angiogram one day. What's involved there is you make a puncture in the femoral artery and feed a thin catheter into the blood vessels that supply the brain. I had a patient one day with very, very tortuous, curvy arteries. It was really hard to get the catheter into place. The whole time that you're doing this procedure, there's a potential that you could cause a stroke; you could chip off a little bit of cholesterol, and it could go careening through the blood vessels and cause a stroke. With this particular patient, the hazard was higher than the normal because his vessels were in such bad shape. I threaded the catheter up into his carotid artery, and I was ready to do the x-ray dye injection to do the run of films, and the machine crashed. The machine was about 15 years old and was every bit as outdated as any 15-year-old computer. The thing was completely dilapidated. I was sweating buckets because I had this catheter in place and I wanted to get it done, for the safety of the patient. I made an elective decision to just wait, and the techs got the machine going, and we got the test done. The patient didn't realize that his risk had been enhanced because of this old dilapidated equipment.

After that I was really upset. I had been talking to the administration of the hospital about how we needed new angiography equipment. I sought legal counsel—from my father, a retired judge. I said, "I'm really worried about working on patients with this angiography equipment." He said, "You know what? If you're worried about it, you're morally and legally obligated to tell the patients that you think the equipment is unsafe." So I went to the hospital administration and said, "This equipment is unsafe. It needs to be replaced. I'm going to tell every patient that it is unsafe." And I started doing that. Within a *day*, I had the money for a new angiography suite. It was close to a million dollar expense. I managed to manipulate the levers of power to get what I wanted. In a free marketplace, it would have been long determined that buying new equipment was a good allocation of capital. If you truly had a free marketplace, you had competing hospitals, they'd say, "Oh, look at Hospital X uses unsafe equipment. We use state of the art." That's one example of how the Canadian system doesn't really work.

I used to sit on the Medical Executive Committee of a Canadian hospital, and once a year it was capital budget time. We had to figure out where to put the money. Here I was in radiology and really knew only about radiology. Yet we would be solicited with all different kinds of types of requests from different specialists in the hospital. The ophthalmologist says, "Oh, we need this new device for use in cataracts. We need these new prosthetic lenses, blah, blah, blah." Then somebody in gastroenterology needs some kind of new scope or whatever. As a member of the Medical Executive Committee, I had to rank arbitrarily what I thought were the best to worst expenses. I was really not knowledgeable in those fields to know for sure if they were good expenses. It was just a hit-and-miss method of determining how to spend the money. It wasn't based on market forces at all. Whereas, if you compared that to Abbot Northwestern Hospital, which is a top-ranked tertiary care hospital here in Minneapolis, they would have had the best of everything because it made sense to them to have the best of everything. It's not based on a *guess* of a bunch of panel members on the Medical Executive Committee.

PN: In America, providers set their prices. In Canada, the government sets prices. How does that difference impact the Canadian health care system?

LK: In Canada, when a doctor is paid, say, 20 dollars for a given service in downtown Toronto, and a doctor is getting the same thing in the remote

community of Manitowage, the artificially set prices blunt the potential for movement of information. If there were a deficiency of doctors in Manitowage, and you allowed the marketplace to work, the prices would go up in Manitowage. The doctor in Manitowage might get to charge 50 dollars for a service that would be reimbursed in a free marketplace in Toronto for only 20 dollars. In such a scenario, doctors would start moving to Manitowage. Once there were more doctors in Manitowadge, the price would tend to correct back downward. Freely floating prices go a long way to solve resource distribution problems. You notice that phenomenon in virtually any reasonably sized town in America. You can get access to a doctor, you can get tires for your car, and you can get gas in remote areas because of market forces working through freely exchanged dollars . I believe that in Canada, you could go a long way to solving the problems of manpower and equity across the country if you let the marketplace work.

I'll give a good personal example. I mentioned intravascular work before. For a long time, I was the only guy doing it in Northwestern Ontario. There's a procedure called angioplasty where you put a thin catheter up into the femoral artery, which may be narrowed by atherosclerosis, and you expand a balloon to stretch it out to increase the blood flow to the legs. For a while there, I was the only guy doing that. Then I made this decision to come to the United States. The vascular surgeons had a fit, because they realized there would be nobody to do the angioplasty anymore. Therefore, they'd either have to do open operations, which would mean far greater recovery times for patients—and such procedures wouldn't necessarily be medically indicated—or they'd have to send patients to Winnipeg or Toronto.

The reason nobody else would do the angioplasty was because it was so poorly reimbursed. For about an hour's work, I probably made less than a plumber per hour because of an artificially set price through the Ontario Health Insurance plan fee schedule. In a true marketplace, prices would correct to where they should be. The fact that you have a government fee schedule with arbitrarily set prices contributes to the shortages that you see in Canadian health care. Furthermore, true costs are driven up because open surgical procedures, or traveling, are more expensive than having the angioplasty done locally. Remember that virtually all medical services in Canada are reimbursed on a fixed fee schedule. Therefore, shortages of medical services are ubiquitous across the country. As Milton Friedman said, wage and price controls lead to shortages or surpluses, always.

To some degree, it's the same here in the United States with Medicare prices that don't necessarily cover doctors' costs. A lot of doctors don't want to touch Medicare patients for that reason. I have a friend who is a gastroenterologist. He tells me that if they were reimbursed across the board on a Medicare fee schedule for endoscopy, they'd have to close their doors because they couldn't cover the costs. The idea that you can just arbitrarily impose Medicare on everybody in the United States to solve all the price problems is absurd. You'd generate shortages, and people wouldn't get the care they need, and you'd end up with waiting lists just like Canada.

With Medicare, you get cost shifting. If, as a health care provider, you're artificially reimbursed too low for some of your clientele, that means to cover your costs you jack up the prices for other clients. As those costs go up, you're actually contributing to the number of the uninsured because insurance costs are artificially inflated, and fewer people can afford coverage.

I think a lot of problems occur in the United States because of governmental intrusion into health care. This is the case not just because of the very

existence of Medicare and Medicaid, which distort the marketplace, but also through other regulations. Regulation drives up costs. You've got to remember that health care is probably *the* most regulated industry in America right now. The regulations are costly to comply with.

Also, I think that there needs to be some significant tort reform in the United States. One thing that I think Canada does that's right is that there is a capitation on reimbursement from lawsuits for pain and suffering with no cap for potential economic losses. I think that's fair. If a doctor legitimately screws up and causes a person to be disabled and lose income, I think it's fair to sue for loss of income. On the other hand, when you say that the sky is the limit for pain and suffering, then you get these huge awards that drive up malpractice premiums. It motivates doctors to over investigate. Costs are driven up also because doctors have to pay protection money to insurance companies in the form of malpractice premiums.

PN: We've focused mostly on Canada in this conversation. But you now practice in the United States where rising health care costs continue to be a problem year after year. To contain costs, many propose a Canadian-style system, which, aside from Canada's tort system, I gather you oppose quite strongly. To conclude our conversation, do have any parting thoughts on what we in the United States can do to get health care costs under control?

LK: Health care inflation is real. It's far above the standard rate of inflation. Even insurance companies don't have a bottomless well of money. With ongoing inflation, they, in some sense, have to function like governments and create rate-lifting steps because the marketplace doesn't work on its own, because patients don't function as consumers. We have a third-party payer system where people have what amounts to first-dollar coverage with no accountability for cost. If patients were accountable for costs and spending their own money for the first $5,000 or whatever of care, they would function as the rate-limiting step and question doctors and say, "Do I really need this test?" They would question hospitals and providers, "Is this cost really justified? Maybe I should go somewhere else."

Certainly, I'm not against health insurance. I would never go without it, but, on the other hand, a lot of policies are not just insurance. They're prepaid medical plans. When everything is covered, then there's no restraint. I want insurance for the catastrophic illness that I may get or if I get in a bad car accident and I have really high costs. I don't really want to have to pay insurance for routine things like my daughter's sore throat or immunization or something like that, which is routine and expected. A good analogy would be house insurance. House insurance is pretty reasonably priced, and it is because we have it for unexpected problems, like our house burning down or being robbed. My premiums reflect the fact that these are unlikely eventualities. On the other hand, if house insurance was based on all of my needs for my household—floor wax, paint, dishwashing soap, new clothes, or whatever—then, as a consumer, I would say, "The sky is the limit. Let's paint the walls every week. Let's put in new carpets every week." The cost for home insurance would be astronomical, and yet that is the exact situation that we have with the standard health insurance in the United States right now.

I'm a real advocate of health savings accounts. I have a fellow Canadian friend who lives in California, and he spends roughly about the same per month as what I pay for health insurance, and yet half of his money goes into a health savings account and half goes to into his insurance product. What I have is just pure insurance. My premium is paid every month through work. I'm pretty healthy. At the end of the year, usually I have no expenses whatsoever.

All that money has been paid out, and I have nothing to show for it at all. On the other hand, he's got a few thousand dollars that he owns, that he has stewardship of. You know if he or his wife need some health care, they're going to go to the doctor or go to the hospital—he's actually done this—and said, "Look, can you give me a better price?" He's been able to negotiate prices down. I would love to see more and more people get that type of a product, and I think that they will catch on.

The other thing is HSAs motivate people to have stewardship of their own health. If a person knows they may have to pay for the consequences of their smoking, diabetes or whatever, that potentially may be a motivator for actually getting them to be healthy. I did primary care for three years, and I was a real advocate that people should eat properly and exercise, and yet I noticed, to a large degree, it just kind of fell on deaf ears to tell that to people. Perhaps, if you hit them in the pocketbook, they may be more motivated to take stewardship of their own health.

To a large degree, the health insurance industry has functioned in a manner that totally denies actuarial facts, which is that some people are going to be at higher risk for illness—sometimes voluntarily at higher risk than other people. The person who is healthy and conscientious is actually subsidizing people who are intentionally not healthy.

Another problem is shall-issue laws that say a person cannot be denied insurance. That gives a healthy person with no pre-existing condition an incentive to say, "What the heck? If they can't turn me down when I get sick, why should I buy it?" That actually contributes to health care inflation: If people are not buying insurance when they should, obviously you have a smaller pool of sicker people paying the insurance costs, so the insurance costs are higher.

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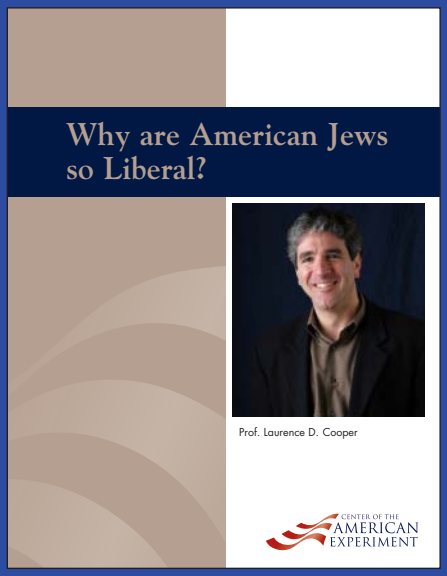

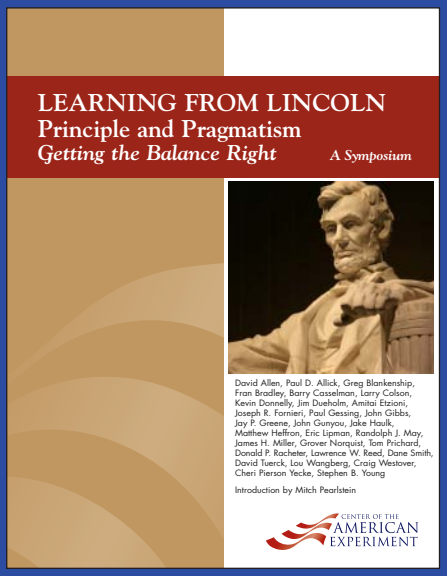

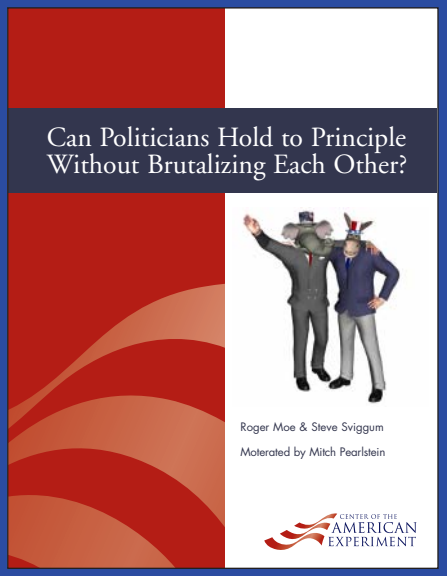

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