

**The following is Dr. Harry Goldsmith's reply (in rRed) to the article titled "Universal Healthcare – A Clear Path to Disaster for the Physician, Patient, and Country." by: Jon Purdy, DPM, which appeared in the Jun 2008 issue of Podiatry Management.**

A universal single-payer healthcare system would not only be a mistake of known proportion, as witnessed in other similar models, it is the opposite of everything that has driven this country's prosperity, making us economically, the strongest nation in the world today. **Supposition, unsubstantiated. "Mistake of known proposition?" Fact: total US expenditures currently exceed \$2 trillion per year, or over 16% of our gross national product. We spend much more on healthcare than any other country, yet by most measures of national health, the United States ranks well below many other advanced countries that spend less. (<http://content.healthaffairs.org/cgi/content/abstract/27/1/58>).** The debate necessarily encompasses political and humanistic ideologies as well as consideration of its economic impact.

In the study of an issue there are various tools one should use to formulate their opinion. It is important to look at the ideologies of the proposition, current similar models of what is being proposed, as well as historic events and trends. Our learned colleague Harry Goldsmith, DPM recently wrote an article outlining his argument for a single-payer universal healthcare system (*A Proposal for National Healthcare - A "Medicare For All" plan could fix our present flawed system*). He begins by backing Bill HR 676 and aligning himself with one of its drafters, democrat and former presidential contender, Dennis Kucinich.

The basic tenants of those subscribing to governmental intervention through entitlement programs is that you, the individual, are not smart enough to know what is in your best interest, nor do you possess the skills or drive needed to live your life successfully. Furthermore, given opportunity and free choice, you likely will not do what we, the government, know is in your best interest. Therefore, we will have to take care of you through all your failures so why not just mandate now what we know is best for you and your future? **Huh? Quite a leap there. Thank you for the commentary. While universal healthcare would certainly be defined as an entitlement program, it would be paid for by the people it covers. Under my proposal, those people would have every right to see any provider, seek treatment in any hospital in the country, as opposed to managed care programs, Jon, you remember managed care programs, and the tremendous freedoms and values that come along with them to those that may get that benefit from their employers, or those that can afford to purchase plans on their own. Let's recount the basic tenants of managed care plans: high cost, pre-existing conditional exclusions, no portability, best deal is achieved through preferred contracted providers (who are paid at fees that are reimbursed sometimes below Medicare rates, sometimes above Medicare rates, but at no time at usual and customary rates), penalties for seeking healthcare from non-participating providers, high deductibles, and on and on. You certainly have the right to reject my proposal outright, Jon, but insult me with fantasy. .**

In 1935, as part of the "New Deal", FDR introduced Social Security and Unemployment. This legislation was introduced during the depression to provide income to persons unable to find jobs. At the same time, it prodded individuals to retire, thereby freeing up jobs for others. As with almost every government program, it was never abolished after the country emerged from the depression and unemployment returned to a nominal rate.

In 1965 LBJ introduce Medicare as part of his "Great Society" vision. Since this time, dozens of entitlement programs have been integrated into our society. Either partly or wholly funded by the federal government, programs such as Medicaid, Medigap, Disability, SCHIP (State Children's Health Insurance Plan) and Supplemental Security Income (introduced by President Carter in 1975), exist to theoretically assist individuals through almost any adversity one can imagine. Now on the table, we have universal health care.

Before considering what is involved in the implementation of a single-payer universal healthcare system, we have to figure out how to pay for it. Let's look at what we have currently and how we pay for that. The United States Social Security Act created the largest government program in the world today costing tax payers over \$625 billion annually. It is funded through another Act called the Federal Insurance Contribution Act (FICA) also known as payroll taxes. Combined, these taxes total 15.3% of the payroll. Fifty percent is paid by the employer and 50% by the employee. Even if you are not a proponent of the Robin Hood concept of governmental function, on the surface this scheme might make sense. However, looking deeper, one finds that it's not this straight forward. First, this program almost went bankrupt in the 1980's. Also consider that the

benefits you pay in as an employer or employee are not necessarily a guaranteed future benefit, nor is it an advantageous investment of your hard earned dollars.

In the 1980's a group of workers in Galviston, Texas studied the performance of invested funds over a period of time and compared private investing to the returned investment of the Social Security program. A worker paying into the system and making an average of \$35,000 would receive a Social Security benefit of \$1,036 per month. Had the same individual invested the same amount of money over the same period of time in a private retirement plan, on average, he or she would receive \$4,915 per month. **Let me see if I have this straight, individuals – about 300,000,000 people in the US – will invest money from their pay checks every month toward a retirement plan so that when they retire they would receive \$4915...you know that Social Security isn't a retirement plan, right? Oh, a couple of days ago, the market lost 315 points. Could a disaster like Katrina, or a major illness, or a loss of a job, or loss of a home impact some of those individuals' ability to regularly put money away for their retirements? And if they spend it because of need or foolishness, what will they do then?**

There are also loopholes and broken promises in this system that most are not aware of. Social Security was presented to the American populous as never to exceed a total of 6% taxation. It is currently 12.4%. The most worrisome is the fact that regardless of what an individual pays into the system over a lifetime, the government retains the power to cut all benefits at any time. As such, it would seem extremely difficult for someone to argue that our government provides a personal security greater than that found in the private sector. If this is not enough, President Clinton during his term in office raised the taxable portion of Social Security to 85%. Why? In large part, to support the very government program that can't support itself.

This begs the question of where the money goes once it is put into the system. Since there are laws against governmental investments in the private sector, and in the case of Social Security, all excesses not paid out are placed into government Treasury Bonds. These bonds are non-marketable and backed by the U.S. Government. In other words, the government is writing itself an IOU. Simply stated, as the government promises more entitlements, it must tax more to bring in revenue to pay for it. Since these programs have a history and projected future of being unsustainable, they look no different than a compulsory Ponzi scheme. Currently, at our rate of taxation the government is struggling to pay for what it has implemented, yet the proposal of universal healthcare vastly increase government entitlements paid for through even more taxation. I hope the patterns are becoming clear. **Actually, and I may have missed something here, but in the past 7 years, taxes have not increased, instead, in this time of war, they have been cut several times. Economically, the US must be doing really well. No? You say we have (as of 4:24 PM Pacific, March 3, 2008) spent \$499,447,858,253 on the war in Iraq – a cost of about \$4,100 per household? And how's that working out for you? If spend in the US, how much homeland security would that buy? How much US infrastructure would that repair? How many jobs would that create? If put into finding real solutions to our healthcare financing and delivery problems, do you think we could come with solutions? "Government is writing itself an IOU?" You got that right.**

Dr. Goldsmith leads his argument with a statement that healthcare should be a "right." I will hold off on the debate of what is and is not a right and simply state, even as a physician, I do not believe in the smallest sense of the term that healthcare is a right. **And I respect your right to your opinion, I just wish you would have explained why you do not believe "in the smallest sense of the term that healthcare is a right." That would be a good debate.** He then presents us with a huge leap into governmentally controlled healthcare through single-payer (Medicare) universal coverage. Within his outline are many promises depicting a perfect world of healthcare with absolutely no defined drawbacks. **Jon, Jon, Jon, I was giving a proposal on my opinion regarding healthcare reform. It wasn't a leap, it was the crux of the article. Promises? It was a proposal. I'm not running for office.**

I would venture to say that most physicians don't love public insurance programs as they are, and making this the only payer would be a disaster. As it stands, Medicare fees follow what is known as the SRG (Sustainable Growth Rate). By this schedule, Medicare reimbursements are slated to be cut 25% to 35% over the next several years. More unfortunate are the continued broken promises from our government. Forty years ago Congress made a promise to "...never establish a physician's fee schedule or interfere with doctor-patient relationships." Then, in 1992 a Medicare fee schedule was established. Physician fees through Medicare

have subsequently been cut 50% to date in adjusted dollars. With the slated future cuts coupled with the rate of inflation, by 2012 physicians will be receiving 25% of the original fee schedule. Are you ready to trust the government yet? Thank God you can trust United Healthcare (“Attorney General Andrew M. Cuomo today announced that he is conducting an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates” – February 16, 2008)! Thank goodness, non-Medicare payers are so much better than Medicare, consistently better fee schedules, less restrictions, common reimbursement policies, clearly published guidelines and definitions, appeals processes, etc. Jon, ask your staff how much time would be saved in your office if they only had to deal with a single insurance plan, with a single payer’s set of reimbursement demands, policies, exclusions, benefits, eligibility, payment, appeals, with no pre-authorizations. Do you think that only having one payer – only one – would save your practice money? Significant money? Do you enjoy working with 25, 50, 100 Aetnas, Humanas, United Healthcares, union plans, ERISA plans, Tricare, Workers’ Comp, PPOs, HMOs, etc.? How many different plans does your office deal with each day, week, month, year? Are we having fun yet? One thing I know for sure, and that is no matter how badly you are treated by Medicare, the whole of managed care is significantly worse to deal with, and continue to get worse. As far as the scare of 25% to 35% cuts in Medicare reimbursement over the several years, it’s only a perennial scare, Jon. We get “saved” every time with only a little bit of loss each year. There won’t be a 25% to 35% cut in Medicare reimbursement over the several years. It gets patched each time until Congress sees the priority to fixing the flawed formula the pricing is based on.

If our working populous can’t pay for the public care our government has extended today, the addition of universal coverage would see tax hikes like we’ve never seen before. Even worse, both patients and physicians will be at the mercy of the system which has already proven to be wasteful, dishonest, and subject to fraud. These items outlined are in addition to the multiple policy changes made yearly, and rarely are they in the favor of the patient or provider. Obviously, you didn’t read my article, or deliberately chose to ignore my sections on “Single Payer System Not Enough” and “How Can We Pay for it All?” The whole idea in my proposal was to eliminate the waste, reduce fraud and abuse, and fund healthcare coverage through a non-profit administrator/contractor. If Medicare mandates contractors to provide all the processing/administrative costs at less than 3%, and a for profit managed care payer does the same work – the exact same work – at 28% to 32%, what are we missing that the for profit is adding to process to make what they do better? Bonuses? Denials? Hanging up on you after 15 minutes on hold?

On the patient’s side, we can look at models such as Germany, France, Canada, and England. In these systems, there are waiting lists on which patients die waiting for their turn at proper care. Scare phrase. Please provide current – last few years - unbiased studies validating that statement. Don’t bring findings from 20 years ago, or anecdotal experiences. We have our own nightmares. In Canada, a study found that 1.2 million people can not locate a primary doctor due to physician shortage. Another 4.5 million have just not bothered to locate a doctor even though their care is free. The study further found that the wait time to get treatment at a clinic or emergency room are double that of the U.S. As an example, it takes on average three weeks to get a potential cancerous breast lump biopsied, and six months to have a routine hip replacement. In these current systems, one can not advance in line if willing to pay out of pocket. The most unimaginable law in existence, and backed by Dr. Goldsmith, is the law forbidding private insurances to cover anything already covered under the universal plan. Can you imagine living in the United States and not being able to pay for a policy that treats you better than the government program? Currently in Canada, this system is being challenged as unconstitutional. I should mention that my article did not introduce or discuss an other country’s model for healthcare. The United States has always been an innovator, and I would expect healthcare reform to be uniquely made in America. I can tell you that in my article I did advocate private insurance company plans existing only to cover what the universal health system did not. The reason I proposed it was with the understanding that it is hard to have a single payer system with multiple “private” payers joining in. But since this is America, I have since rethought that. As long as the “primary” universal payer is non-profit, I say, hey, let other insurers compete against 3%-6% administrative costs. We’ll see how fast they jump in.

I’m not sure I understand Dr. Goldsmith’s argument that public insurance is an efficient payer with simplistic reimbursement. Medicare on average makes up 30% of a physician’s payer pool. In a majority of offices it is a top 10 insurance and is also one of the lower paying plans. Umm, that is not a universally true statement. In some offices nationwide it is in the top payer category. And, unfortunately for the new practitioner with nothing but debt, it typically takes six months to become a provider. While that is true, most practitioners, if they fill out

their application correctly and in a timely fashion, and have a valid medical license, will be enrolled in the Medicare program. While claims can't be submitted until the provider number is issued, patients can be seen in the interim with the claims submitted retroactively for the entire 2, 3, 6 months it takes. Oh, by the way, some managed care plans may not let you become a provider – sorry, panel is closed; we have more podiatrists than we currently need. Some ERISA programs won't pay you at all because you are a podiatrist. And, sometimes, it takes a long time to get into a contracted plan...just like Medicare, only you can't see their patients until you are in...somehow. Recent practitioners have seen Medicare change from a UPIN to an NPI number, transition from paper to mandatory electronic filing, propose large annual cuts in reimbursement, place holds on DME applications, and now considers taking DME dispensing away from doctors. And your point, Jon, is what? NPI is an equal opportunity number; non-Medicare payers are looking to transition from paper (more closely to process; and definitely a last century thing) to electronic claims submission. Are non-Medicare payers universally offering you fee raises each year? And DME is a supplier thing, not a doctor thing. Medicare is trying to figure out how to treat doctor-suppliers different than supplier-suppliers. Ultimately, the rules for suppliers might make it impractical for doctors with "small" supplier operations to afford accreditation, a \$65,000 surety bond, and the time (and time is money) it takes to complete the paperwork and remain supplier compliant...and doctors will be forced out of the supplier-side of the business. Of course, all it takes is for Medicare to reduce DME profits, and doctors will, for the most part, leave DME to non-physician suppliers.

The Medicaid program, arguably the lowest of all payers, is the barrier to podiatrist being defined as physicians. These public payers have multiple layers of oversight and review that commonly burden the practitioner with denied claims, pre-pay audits, chart reviews, and full blown audits far beyond that of the private payer. Imagine if this were to become your only payer. Boo! Why would you waste a fraction of a second to imagine that? What has that got to do with my proposal? Is more government intervention looking promising yet? My proposal is not "Medicaid for All" – it is taking the best of the current Medicare system, so I don't want to discuss Medicaid.

Dr. Goldsmith speaks of how he is impressed with the low overhead of our public administered insurance. I believe he may have failed to take into account that these funds are being filtered through our government which is borrowing money to the tune of 480 billion dollars annually in paid interests. Huh? "Funds are being filtered through our government which is borrowing money..." what are you talking about. Is this the fluoride in the water argument reshaped? There is no "fund" when it comes to mandating that Medicare contractors operating at a less than 3% cost. Period. The rest of this paragraph is related an orange response to my apple impression.. On top of that, Medicare spending is growing at a rate of 7% a year, far ahead of inflation, to an annual cost in 2006 of \$408 billion. In a CMS report, Medicare expenditure per enrollee in 1970 was \$368, and in 2006 it was over \$3,000. If adjusted for inflation, today it should be only \$662. This has nothing to do with "the low overhead of our public administered insurance" notation above. And for the record, yeah, I am more impressed that the administrative costs can be held to less than 3% (mandated) for "public administered insurance" – is that Medicare you are talking about? – versus 20%, 25%, 30%, or more for "non-public administered insurance" [companies].

In the case of private payers, as reported in 2004, average employee salaries were \$61,409. Since 2001 family coverage premiums increased 78%. Statistics such as these reflect dominance in a non-competitive market. It is quite obvious to see that there is much room for normalization of premiums if competition were allowed to drive free market balance. It may also be of interest to note that in 1997 Medicare part C came into existence creating Medicare Advantage Plans. In essence, this is a melting of public and private insurance with Medicare paying capitated amounts to private payers. Huh? We are still talking about Medicare, right? There are no Medicare Advantage Plans in my proposal. Unfortunately, public funded insurance continues to meddle in the free market causing price inequality. Is your point that there is no competition in the current non-Medicare insurance marketplace? Of course there is. It's just that without fixing the problems – lack of evidence-based treatments, overutilization, unchecked new technologies, fraud/abuse, reduce the complexities of coding and reimbursement, unwillingness to go electronic and "open," etc. – the cost of healthcare and the insurance needed to cover that cost will be – get this – very very high.

Another area aside from delivery that should be the subject of debate is government regulation. One of the regulatory bodies overseeing these government programs is the Joint Commission. It is a private non-profit

company founded in 1954, and oversees the compliance of hospitals participating under Medicare. The company has been under recent scrutiny because of its monopolistic powers which are received through statutory protection from our government. Other entities, most recently in 2006, have been denied competitive opportunity. With annual revenues totaling \$113 million, and without required public disclosure, it is difficult to assess its financials. Again, we see our government disrupting the free market. **I hate when that happens. Let's deregulate the energy market...oh, that's right the cost of energy in California went through the roof; let's deregulate the housing/mortgage market...oh, we're still living through that one. I think you're beginning to convince me...let me see, government bad, rich people good, poor people bad, rich people good, government bad. Got it.**

Within the proposal of universal healthcare, the question is asked "How do we pay for it?" Dr. Goldsmith answers, "Simple." His simple answer is to take more of what you earn, filter it through governmental bureaucracy, and give it to those that don't earn or didn't invest in their futures. In other words - tax, tax, and more tax. **Actually, I didn't say that. I said tax Jon Purdy universally. Actually, I said one component of the payment would be through taxes (with tax deduction) – there would essentially be a trade-off: instead of spending on a healthcare premium (i.e., money spent for coverage), you would pay for your coverage through a tax (i.e., money spent for coverage) which would be based on income, but capped for the higher earners. The tax for healthcare coverage would be less than current healthcare premiums? How will it be less? Simple. (there's that word again, Jon) The patient pool is universal to the entire United States of America; employers would contribute after all your employment may result in health issues (and there would be no Workers' Comp, see employees would be covered under a universal plan)...**

The most preposterous of his tax hikes occurs with an increase in the gasoline tax. He justifies this not only as a usage tax but as a type of sin tax. In his mind, the more you use gas, the more of a liability you are to the health care system through increased accidents, disability, and respiratory problems to name a few. **Duh. It doesn't take a rocket science...the more you drive = more possibility a bridge will collapse under you...the more you drive with a bad muffler, burning oil, the more junk you spew into the air...cough, cough...and the more polar ice you melt...is there sin in gas? Oh, and since there is no more "health liability" component to your auto insurance, it will be considerably less costly, and if you happen to run over someone with the SUV, the good news is their healthcare is covered; the bad news is it will cost you a fortune to fill up the SUV to cover the guy you ran over.** So, part of his proposal is to fund an entitlement (**entitlement sounds so...sinful**) through increased taxes on alcohol, tobacco and gas. What sense does it make to bolster a program with consumption taxes on the very items our nation is aggressively trying to eliminate the use of? **Wait a minute. That's where I draw the line. Are we as a nation trying to get rid of alcohol? Did I miss that? I was ready to pay the extra tax on drinking (responsibility), and alcohol could be gone? Where it go? That's quite a flaw as I see it. In the case of petrochemicals, which literally run our lives and economy, any increase in cost is passed on to the consumer. As fuel prices rise, so do the prices of almost every product and service Americans use. Or American seriously invest in alternate fuels, public transportation, maybe walk more, or get a horse (or pony).**

Part of the physician incentive Dr. Goldsmith touts is an increase in payroll tax, increase in state and local taxes, and a decrease in tax deductions for "high end earners," of which the definition is conveniently left out. I conveniently left the definition of "high end earners" out since that's a goal I'm trying to get to. Also, those are details for the GOVERNMENT to determine (boo, scared you) – just kidding, I haven't decided who specifically will implement my touts. He also proposes the elimination of for-profit insurers, and elimination of payments to the Workers Compensation Fund. From a physician's standpoint, my highest payer, Workers Comp, and my second highest private insurance payers are eliminated. However, I am guaranteed to make less and pay more taxes. So far I'm not getting it. **No, I think you are getting it. You're trying to scare the reader without once making ANY proposal for healthcare reform of your own.**

Also consider in the proposal that physicians would be penalized and booted from the system for poor performance but there would be no reward for efficient or excellent care. **Actually I said, "good medicine is expected – one does not get (or deserve) a bonus for providing excellent care." A fair payment is all we should expect. Are you having a problem with my also saying, "Delivering consistently poor or below expected standards-of-care, overutilization of services, billing abuse, and, of course, fraud would be grounds for termination of provider status?"**

So why don't people have insurance now? Statistics show that 85% of Americans do have health insurance. Does that leave 15% of Americans that just can't afford health insurance? Not necessarily. Included within the 15% figure are 11.4 million non-citizens. **Actually, that's not true. It's 15.9% of our citizens, or 45-47 million Americans.** Of households earning over \$50,000, 37% do not purchase insurance. Estimates reveal overall, that 20% could afford insurance but don't get it, and 25% are eligible for assisted coverage yet don't seek it. **So, 45% choose not to be insured. I'm sure when they get sick or hurt, they're not a burden on the rest of us...someone else must be paying when they show up in the emergency, or have delayed treatment – didn't have insurance, elective or otherwise – to the point that the cost the public has ballooned significant so we get to pay one way or another for the 47 million.** Using these figures, one is left with 5.9% of our population falling into medical insurance limbo. Of course, there is always the emergency room open door policy in which any individual can find same day care without regard to payment. With average wages outpacing inflation, and our "poor" being the richest poor in any country, this figure should be even smaller. Nonetheless, healthcare coverage costs must stabilize before extremely low wage earners can afford quality coverage.

Another way our own government destabilizes market competition in the area of health care is with passage of laws prohibiting the building of many efficient, low overhead, diagnostic and surgical facilities that compete with wasteful hospital systems. Let's look at what else contributes to skyrocketing healthcare costs in the United States. For this answer we can compare ourselves with our neighbors to the North. Canada's health care per capita, including medication costs, are much less than ours. **In 2005, per capita spending for healthcare in the US was \$6,401 while in Canada it was \$3,326. The World Health Organization ranking of the world's health systems puts Canada #30 and the United States at #37 with Dominica and Costa Rica, among others, beating us out. Hey, but we nosed out Slovenia #38.** Why is this? For starters, our medical malpractice awards have increased 43% since 1999. The cost of litigation has increased 12% annually since 1975, and compared to Canada, the U.S. files 350% more malpractice suites per year. **That must be the reason.**

Another consideration is the drain some 11.4 million illegal immigrants place on the system. Illegal immigrants impact our healthcare system by utilizing the emergency room, labor and delivery, contributing to motor vehicle accidents, perpetrating crime, and the introduction of diseases, the worst of which is Tuberculosis. Canada does not have to contend with these numbers. **Where did this "fact" come from? How much is the US public making up for the healthcare costs of illegal immigrants?** Unless something is done, these costs will increase in addition to the increasing costs of current or proposed universal healthcare.

In Dr. Goldsmith's world, the government will do a 180 and all the issues we can't solve today will be miraculously solved when more governmental intrusion is placed upon our society. **Shame on you, Jon, for trying put words in my mouth. I didn't say that, and have never said that.** For example, he speaks of combining all healthcare administration to reduce overhead. We already have Medicare and Medicaid which are federally funded programs with regional and state distribution, yet they function completely independently. **And your point is, what? Are you arguing that consolidating to a single non-profit payer will not reduce costs? That it is better and more economic to have 100s/1000s of payer systems and processes to do the same job, process claims?** He speaks of the quality of care that will be monitored through the creation of another national oversight board. In light of the Walter Reed Army Hospital scandal I think the government is struggling to oversee what it administers now. Somehow the quality of medical care is going to increase with his proposal to flood the system with pseudo-physicians such as nurse anesthetists, physician assistants, and the like. **All I said was, "The training and use of physician assistants and other extender would be significantly increased." Did you even read the article I wrote?** All this will presumably be accomplished as the baby boomers retire at a rate greater than those entering the work force. Also within this bubble of retirement class are the retiring physicians. The math just doesn't work. **I didn't speak to this issue. Must have been some other article you are referring.**

This begs the question of exactly where does one stop? What about patients that don't adhere to the doctor's orders, miss scheduled appointments, don't fill prescriptions, or use illegal substances? Should these patients be responsible for their entire medical bill? Could we base their percent co-pay on their glucose level, blood pressure or body fat percentage? Of course not; personal responsibility is never a consideration in entitlement programs. So what about individuals who exercise, eat right, follow their doctors orders, are high wage earners paying a disproportionate amount into the system, and use only a fraction of the health system the

average citizen uses? Do these individuals get rewarded? Of course not; entitlement programs by definition reward those who use them and penalize those who don't.

The issues we face today are the high cost of healthcare, a social welfare system that can't sustain itself, and politicians facilitating people to live their lives without the burden of individual responsibility or self preservation. Once the flood gates of opportunity and paths to independence are as open as they are today, the government needs to step out of the way and let individuals decide for themselves. **Vigilante healthcare – let the people fend for themselves.** Facilitation through the educating people to consider their futures will always be a public service worth promoting. Ask yourself this question. Is it better for a government to create a system so encumbered, as we see in France (oh, by the way, did I tell you that France is #1 in the World Health Organization ranking for world health systems with per capita spending of \$3,048 in 2003), Canada, and England (#18 with per capita spending of \$2,745 in 2003), that people die waiting for it's assistance? Or, would it be better to allow individuals to die due to their own negligence and lack of self preservation when the only barrier to success was themselves? It's a tough question to ask but is non-the-less a reality.

Does it not make sense that as an economy blossoms less government intervention would be sought? With our current attainments of an unemployment rate at an all time low, wages outpacing inflation, and median incomes per household of \$48,201, shouldn't we be observing more self reliance and independence? So far, the exact opposite is happening.

The question some might ask is, "Where does one turn when in need if the government has not strung out a safety net?" Many politicians like to sell their programs by painting a picture of people spilling out of their government subsidized housing to die in the street as their entitlements are taken away. In actuality there is simply a shift from the public to the private sector. Families actually have to help each other and neighbors help neighbors. People can turn to private charities, churches, and companies that play a large part in community assistance. The most important help is not the hand out, but the lesson. Without a constant stream of charitable reliance, people will actually have to plan for their futures, invest wisely, and live within their means, which benefits us all. **Is this your proposal for healthcare reform?**

If our government returned to its rightful owner more of what we earned, the individual would have more money to invest for their future retirement, disability insurance, health insurance, and other personal investments. We would receive a greater return on investment and overall have more disposable income to voluntarily give to charities or individuals in need. If the government would stop its meddling in the private sector, free market competition would see health care prices marginalize. **Is this your proposal for healthcare reform? By the way, there is no such thing as free market competition benefits in healthcare. Unlike any other business, competition has consistently driven up the cost and utilization of healthcare resources without appreciable improvement in the quality of care.**

People could more afford private Health Saving Accounts (HSA) which provide a tax shelter, a private funded return on investment, and an incentive for individuals to stay healthy. The HSA works in concert with high deductible private insurance plans. It allows a person to place tax deferred money, only to be used for their healthcare, into an account that works like an IRA with immediate fund availability and without penalty. The money can then be used like a retirement account after age 65. A study found that 85% of these type plans paid 100% for preventive health care without an imposed deductible. **Is this your proposal for healthcare reform?**

Because we lack universal coverage are we falling far behind in health care deliver and overall health? We're not in first place within that category but are certainly at the top (I guess it is all relative, we spend more per capita, by far, than any other country in the world, and yet only rank #37 – successfully beating out Burei #40 – but not Columbia #22). We are also a nation with obesity of epidemic proportion which appears to coincide with our affluence. However, we are in the lead when it comes to advances in modern medicine. The United States sees a large influx of patients coming from other countries to become providers or to get the medical care their country isn't providing them. One does not see U.S. citizens going to other countries for modern medical care. (You may want to check out "60 Minutes" - <http://www.cbsnews.com/stories/2005/04/21/60minutes/main689998.shtml>). Alone, I think these facts are pretty strong commentary.

So the proposal of universal healthcare, in essence, will equate to lower reimbursements for physicians (where did that come from?; did you just make that up?), less net income for all (where did that come from?; did you just make that up?), and higher costs of goods and services (where did that come from?; did you just make that up?). But, should you need health care, it will be taken care of; as long as you pay your 20% co-pay, wait your turn in line, your procedure is deemed medically necessary by our government, and your doctor of choice is accepting Medicare at that time. Although Dr. Goldsmith advocates tort reform, there is utterly no indication of this happening any time in the future. I'll tell you what Dr. Goldsmith, you first show me tort and immigration reform and then let's revisit this debate. Okay, I'll get right on immigration reform, and then world peace, then we can revisit this.