The Prisoner's Dilemma: Economic Lessons from the Failures of North American Health Care Systems

The title of my speech today is "The Prisoner's Dilemma: Economic Lessons from the Failures of North American Health Care Systems." What I will show is how health care in North America fits the economic definition of the negative sum game known as the Prisoner's Dilemma, why health care is the only product or service in our economy that has grown progressively worse and more expensive over the past half century, and how Singapore and other Asian nations can avoid our mistakes.

The Prisoner's Dilemma

Let me illustrate the absurd process of procuring health care in the United States, where the average working adult knows nothing about the cost of health care, because she does not purchase it. Instead, she allows her employer, who knows nothing her health, to purchase it for her, deciding which doctor she can see, often forcing her to visit two doctors, when she only needs to see one. And worst of all, neither the patient, nor her doctor, will decide how she will be treated. That decision will be made by a nurse — employed by the insurer — who has never met either of them, and who may be several hundred kilometers away. This is what is known in the United States as "managed care."

The common saying, "It's as simple as A-B-C," does not apply to health care in North America, where A, buys health care from B, but which is paid for by C. The common saying, "Two's company, but three's a crowd," more accurately describes our health care system. The simple health care transaction between the patient (A) and doctor (B) is complicated by a third party (C), the employer. The interference by a third party, C, creates tension between the A and C, and between B and C, which results in a prisoner's dilemma.

The Prisoner's Dilemma is a subset of the economic discipline of choice theory, which was the creation of James Buchanan, and for which he was awarded the Nobel Prize in Economics in 1986. Buchanan defined private choices, such as the food you eat, clothes you wear, or car you drive. You get exactly what you want based on your personal preferences. And your choices — whether good or bad — do not affect anyone else.

Then there are public choices, such as the politicians we elect, the MRT subway schedule, and the temperature in this room. These decisions are based, not on your personal preferences, but on the aggregate preference of the group. These choices are forced on you, and you have virtually no chance of changing them, regardless of how hard you try.

One would think that health care, which is personal, private, and delivered one patient at a time, would be a private choice. But in North America, it's a public choice. And the Prisoner's Dilemma represents a scenario where your preferences are ignored, your actions are futile, and your fate is decided by someone else.

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PHOs, HMOs and Managed Care

Perhaps the best way to summarize the severity of the health care crisis in North America is to tell the story of the fast rise and fall of the institution known as Physician Hospital Organizations, or PHOs. PHOs were extensions of HMOs, or Health Maintenance Organizations, which were mandated by law back in 1973.

Despite the fact that every introductory economics course teaches that no one can simultaneously control both the price and quantity of anything, PHOs propagated the myth that physicians and hospitals could provide all the health care needs of a given population for a fixed dollar amount. This was known as capitated health care, priced on a per member/per month, or PMPM, basis.

Common sense dictates that when someone is sick, they hire a physician to diagnose and treat their illness. And when someone faces a financial risk, they hire an actuary to design an insurance product. However, PHOs were founded on the idea that actuaries — who have no medical training — would tell doctors how to practice medicine. While physicians — with no actuarial training — would manage health insurance risk. PHOs no longer exist, and HMOs are dying out. Like so many dot-com start-ups during the Internet bubble of the 1990s, they had a short-lived meteoric rise and crash, leaving a trail of bankruptcies among the physicians and hospitals who invested in them.

Several years ago, I attended a Society of Actuaries conference where the featured speaker was an actuary who made his living designing PHOs. Reflecting on the failure of the capitated PHO model, he placed the blame solely on the doctors. "Because," as he said in exasperation, "doctors don't understand insurance."

I tried to explain to him that actuaries don't understand medicine. And that perhaps a better division of labor would be for actuaries to manage insurance risk, and to let doctors practice medicine. He resolutely held to his position. In retrospect, it's easy to understand why. The capitated PHOs he designed made him wealthy. It would have been much easier to have a dialogue with him, had he lost his life savings, and been driven into bankruptcy. Impoverished doctors I've discussed this topic with have no trouble identifying the fundamental flaw of the PHO model, because they have paid an enormous price to learn this painful lesson.

Knowledge, Interest and Power: The Structure of Liberty

The decline of the U. S. health care system began 64 years ago in 1943. Its history — as illustrated by the A-B-C model of the patient who knows nothing about the cost of health care, who will be treated by a doctor chosen by her employer, in a manner dictated by a nurse she has never met — has three parts, posing three problems, represented by three words, summarized with three stories. The three words representing the three economic problems of "knowledge," "interest" and "power," are borrowed from the book, *The Structure of Liberty*, by Randy Barnett.[1]

The story of the ***knowledge problem*** dates back to the 1980s, when the failure of Soviet central planning became obvious to everyone, and a joke began to circulate that Mikhail Gorbachev was retreating from the traditional communist goal of world domination. The new goal of the Soviet Union was to take over the entire world … except for Singapore. When asked why the Soviets were not interested in conquering Singapore, Gorbachev answered that he wanted to leave Singapore alone so the Soviet central planners would know what market prices should really be.

The knowledge problem is the problem of market prices, which are the most concise and efficient form of communication ever created. In lieu of an economics lecture on the fundamentals of market prices, I refer you to the short book by Ludwig von Mises, titled, *Economic Calculation in the Socialist Commonwealth*,[2] originally published in 1920, and which is still in print today. It describes in detail — and well in advance of history — why socialist economic systems that deny market prices are destined to fail. Because market prices represent real-time information. And fixing tomorrow's prices in advance is like trying to fix tomorrow's newspaper headlines in advance. No one can predict the future.

The second true story of the ***interest problem*** also comes from the Soviet Union, where the central planners in the Kremlin decided to measure the productivity of factories producing nails by quantity alone. The unexpected result was that the factory managers decided they could produce the greatest quantity of tiny thumb tacks from their limited quota of iron. Thus the Soviet Union was awash in thumb tacks, while larger nails for building houses, and even larger railroad spikes vanished, leaving these industries with shortages.

To correct this situation, the central planners changed their productivity measurement from quantity to weight. And the result was that the factory managers decided they could most easily maximize the weight of their output by producing only railroad spikes. Soon the Soviet Union had a surplus of railroad spikes, while nails and thumb tacks disappeared.

The interest problem is the problem of incentives. The best interests of the Soviet Union were served by the production of a certain ratio of thumb tacks, nails and railroad spikes. However, the interests of the Soviet economy had to be compromised because the central planners had no way of solving the knowledge problem without market prices. Hence the factories producing nails were operated — not in the interests of consumer demand — but in the interest of the factory managers, whose only goal was to meet their quota, as defined by the central planners.

The third story of the ***power problem*** dates back to Thomas Jefferson, one of the founding fathers of the United States. Jefferson was both a farmer and a slave owner, whose wife died prematurely in 1782. There are two major differences between medical practice in the 18th century and modern medicine. First, in Jefferson's time, the medical profession was more likely to harm a patient than it was to cure her. The most common medical treatments of the 18th century — such as leeches and bloodletting — are now classified as quackery. Second, the medical profession was so primitive that there was no distinction between a medical doctor and a veterinarian. Treating a barnyard animal was the same as treating a human being.

Legend has it that when his wife fell ill, Jefferson called a doctor to his estate. After examining his wife and recommending a treatment, he asked Mrs. Jefferson for her consent to proceed.

Because one of his horses was ill, Jefferson asked the doctor to examine the horse. The doctor advised a remedy and asked Mr. Jefferson for his consent to proceed. Then Jefferson remembered that one of his slaves was sick, so he asked the doctor to look at him. After examining the slave and recommending a treatment, the doctor asked Jefferson for his consent. Like the patient in today's managed care environment, the doctor didn't bother to ask the slave, because the slave was a piece of property to be used and discarded at the whim of the owner.

The power problem was phrased most concisely and bluntly by Vladimir Lenin with his rhetorical question, "Who? Whom?" Or, "who decides for whom?" Are you the customer to be served? Or the prisoner to be manipulated? Madeleine Cosman, a medical attorney, addressed the power problem by posing the question, *Who Owns Your Body?* Are you free to decide what's best for your health? Or are you a prisoner, controlled by your employer, or government?

The Knowledge Problem of Prices: Monetary Segregation and Health Care Inflation

I begin with the knowledge problem of prices, which dates back to 1943, when the wartime economy was constricted by wage and price controls. Employers were not allowed to combat the labor shortage by offering higher wages, so they circumvented the law by offering non-cash health benefits as enticements to attract workers. Thus a worker's income was artificially segregated between taxable cash wages, and non-taxable health benefits.

This tactic spread so quickly, the government was unable to stop it. Rather than combat this widespread practice of violating the law, the government decided to tax the non-cash benefits. However, the opposition from citizens was so great, the government — fearful of crippling the wartime economy — decided to back down. Thus was born the phenomenon of monetary segregation of income by the tax code, which has driven the cost of health care into an exponentially increasing spiral that shows no signs of abating, along with the institution of employer-sponsored group health insurance, which — as I will explain — is an oxymoron

First I will explain the phenomenon of increasing health care costs, which has consistently exceeded the Consumer Price Index (CPI) for more than fifty years. Despite this, costs for a few select categories of health care — such as lasik and cosmetic surgeries — have fallen exponentially over the same period. You might be naturally curious as to how this can happen?

Actually, the answer to the puzzle is a matter of basic economics. The health care costs that have been rising are those confined to the universe of the A-B-C model, covered by third party insurance, provided by employers via tax-exempt health benefits. While the health care costs that have been falling are those outside the A-B-C model, not covered by third party insurance, but which are paid for directly by patients with after-tax earnings. Simply stated, insured health care costs are rising, while uninsured health care costs are falling.

To understand the corrupting influence of monetary segregation of wages by the tax code, consider the decision facing an employer of how to reward its workforce. Does it give each employee a $10,000 raise, or should it buy medical benefits for them? If salaries are increased by $10,000, 15% (or $1,500) will go to pay Social Security and Medicare taxes (which are the U.

S. equivalent of Singapore's Central Provident Fund), 28% (or $2,800) will go to pay federal income tax, and 7% (or $700) will go to pay state and local taxes … leaving employees with an after-tax raise of only $5,000, or half the initial amount.

But, if the employer decides to buy health care benefits instead, none of these taxes has to be paid. Essentially, the employer has two options: [1] allocate profits in cash as salary, half of which will be taxed away, or [2] allocate profits as health benefits, in which case the employees (apparently) get to keep it all.

The choice between 50 cents in cash after taxes, or a dollar in tax-exempt health care, is an offer that most people can't refuse. The ultimate effect of this economic perversion is that, while a "health care dollar" is nominally worth twice as much as a "regular dollar," its true value is reduced by half, because there are artificially twice as many. In other words, doubling the supply of money does not double output; it only doubles prices.

The Health Care Shopping Mall

To see why, imagine this scenario: tonight the Internal Revenue Authority of Singapore (IRAS) seizes the assets of the Suntec City Shopping mall. The IRAS reopens the mall tomorrow morning as the "IRAS Mall" with two new rules that separate it from all the other malls and stores in Singapore.

The first rule states that the IRAS will double the amount of money in the wallets of shoppers entering the mall. If you show up at the mall tomorrow with $500, the IRAS will give you $500 more. So you now have $1,000. The second rule states that the IRAS will confiscate half of the cash left in your wallet as you leave the mall. So if you buy $900 worth of goods, the IRAS confiscates $50 of the $100 you have left, leaving you with $900 worth of goods and $50 in cash. The net result of your shopping trip is that you are able to buy $900 worth of goods for only $450 you brought from home.

Sounds like a great deal, doesn't it? If this actually happened, would you like to shop at the IRAS mall? Do you think some other people would also like to shop there? As customers swarm the mall — as the IRAS pumps mountains of cash into its new mall — what do you think will happen to the prices of the goods at this mall? If you owned a business, wouldn't you like to set up shop there? So what do you think will happen to the cost of retail space and the cost of doing business at the mall?

In essence, the IRAS Mall is the "Health Care Shopping Mall" (HCSM). You pick up your paycheck — without having to pay any taxes — in the HCSM. And you can spend as much in the mall as you please. The problem is: the only thing you can buy is health care. As you try to exit the mall to buy everything else you want — such as food and clothing — the IRAS confiscates half of your wealth. The only way to avoid the IRAS is to buy more health care — even if it's more than you want or need. Thus, by doubling your money when you enter the HCSM, the IRAS fuels price increases. And by confiscating half of your income when you exit the HCSM, the IRAS promotes unnecessary use of health care to avoid taxation.

If you work for a company with health benefits, this illusion of tax-free health care isn't worth the bother. Because, although you have twice as much money to spend, all the prices have doubled. But if you don't — if you're one of the uninsured and on your own in the HCSM, without the IRAS subsidy — it doubles the cost of health care. This is why the U. S. is preoccupied with the artificial problem of the "uninsured." The uninsured are prisoners — who do not get the tax-exemption — and who must pay twice the price for health care.

The Interest Problem of Incentives: The Oxymoron of Group Insurance

The second problem is the interest problem of incentives, which explains the oxymoron of group insurance, and which has two parts. This first is the fact that group insurance does not exist in the modern free market economy. Auto insurance is not sold to groups, neither is homeowners insurance. Like most other insurance in the U. S., they are sold to one customer at a time. Group insurance only exists in the United States because of the income tax-exemption, which provides an artificial 2-1 cost advantage making it feasible to underwrite.

One hundred years ago, there were no income taxes in the United States. And of course, there was no such thing as group insurance. If the income tax rate was only 3% — as it was for most people when the income tax was enacted in 1913 — the miniscule 3% incentive of a tax-exempt benefit wouldn't be worth the effort. Thus, the higher the tax rate — which today is effectively 50% — the greater the incentive to enter into an economically wasteful contract of group insurance, because the insurer could cover its unknown excess risk with the artificial subsidy provided by the tax-exemption.

The abuses of monetary segregation became so egregious that in 1974 Congress passed the "separate but equal" modification to the tax code known as the Employee Retirement Income Security Act, or ERISA. In the three-plus decades since, ERISA has been modified and reinterpreted by the courts numerous times to preserve the notion that income must be segregated between taxable cash and tax-exempt benefits.

The second part of the oxymoron of group insurance is that the principles of insurance have been violated. Virtually all health care is purchased under the terms of an insurance arrangement. This would be like purchasing an auto insurance policy that pays for your gasoline and car washes. Instead of prudently insuring yourself against the rare event of large unforeseen health expenses, the pernicious principle of tax-exempt health benefits, along with the economic logic of the prisoner's dilemma, coerces people into insuring every health care expense — no matter how small — to take advantage of the nominal doubling of their money in the HCSM.

Thus, group insurance is an oxymoron for two reasons. First, it only exists because of the incentive of the tax-exemption. And second, because employer health benefits do not meet the definition of insurance — as they approach a zero dollar deductible — they become pre-paid health care that appears to be free to the employees, but at twice the cost.

Rational Ignorance and the Prisoner's Dilemma

Because employers and the government have been paying for the vast majority of health care, patients — or A in the A-B-C model of health care delivery — logically and rationally have not been responsible for their health, and have not been held accountable for the health care they use. Because they have little or no information about cost or treatment options, their view of health care is roughly equivalent of a six-year old at his birthday party: offering nothing, while asking for everything.

Economists call this acting from a state of rational ignorance. ***Rational ignorance*** is defined by the phrase, "I don't know; and I don't care." Everyone attending this conference is rationally ignorant about the color of the carpet and the design of the wallpaper in their hotel rooms. They don't know and don't care, because these decisions have no effect on them. The shocking fact about conferences in the U. S. is that the participants are also rationally ignorant about health care, because they purchase health care in a shopping mall, where the items have no price tags, using their employer's credit card, which has no spending limit, and where they are not held accountable for their purchases.

Because the physicians, B in the A-B-C model, have little information about what patients are willing to pay, they logically and rationally have charged prices and delivered services designed to grow their practices and advance the medical profession. It's a fundamental fact of economics that you can't have an efficient allocation of resources with rationally ignorant participants. If you could, there would be lots of six year-old corporate CEOs managing billions of dollars of shareholder capital.

Because employers and the government — the third party C in the A-B-C model — were paying for all this health care, they were forced to take dramatic measures to control costs. All they could hope to accomplish was to deter and prevent rationally ignorant patients from seeking medical care, and to deter and prevent rationally ignorant physicians from providing it.

Thus, the two key participants — patients and physicians: A and B — are acting from a state of rational ignorance. And the peripheral participants — employers, insurers and the government: C — have been desperately trying to control them. They have been trying to contain costs with all of the insight of a blind man looking for a black cat in a dark room that isn't there. The tragedy is that the current structure of the U. S. health care system is designed to best serve those who have the least interest in — and place the least value on — their personal health.

In his book, *Free To Choose*, the late Nobel Laureate economist Milton Friedman observed that you are either spending money on yourself, or on someone else. And the money spent is either yours, or someone else's. Economic resources are allocated most efficiently when you are spending your money on yourself. While economic resources are allocated least efficiently when other people, spend other people's money, on others. Unfortunately this is the A-B-C model of health care in North America, where our rational ignorance has forced us into a prisoner's dilemma where we have irrationally chosen the least efficient method to allocate valuable health care resources.[3] All of us came to this conference because we agree that health care is vitally

important. I hope we don't all leave this conference with the understanding that health care should be allocated in the least efficient manner.

The Power Problem of Decision: The Seven Categories of Health Care *Muda*

The consequence of the rational ignorance and the prisoner's dilemma of the A-B-C model, is that our health care system is purposely designed to do the wrong things. It makes it harder — not easier — to obtain health care. And it adds waste and cost into the process, what the world-renown Toyota production engineer, Taiichi Ohno, referred to as *muda* — which is any activity that adds cost, but does not add value.

Ohno defined seven categories of *muda* or waste: Delay, Movement, Oversight, Inspection, Rework, Overproduction, and Poor Design.[4] Allow me to provide a sample of the *muda* in the U. S. health care economy:

- **Delay** — is idle time spent waiting for something. In Singapore, when you get sick, you call a doctor. In the U. S., you call your insurance company first, so you can get permission to call your doctor.
- **Movement** — is unnecessary movement of products, people, or information. In Singapore, if you've broken a bone, you see an orthopedic surgeon. In the U. S., patients are often required to see a general practitioner, or primary care physician, before being referred to the orthopedist.
- **Rework** — is performing the same task a second time, usually to fix a defect. In Singapore, a specialist can recommend that you have surgery. In the U. S. we require two specialists to recommend surgery.
- **Oversight** — is when one worker watches another do his job. In Singapore, a doctor will order a test to diagnose an illness. In the U. S. a doctor has to request permission from the insurer before ordering a test.

There is a priceless story about Taiichi Ohno in the forward to the current edition of Henry Ford's classic book on manufacturing, *Today and Tomorrow* [5], originally published in 1926. In 1980, when the quality of American cars was at its worst, and when America's automakers humbly made the pilgrimage to Japan, begging to learn the "secret" of their methods, a group of engineers from Ford Motor Company bombarded Taiichi Ohno with questions about what inspired his thinking on manufacturing quality. Ohno just laughed and told them that he learned it all from Henry Ford's book, *Today and Tomorrow*.

The lesson to take away from this story is that, like the auto industry, the medical profession is a case study of the classic business proverb, "shirtsleeves to shirtsleeves in three generations." Just as it took three generations to bring the once mighty U. S. auto industry to its knees, in the span of three generations we have brought the U. S. health care system to its knees as well.

The key point to remember here is that health care services, which are not covered by employer health plans, are not purchased and provided by rationally ignorant participants. Consequently, these services — such as lasik and cosmetic surgery — do not have any of the wasteful *muda* built into their cost structure. And they don't use the irrational A-B-C model of economic

transactions. Hence, like other products and services in the economy, their prices are falling over time, not rising.

Gammon's Law

Nor should you be surprised to learn that over the past 15 years, the percentage of the U. S. population employed in the health care industry has grown by 50%, while the number of hospital beds has fallen by 25%.[6] Over time, the natural progression is to produce more with less. For example, the U. S. grows more food with less farmers, and builds more cars with less workers. But for some reason we need more health care workers to provide less health care.

This is Gammon's Law in action, named for Dr. Max Gammon, a British physician who sought to solve a public policy riddle: Every year, the government spent significantly more on health care, but the British National Health Service (NHS) didn't seem any better for it. After an extensive study of the NHS, Dr. Gammon formulated his law: "In a bureaucratic system, an increase in expenditure will be matched by a corresponding fall in production. Because such systems act like 'black holes,' in the economic universe, simultaneously sucking in resources, and shrinking in terms of emitted production." [7]

The result in the U. S., is those with medical training who come in contact with patients — i.e. doctors and nurses — are financially and professionally worse off. While those in the health care industry who do not interact with patients — i.e. actuaries, accountants and attorneys — are financially and professionally better off. The steady increase in employment in the health care industry is not driven by doctors and nurses treating patients. Rather it represents an exodus of doctors and nurses from the medical profession of treating sick patients into the bureaucratic maze of managed care *muda*.

Medicare and the Folly of Socialized Medicine

Four decades ago, in 1967, health care procurement via the A-B-C model by rationally ignorant participants, was broadened to include virtually all health care services, for all citizens above the age of 65, with the enactment of Medicare. In 1994, Robert Myers, the former Chief Actuary of the U. S. Social Security Administration (SSA) confessed what anyone with a basic training in economics could have predicted: that the 1990 costs of the Medicare system were more than seven times greater than he originally projected. And Myers concluded that — if he was an honorable man — he should commit suicide.[8]

A few years later, another actuary from the SSA, Ben Gottlieb, admitted (and I quote) "I went to work at the Social Security Administration under Robert Myers. Medicare was in its infancy, and doing cost estimates was an important job for the office of the actuary. One important lesson I learned was the superiority of accounting records versus records based on surveys. Before Medicare started-up, surveys were used to ask people about their health care spending in the previous year. The problem was that the people who had spent the most were already dead. The most expensive people were unavailable to answer the questions."[9]

Fortunately for Singapore, what Myers and Gottlieb had to learn, Lee Kuan Yew already knew. In his autobiography, *From Third World to First,* Lee Kuan Yew wrote, "I learned to ignore criticism and advice from experts and quasi-experts, especially academics in the social and political sciences. They have pet theories on how a society should develop to approximate their ideal, especially how poverty should be reduced and welfare extended. I always try to be correct, not politically correct."[10]

Medicare forced every citizen over the age of 65 to use valuable health care resources on the rationally ignorant A-B-C model, and every physician and hospital to be rationally ignorant in the allocation and pricing of their services. As you might expect, when patients are allowed to act like rationally ignorant children, using as much health care as they want at no cost — and doctors and hospitals are allowed to charge as much as they want for this limitless demand — the cost of health care rises exponentially.

Marx's Labor Theory of Value and the Corruption of Medicine

Hence it wasn't too long before these rationally ignorant patients and physicians soon found themselves in a prisoners' dilemma, where they had to bargain with their captors in a game of survival. By 1983, the U. S. government was forced to contain the exponential increase in health care cost by legally defining hospital services with a scheme known as Diagnostic Related Groups, or DRGs, and fixing hospital prices. It then legally defined physician services by a scheme known as Current Procedural Terminology, or CPT codes, fixing these prices as well.

By forcing the art of medicine into a system of rigid numerical hierarchical quantification, the next inevitable step was the application of Marx's Labor Theory of Value to the pricing of medical services, with the creation of the Resource Based Relative Value Scale, or RBRVS. This assumes that the value of all health care services can be universally numerically quantified and ordered into strict ratios for pricing by central planners.[11]

RBRVS is an attempt to control both the quantity and price of health care, and ultimately the practice of medicine. Because RBRVS, along with DRG and CPT codes, are the law for all health care services delivered to patients over the age of 65 — who consume a disproportionate share of health care services — the rest of the health care industry eventually adopted it in one form or another.

The bizarre consequence of government dictated prices is that health care is the only product or service in the U. S. economy where higher quality cannot command a higher price. In Singapore, dinner at My Humble House commands a higher price than dinner at McDonalds — even though they both supply the same number of calories. A new BMW commands a higher price than a used Proton — even though they both supply the same basic transportation. And, I assume, the services of the best and most experienced surgeon command a higher price than those of a surgeon who just graduated from medical school. Not so in the U. S., where Medicare prices are fixed and mandated by law.

The consequence of fixed prices, which are not allowed to fluctuate with changing supply and demand, and which are not allowed to vary to signal higher or lower quality, is that doctors have learned to diagnose and treat patients, not according to their illnesses and conditions, but according to what the government or insurer is willing to pay, in response to the prisoner's dilemma game of survival.

The most popular condition to diagnose is depression, because it's a matter of opinion that can't be challenged by managed care case mangers. This is why antidepressants are the number one category of drugs prescribed in the U. S.[12] Two others are hypertension and high cholesterol, of which Dr. Jane Orient, executive director of the Association of American Physicians & Surgeons, states, "The acceptable measurements keep getting lower and lower, and the drugs generate lots of side effects. There's nothing like turning healthy people into patients to generate a lot of repeat business from people with a limited, well-defined problem."

Because this prisoner's dilemma is a negative sum game, the medical profession is slowly being strangled. Perhaps the hardest hit specialty is ophthalmology, which has been permanently corrupted by the legally sanctioned optometric-ophthalmic kickback scheme, which was written into federal law about 15 years ago.[12]

According to Dr. Robert Gervais, an ophthalmologist and past president of the Association of American Physicians & Surgeons, "In a vain attempt to cut runaway costs in eye care, the government decided to transfer medical decisions from high cost ophthalmologists to low cost optometrists. It legalized the 80/20 splitting of cataract surgery fees between ophthalmologists and optometrists, assuming that costly follow up visits to ophthalmologists could be averted if optometrists performed that function. This intended effect failed to materialize, because patients needing close post-operative care were followed by surgeons, not by optometrists. In short, optometrists received 20% of a surgeon's fee for making a simple phone call to refer the patient.

Because the diagnosis of cataracts is very subjective, government gave optometrists an irresistible incentive to create — or grossly magnify — the indications for cataract surgery. Pathologists cannot verify these indications, because the cataract is liquefied at surgery effectively destroying the pathological specimen. And because the government's Marxist Labor Theory of Value price fixing scheme continues to drive down the legally mandated fee for cataract surgery, ophthalmologists are forced to perform more surgeries just to survive. Tragically, for patients in the U. S., the incentives for cataract surgery are dictated by central planners, just like nails in the Soviet Union.

To quote the famous quality guru, William Edwards Deming, "You get whatever the system is designed to deliver." If you design a health care system to prevent the treatment of certain conditions and diseases, you will get fewer cases of those diseases. And if you design a system that forces doctors into a prisoner's dilemma of diagnosing and treating the few diseases and conditions participant C is willing to pay for, the data will show an epidemic in these non-existent diseases.

Dr. Richard Dolinar, an endocrinologist and co-author of the book, *Diabetes 101*,[14] describes the current state of managed care this way: Doctors in the U. S. are closely monitored and

scrutinized by the insurance companies that pay their salaries. If they are employed by an HMO on a fixed salary, their incentive is to work as little as possible and provide minimal treatment. When they encounter someone truly sick, their incentive is to refer them out to a specialist, so the costs of subsequent treatments are not charged to their patient base, thus raising their average cost and lowering their efficiency scores.

If they are paid on a fee for service basis, their incentive is to treat the healthy and avoid the sick, keeping the patient as long as possible, providing minor recurring treatments and prescription drugs that do not trigger the high-cost alarms of the ever-watchful insurer, and which will provide a steady annuity of income.

The consequence is that the data on the incidence of diseases, treatments, and services bears progressively less relation to reality over time. The health care data collected by insurers on the U. S. population are about as accurate and valuable as the data on the production of nails in the Soviet Union.

Milton Friedman summed-up the A-B-C model of the U. S. health care system by stating, "We have a socialist-communist system of distributing medical care. Instead of letting people hire their own physicians and pay them, no one pays their own medical bills. Instead, there's a third party payment system. It is a communist system and it has a communist result."[15]

Even George Orwell could not have predicted how absurd things would get. In his novel *Animal Farm*, he makes the classic statement that "some animals are more equal than others." Yet in North America, while some animals are more equal than others, with respect to access to health care, all animals are superior to human beings.

In North America, it is widely reported that it is easier to obtain health care for your pet dog or cat than it is to get health care for yourself.[16] And in Canada, it's legal to purchase x-rays and lab tests for your pet, but illegal to purchase these same services for yourself.[17]

The Road To Singapore

The principles of knowledge, interest and power, I have used to describe the decline of health care in North America, can also be invoked to construct a robust and vibrant health care system in Singapore and southeast Asia.

First: the knowledge problem of market prices. Are your health care prices distorted by monetary segregation and fixed by central planners? Or are they set by individual physicians, and do they fluctuate to match the continual changing supply and demand? Sitting at my computer, I can search the Internet to find realistic and reasonable prices for doctors and hospitals in Singapore, yet I cannot find them for doctors and hospitals in my hometown of Phoenix, Arizona.

Second: the interest problem of incentives. Is your health care system designed to serve and treat patients? Or is it founded on the A-B-C model, and dominated by incentives to serve third

parties? Health care is a private good delivered one patient at a time. Is your health insurance sold to one customer at a time? And do physicians treat one patient at a time? Or do they manage their practices to meet quotas designed on the assumption that health care is a public good, and that all patients are alike?

Third: the power problem of decision. Does the doctor, B, work for the patient, A? Or does the doctor work for C, the employer, government or insurer? Does the doctor make the diagnosis and treatment decisions? Or are these decisions superceded by faceless third parties, who never meet the patient?

To illustrate just how vital these three economic problems are, go back in time nearly 50 years to 1959 — when Cuba was a modern tropical tourist paradise untouched by Second World War — while Singapore was a third world state still recovering from the devastation of its wartime occupation. Which country would you have invested in? And which country would you have thought had the brighter future?

Lee Kuan Yew and Fidel Castro are only two years apart in age. Both took over formerly colonized nations at the same point in history, and at the same point in their lives. Castro chose to follow the path of socialism, statist repression, and rule by force. Lee Kuan Yew chose the path of capitalism, individual liberty, and the rule of law.

The title of the second volume of Lee Kuan Yew's memoirs is, *From Third World to First*. The title of Fidel Castro's memoirs naturally should be, "From First World to Third," or more appropriately, "From First to Worst."

Singapore made specific choices in the past half century that made it the second most free and most prosperous nation on earth.[18] While Cuba chose the opposite path resulting in its devastating poverty. Unfortunately, with respect to health care, Canada and the United States have aimlessly followed similar paths to slowly strangle their health care systems. Singapore is poised to learn from our failures and create the freest and greatest health care system in the world.

Before my first trip to Southeast Asia seven years ago, a veteran world traveler game me the following advice, "If you get sick in Vietnam, go to Singapore. If you get sick in Indonesia, go to Singapore. If you get sick anywhere in southeast Asia, go to Singapore." And if current trends continue, we will have to add the statement, "If you get sick anywhere in North America, go to Singapore." Keep in mind the three problems of knowledge, interest and power, which represent market prices, incentives and decisions. Perhaps it really is as simple A-B-C.

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