A Bold *(But Workable)* Healthcare Solution for America

How to Operate a Single-Payer Healthcare System in the Free Market

Version 20

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Summary of a Bold and Different Proposal

The following proposal is bold and one that should appeal to both sides of the Congressional aisle. It's different. It's not fully vetted. Yet, it should be considered because nothing else seems to be working. Open your mind and read on:

- Turn the US healthcare industry into a competitive *"National Healthcare Utility"* that provides equal high levels of essential healthcare services to all citizens:
  - Implement a single-payer system that is regulated by the U.S. Department of Health & Human Services (DHHS), but operated by private profit, or non-profit contractors.
  - Divide the country into TWENTY Healthcare Regions (HCR's), each with approximately 16 million participants.
  - Request bids from any qualified hospital chain, insurance company, doctors' group, HMO, physicians' group or hybrids of these; to provide essential medical services for 7 years to all participants (citizens) in their respective HCR.
  - Will not cover *"vanity"* services and surgeries that are better served in the existing fee-for-service, or supplemental insurance models.
- Because the massive size of each HCR "*group*" spreads risks of the minority heavy-users of healthcare services over an HCR's entire population of 16 million lives, the **annual** per-participant bid costs will likely be in the $3,000 to $4,800 range ($250 to $400 per month, per participant!). This is the TOTAL cost… **no copays, deductibles or even lifetime caps!**
- This results in a regulated public-utility type healthcare provider that generates annual revenue between $48.0 billion and $76.8 billion per private sector regulated HCR utility, while at the same time delivering improved services at a lower cost than current healthcare provisioning systems:
  - All citizens in the HCR are "*customers*" of the "*utility*," and therefore all must receive a defined level of healthcare services… just like electricity, sewage, telephone and natural gas. No individual underwriting will be required as a result of the massive group size and the associated minimization of risks.
  - The estimated revenue streams to private sector operators (noted above) will create IMMENSE competition and incentive for the best and largest private sector providers to want to be in this business. We believe that a whole new enterprise category will be developed in America to be part of these exciting new "*utilities*." It is easy to imagine that big systems companies like IBM (and "*Watson*"), PeraHealth (big data health monitoring), Innoplexus (diagnostic visualization technologies), Zephyr Health (machine-learning diagnostic algorithms), Flatiron Health (Google-funded oncology big data) or Apixio (cognitive computing platforms) could partner with healthcare delivery companies like Hospital Corporation of America (172 hospitals, 119 freestanding surgery centers, 240,000 employees, 37,000 physicians and 80,000 nurses), or Community Health Systems

(118 hospitals, over 20,000 beds and 120,000 employees) to create entirely new hybrid organizations to serve this new MASSIVE economic opportunity. Indeed, several large healthcare delivery organizations are already developing proprietary big-data platforms or partnering with companies like the ones mentioned above to dramatically shift the quality of healthcare provisioning in America.

- We also believe the immense level of revenue and profit opportunities will accelerate year-over-year because of:
    - Continual innovations in healthcare delivery mechanisms.
    - Development of new treatment technologies, drugs, therapeutics and disease management protocols.
    - Bringing into healthcare nontraditional companies that focus on technologies useful to healthcare provisioning, including IBM and *Watson*, big-data, e-records companies, intelligent surgical robots, automated drug distribution centers, augmented reality diagnostic and visualization instruments, secure clouds, etc.)
    - Adoption and propagation of digital healthcare recordings and records management… a critical enabler to administrative efficiencies and outcomes leadership.
    - Focus on *treatment outcomes*, in contrast to quality of delivered services alone.
    - Cost control, management and reduction… remember, the profit motive is an essential element of this model. Tangentially, just as telecommunications technologies dramatically advanced after competition was introduced via the 1982 breakup of the Bell System monopoly, it will be innovative technologies incentivized by this approach that will further target meaningful cost reductions.
- The total annual bid-price to provide inclusive healthcare services in an HCR will be divided by the number of citizens in the HCR to determine the **precise annual tax** to be collected by the Federal government to pay the selected contractor(s). Every citizen within an HCR will be expected to pay the SAME tax. Those who cannot pay will become each state's (in the HCR) responsibility. The state will have to pay the federal tax on behalf of their citizens using conventional funding sources and local taxing authorities. This model can also work at the state level, assuming appropriate enabling federal regulations and performance expectations can be developed and enforced.
- Employers big and small, can also pay the Federal government (or state where appropriate) directly on behalf of their employees, thereby retaining company paid healthcare costs as a pre-tax business expense and a talent retention benefit.
- Individual citizens who pay the tax directly will receive a dollar-for-dollar tax credit up to the published per participant cost (re: tax).

- DHHS, working in partnership with industry groups and research professionals, will develop "*Standards of Care*" and "*Outcome Expectations*" that will be used to measure performance of each HCR prime contractor, as well as its service-delivery subcontractors. Those prime contractors that measure up will receive an automatic renewal for 7 years. HCR prime contractors that do not measure up will see their HCR put out to bid in the 5th year of their 7-year contract cycle… or sooner if necessary. With between $48.00 billion and $76.80 billion of

annual revenue at stake, these large new hybrid healthcare providers would have substantial incentive to provide exemplary service to their *"HCR customers."*

- Current annual per person healthcare costs in America exceed $13,750 (over $3.8 trillion in total). **This proposal could represent more than a 60% reduction in total healthcare delivery costs in the U.S**.
- This new business model will result in participants having full choice of hospitals, doctors and other services provided within their HCR. Though all delivery points will be owned, managed, partnered or contracted by a single HCR management entity, patients can go anywhere in the HCR to acquire healthcare services. Provisions for receiving services outside one's resident HCR will have to be developed.
- Consumer entrance to healthcare services will be through an appointment initiated by the participant. Consumer payment to specific service providers will be covered by simply showing one's HCR participant's ID card. Again, there will be no copays or deductibles to meet. All services will be covered by the HCR tax.
- All medical records will exist in secure transportable digital form, allowing patients to go to any facility and medical professional within the HCR system.
- HCR prime contractors will be responsible for compensating their employees and subcontract service providers (hospitals, doctors, specialty service providers, pharmacies, specialists, etc.).
- This proposal capitalizes on the existing strengths of current healthcare provisioning constituents. More about this will be discussed later in this document.

Underlying Logic of This Bold New Proposal

Before we further discuss healthcare, who pays for it, how much it costs and what is covered; we first need to address the moral question, "*is healthcare a service or a right?*"

Healthcare as a Service

If healthcare is a service, then the traditional insurance model *mostly* works. It works for employers who can compete for talent partially by offering better insurance coverage than their competitors. It also (theoretically) works for privately insured citizens (and even non-citizens) who pay for healthcare services based on their individual risk profile to the insurer. A non-smoker pays less than a smoker, not because the insurance company is altruistically trying to drive healthy behaviors, but because it is in the insurance company's (meaning the shareholders of the insurance companies) best interest to not accept out-sized risks for under-sized premiums. Its market economics, plain and simple.

Unfortunately, the problem for the individual who does not participate in an employer group policy (think self-employed, small business or citizens lower on the socioeconomic scale here), is that one's risks might be so great that the insurance company does not want to write a policy to cover the high-risk individual. Or the insurance company will write an individual policy, but at a premium that is substantially and disproportionately higher than if the individual was insured as a "*single life*" within a larger employer group policy. In other words, from a healthcare coverage AND cost perspective, it is not good to be unemployed (temporarily or long-term), self-employed or work for a small company if you have a pre-existing condition that actuaries do not like! Even with passage of the **Affordable Coverage Act (ACA)** that requires carriers to NOT consider pre-existing conditions, insurers have found legal

means to reduce outsized risks. This has mostly been accomplished through increased deductibles, HUGE consumer penalties for provisioning services outside a pre-approved network of providers, and most nefarious of all, increasing copays while at the same time, NOT including these copays within deductible calculations. While well-meaning in design, it is clear that ACA, using a mandatory insurance model without concern for insurance companies' shareholders, has resulted in INCREASED healthcare costs to consumers.

This does not mean the insurance model is without merits.

Historically, the employer-paid model has worked *reasonably well* in the United States, **but only for larger organizations.** This is because insurance companies can minimize their risks by selling insurance to companies with large numbers of employees where the law-of-averages would apply to the total insured population. This means that when an insurer writes a group policy for, let's say 5,000 employees, the cost of serving the small number of heavy insurance users (aka: the 100 or so unhealthy participants in the policy group) would be overwhelmed by the much larger population of healthy or "*healthy-enough*" participants. Thus, the policy cost would be based on writing a policy that would have an actuarial prediction of around 2% heavy users of medical care services as compared to 98% low-to-moderate users of medical care services.

This model works especially well for insurance companies when they are allowed to exclude high-risk individuals with pre-existing conditions… the norm before ACA of 2010.

The problem with employer paid insurance is that only large organizations with large numbers of employees can benefit from healthcare-averaging as a risk-mitigation mechanism. It does not work for small groups… or groups of one. It does not work for every socioeconomic level and is clearly skewed to higher levels. Healthcare averaging is not available to smaller employers where 5 sick employees out of 25 total employees, raises the actuarial prediction of heavy medical service users to 20%, resulting in a disproportionately higher aggregate company premium. This in turn leads to either the small employer having to pass on a higher portion of its medical premium to the employees or worse, NOT insuring them due to disproportionately higher costs. And even when the employees are offered the insurance at a higher cost, it is easy to understand why many will decline coverage… again because of cost.

Add to this a stagnation of middle-class wages over the last 30 years and rising housing and living costs that have left more than 500,000 Americans homeless and more than 43 million living in poverty; and it is easy to see why so many citizens do not purchase health coverage even in a mandated-coverage market. Congress needs to face the reality that for a significant cross-section of American citizens, purchasing healthcare insurance to protect against a potential FUTURE EVENT will always be less important than buying food and shelter in the CURRENT period.

The *Real* Purpose of a Traditional Healthcare Insurer

At this juncture it is important to understand the real mission of any for-profit medical insurance company… **to raise a pool of capital that can be invested in other businesses that generate above cost-of-capital returns. Yes… insurance companies exist to get hold of your money to invest it in some other venture.** This is the purpose of all insurance companies, whether they be mortgage insurers, property and casualty insurers or even auto insurers. Insurance companies are capital acquisition and reallocation companies who want your money but know that they must promise something in return. That "*return*" in the medical insurance market manifests in the reduction of a patient's risk of financial damage because of an illness or other medical malady.

To increase its valuation to its shareholders, healthcare insurers need to focus on three major drivers of THEIR prosperity:

1. NOT writing policies for excessive or seriously unpredictable risks.
2. Minimize payments of claims.
3. Reallocation of capital into investments that provide higher levels of returns.

These principles are immutable if a healthcare insurer is to make money for its shareholders. This means that unhealthy individuals who are excluded from the benefit of healthcare averaging, will pay more for insurance, and will likely be excluded altogether from acquiring certain types of healthcare insurance.

Healthcare as a "*Right*"

It is impossible to discuss the provisioning of healthcare to individuals in our society without addressing the economics of that provisioning. Much of this is because of the insurance model that was invented to spread outsized individual risks over a larger population. Some of it has to do with the enormous costs of technologically advanced medical care. Some has to do with arbitrary rules that reduce competitiveness… like constraining group policies by state boundaries. Even more of it has to do with the "*preciousness of life*" belief system that often results in a disproportionately larger amount of healthcare spending in the last few years of life. And logically, the aging population is certain to exacerbate these costs. There is ample evidence that high quality individual healthcare depends on wealth as much as medical advancements.

Yet, there is something that seems immoral about all of this. If you are fortunate enough to work for a large organization, or better yet are independently wealthy, then healthcare costs are not a lifestyle discriminator. But for most Americans, these costs are HUGE discriminators… in a number of seen and unseen ways.

Uninsured individuals really do receive less preventative healthcare. They often receive substandard and delayed care when emergencies strike. Moreover, those with great employer-paid (or subsidized) healthcare may stay in jobs that they hate out of fear of losing healthcare benefits. I think practically every American knows someone in this predicament. And think of the toll this takes on entrepreneurship when a person is unable to take a risk on a new technology or a new venture because they are worried about being excluded from reliable healthcare coverage.

This leads us to wonder if healthcare provisioning in a modern civil society is really a "*civil right*" accruing to every citizen. **It causes us to wonder why our government declares the provisioning of electricity, water, sewage, trash pickup, natural gas and highways as public utilities… without according the same status to healthcare.** No one questions the value that electricity, water, sewage, trash pickup, natural gas and highways accrue to the benefit of society as a whole… and should be paid for by society as a whole. Interestingly, no one seems to want to question why utilities should be run by regulated private companies, and not the government. The reason of course is that regulated private companies simply perform better than equivalent government entities. So why should healthcare be any different?

What would be so wrong with declaring that every man, woman and child in America is due the SAME level of essential quality healthcare as any other citizen? What would be wrong with declaring that if everyone has a right in our free civil society to clean drinking water, sewage, highways and electricity, then everyone should also have a right to decent quality healthcare? What would be

wrong with declaring that the right to pursue happiness implies a right to pursue good, not minimal, health?

The obvious answer to the above questions is "*economics*" and individuals' rights to NOT pay for someone else's healthcare. To me and my colleagues, this argument falls flat when one looks at the analog of public utilities. Clearly, our country does not know how to provision healthcare to the masses as well as it provisions electricity, water, sewage, trash pickup, natural gas and highways. There is something to learn from the successes of a regulated private sector… shareholder owned public utilities where benefits accrue to society as a whole and private sector profit motives work as a positive enabler of the utilities' missions.

A Logical Case for Utility-Like Single-Payer Healthcare

I am reluctant to walk away from the insurance model our country has invested in for over 90 years. It surely has its weaknesses, including the addition of brokers and other channel intermediaries that add costs to national healthcare in the form of more profit layers. On the other hand, these same channel intermediaries, with their profit motives, have clearly aided in keeping healthcare prices in check… though admittedly, their success rate could easily be debated. By utilizing a model that spreads individual risks over larger populations, insurers have inserted themselves into the pricing of virtually every healthcare service from the emergency room to the pharmacy. I shudder to think about the price (notice I did not say cost) of healthcare without the bulldog insurance companies questioning procedures, prescriptions and performance of healthcare providers. Yes, I know on an individual basis, insurers can be meddling troublemakers to both doctors and patients, yet without them, there would be NO control over pricing… unless of course government imposed price controls. And as most students of macroeconomics know, the imposition of price controls rarely works in a free market society. Its only chance of adding societal value is in times of national crisis, and that is historically, only temporarily positive.

When you think about it, the insertion of insurance companies between patient and provider is one of the most brilliant elements of healthcare cost control, albeit with too many individual stories of alleged dysfunctional insurer behaviors.

The reason I have concluded that any future healthcare delivery model should include insurance companies is quite simple. Did you notice that most of these companies are non-government organizations? It should occur to you as it has to me, that industry does a better job at long-term price regulation than do governments. It's called competition… something missing in government. Lack of competition is the reason government pensions are out of control. It's also the reason why salaries for many government jobs exceed salaries for similar positions in the private sector. Its why government employee unions have so much power.

In the private sector, unions can negotiate hard… but only to a point. They serve no benefit to their members if they drive the employer out of business by demanding higher wages that cannot be supported by high prices to the employers' customers. But in government unions, their employers (a government or agency within a government) have NO COMPETITORS. This is why government unions can keep demanding higher wages, better healthcare and premium pensions. There really is no one to stop them.

I purposely digressed slightly here to make a point. **While I have come to the belief that quality medical care is a moral right in a civilized society, I do not trust an uncompetitive government bureaucracy to run it.** I like a single-payer plan… I just do not trust the government to run it. I might trust them to regulate it as a utility-like sector but run it… no way!

Perhaps this is part of my personal bias that says government should only do what individuals and companies (1) cannot do well, (2) should not do, or (3) simply will not do. And just as I believe we should never allow a private company to run our military, I also believe we should not allow government to run our healthcare delivery systems. You do not have to look any further than the Veterans Administration (VA) and the never-ending scandals at their captive hospitals to understand why one could imagine that private industry is better suited to deliver exceptional healthcare to American citizens.

Building off the combination of the private sector medical industry's ability to invent… AND innovative new healthcare technologies, drugs and procedures… AND the private sector healthcare insurance companies' ability to bring free-market price controls through their inherent risk-allocation business model, an interesting solution can emerge. To implement it will require courage and in itself, some risk. Following is what I believe to be a reasonable solution that should be included in the national healthcare debate.

Utility-Like Single-Payer Healthcare Specifics

I am shocked that no one seems to have noticed the good points of all the elements currently in play within our healthcare system. It seems that everyone focuses on what doesn't work and as a result, fails to be inspired by what actually does work. I am convinced that this is why the utility-like model has been either overlooked, or purposely ignored. So here is a more specific look at such an inspired model:

> Divide the United States into twenty "*Healthcare Regions*," each with approximately 16 million people, each who presumably require differing levels of healthcare. By legislation, we would create these risk pools with an expectation that certain private organizations will be interested in bidding to operate each Healthcare Region (HCR). If you remember my "*law of averages*" discussion earlier, you will appreciate how desirous a 16-million-person risk-pool would be to any healthcare insurer, hospital group or other form of provider! The bigger the risk pool, the easier it will be to manage the costs of the fewer extraordinary users of healthcare services. Also, size will surely bring operating efficiencies that can result in a check on rising healthcare delivery costs.
>
> After establishing the twenty HCR's, we inform ALL qualified healthcare providers and insurance companies that they will have to "*bid*" to provide exclusive services in each of the twenty regions. **Only one company can win the contract to provide healthcare in any HCR…** kind of a winner-take-all for each region. Bidders can be insurance companies, physicians' groups, hospital chains or hybrids created expressly for managing the healthcare delivery system in a specific HCR. **Given the magnitude of business opportunity here, it is easy to imagine whole new companies will be born to enter this new market opportunity.**
>
> Private companies can bid to deliver ALL healthcare in one HCR, or all twenty HCR's… if they believe they can *really* deliver defined levels of excellent services AND have the capital strength to do so. Winning a bid to provide healthcare services will require the bidding entity:
>
> 1. Understand the general health risks in the HCR.
> 2. Is competent to deliver required patient services.
> 3. Has sufficient capital to operate a large healthcare delivery organization.

4. Can propose a SINGLE annual price to the federal government, effective for 7 years.

An example of how this could work is described below:

> Let us imagine that Galactic Healthcare Corporation (a fictitious company) bids on one of the twenty HCR's. Galactic proposes to provide comprehensive state-of-the-art healthcare services to all 16 million people in the region, for let's say a fixed price of $44.0 BILLION per year, each year for 7 years. In other words, Galactic is telling their partner (the United States federal government) that for a 7-year contract worth $308 BILLION, Galactic will provide healthcare that meets an agreed standard to ALL 16 million people in the HCR. This amounts to $2,750 per person, per year in the bid HCR. A family of 6 (2 parents plus 4 children) would cost $16,500 per year ($1,375 per month) saving approximately 50% to 75% of the current total participant cost. Remember, the $2,750 per participant cost is ALL that would be paid… no copays, contracted rates or deductibles. **This $2,750 per person cost would be the tax imposed by the federal government on each member in the region.**
>
> Each citizen in the region will be expected to pay this amount per year. They will be issued an HCR Healthcare Card, which is all they need to secure medical services in their region. No copay. No deductible. Just the annual tax payment ($2,750 per person, total annual tax deducted from paychecks) to cover ALL healthcare requirements. Everyone gets the same quality of care for the same price.
>
> Companies wishing to use healthcare subsidies as a means of talent acquisition and attraction, can offer tax-deductible reimbursements to employees at any rate they want. Again, this model seeks in all ways to keep health DELIVERY and PROVISIONING out of government hands. Government will only be responsible for:
>
> 1. Collecting the tax.
> 2. Establishing healthcare delivery quality requirements.
> 3. Selecting the appropriate contractor for each HCR.
> 4. Holding the contractor's feet to the fire in terms of service quality.
>
> If an individual member in the HCR cannot pay the premium (now in the form of a tax), the states will have to pay for them. Perhaps there are some yet un-thought-of mechanisms to collect this tax. Admittedly, this still requires some exploration. But then again, this does suggest that States should participate in the solution.

Though such a solution is not without impediments and challenges, it warrants thoughtful consideration because many of its implementation requirements are already in place… and working. Private sector insurance companies can play a key role in the implementation of this model and can play a key role towards its success.

This plan doesn't just preserve the insurance model… it super-charges it by creating a giant consumer base, resulting in a substantially enhanced capability to manage extraordinary-user costs that would exist in any risk pool. Further, it changes the business model from a multi-level responsibility matrix to a single-level responsibility. These new hybrid companies, probably made up of hospital chains, insurance companies, technology innovators and doctors themselves, would remain in the for-profit world, where cost management, customer service, competitive advantage AND innovation are equally valued. One

would expect an organization that is responsible for meeting health outcomes to be willing to invest in technologies to keep people from using services… staying healthy in other words.

This solution also greatly simplifies much in the U.S. healthcare system. Beginning with the consumer, they only need to prove they are part of an HCR and they are admitted to any hospital in the HCR. Same with prescriptions, doctor visits, etc. It is conceivable that electronic medical records could be digitally connected to each card, allowing for full transportability of patient information, across all individual providers in the HCR. This same data would make it easier to measure treatment outcomes, drug efficacies and quality of medical procedures.

Similarly, doctors would no longer have to manage the myriad of insurance agendas, rules and reimbursement procedures. They simply bill the HCR (a utility-like company), a process that could easily be automated, thus reducing the doctors' administrative (re; non-medical) expenses. Think about it. Doctors spending most of their time in patient medical activities instead of administrative tasks!

Standards of delivery and aggregate health outcomes would have to be developed. As a proxy of the people, this is what government does best. In the proposed model, we leave this to the government. Methods for establishing such standards as well as methods to assess performance against standards would have to be developed. I know this will not be easy, but that does not mean it is impossible.

Organizations chosen by our federal government to operate each HCR would be assessed each year. Every seven years their contracts will be up for renewal. If an operator's performance is low, the government will allow other operators to bid. I am confident that any company with 16 million customers who has figured out how to generate $40 billion in annual revenue, will work hard to be renewed and to not allow competitors to get a market foothold. Again, competition provides an incentive to perform. Seriously, what comprehensive provider would be willing to walk away from a $40 billion annual business? If they cannot make it profitable and as a result, choose not to bid in subsequent years, then maybe they should not be in the business! Again, I trust the private sector and competition to make better decisions than bureaucrats who learned all they know about healthcare delivery from the VA!

Analogs… *Why We Know This Idea Can Work*

There are numerous analogs to this bold idea of reinventing healthcare as a regulated public utility. We find these analogs wherever private sector service providers cannot generate above cost-of-capital returns when serving certain market segments that require enormous capital investments. We also find analogs where investments required to service a market are just too great for government and the private sector to individually finance. Historically, numerous non-incremental projects in America have been accomplished through various combinations of public/private partnerships, often in the form of regulated public utilities or bold government-incentivized ventures. Here are just FOUR relevant examples that suggest to the reader that solving the massive healthcare provisioning problems in America are NOT insurmountable:

1. A Bold Plan - The Rural Electrification Act of 1936

In 1935, more than 90% of America's rural landscape had no access to electricity. Without power, farmers were unable to update their equipment and facilities to modern, faster and more efficient methods. The lack of electricity also had ramifications on a personal level for rural citizens. Many rural Americans suffered poor sanitation and poor heating in their homes. Additionally, few had running water and most had serious storage issues for their food. By the mid 1930's, lack of electricity had become a public safety issue in rural America.

Large cities where demand for electricity was high, had all the attention of the power producers and distributors. Unfortunately, it was too costly to electrify the rural communities… a result of large landscapes with small populations. The prohibitive costs of running distribution lines to small, sparsely populated communities could not be compensated enough by the smaller population of customers to offset the high initial investment.

The federal *"Rural Electrification Act"* (REA) was passed in 1936 as part of President Franklin D. Roosevelt's *"New Deal"* program. The REA made it possible for the federal government to deliver low-cost loans to farmers who had banded together to form non-profit power collectives. The REA is what brought electricity utility to rural America. It was bold and it was a non-incremental approach to addressing this rural public safety problem.

The need for the REA is indisputable. The REA enabled farm power collectives to boldly change the way they operated. Low-cost, temporary government subsidized loans were the most important solution element in moving rural electrification forward. Because the farming collectives now had money, they could purchase generators and distribution facilities for the farms and all of rural America. The money also allowed the farming collectives to create assembly-line methods of electrical line construction, using standardized hardware. As a result, electricity to rural customers became substantially more affordable. By 1950, just 14 years later, 90% of rural America had electricity.

After the initial success of the REA, Congress saw the wisdom in making a significant amendment to the act, including an amendment in 1949 that incentivized extending telephone service to rural communities… a basic service that could not have been provided without a utility-centric partnership between government and industry.

2. A Bold Plan – The War Production Board Act of 1942

In 1942, President Franklin D. Roosevelt, created the War Production Board (WPB) by Executive Order. The WPB directed conversion of American industries from peacetime work to support wartime needs, allocating materials, establishing priorities in the distribution of materials and services, and prohibiting nonessential production. The Board rationed numerous commodities, including gasoline, heating oil, metals, rubber, paper, plastics and various chemicals. Between 1942 and 1945, the WPB supervised the production of more than $183 billion ($2.91 trillion today… nearly as much as we spend today on healthcare!) in weapons systems and supplies, including more than 40% of the world's output of munitions. Approximately 25% of the US output was warplanes; 25% was warships, and the remaining 50% were vehicles and various war-centric spare parts and supplies.

Of interesting note during this period, the US civilian standard of living held steady with little degradation in any geographic sector.

The WPB was a bold plan born out of necessity. There was a war-of-all-wars that had to be won. WWII was essentially an exceptionally large project that could not fail. To avoid failure, the United States had to quickly construct and implement global supply chains, including massive new production capabilities that could support the Allied Powers fighting across the global WWII battlefields. President Roosevelt understood that during dire national times, government MUST convince and lead ALL constituents into new roles… roles the constituents may never have considered in normal times. This is why he created the WPB through Executive Order #9024. He knew a crisis unlike any America had ever faced was looming, and he was desperate to create the infrastructures necessary to support a global war effort… for a war that

COULD NOT be lost. Indeed, many war historians believe the FIVE most significant contributors to the Allied success in WWII were:

a. Rapidly scaled and highly focused United States supply chain capabilities, incentivized through bold private enterprise and government partnerships. This in turn supported many brilliant battlefield strategies (air, sea & ground), which themselves were largely developed and driven by well-trained United States, British and Soviet military leadership.
b. The inspired bravery, heroics and tenacity of Allied troops.
c. Strategic destruction of Axis Powers supply chain capabilities, mostly through non-stop tactical bombing campaigns… campaigns that were supported by robust supply chains.
d. Numerous unrecoverable strategic and tactical blunders by Axis Powers' military leaders.
e. Breaking the secret German communications codes by the geniuses at Bletchley Park, providing invaluable advanced battle knowledge to Allied Commanders.

Without Roosevelt's executive order that *"partnered"* the military and US manufacturing sector, it is unlikely that private enterprise (as a whole), would have ever fully understood their noble new role to protect the free world against the Axis Powers' brutal march across Europe. The massive conversion of commercial manufacturing to war machinery production, and the rapid scale-up of this new capability COULD NOT have been led by government or industry alone. It required a collective agreement between government and industry, coupled with a bold, non-incremental mindset that was more interested in final outcomes than in short-term gains. Again, we have historical precedence for bold and big ideas that indeed, did work… and worked well!

3. A Bold Plan – The Unitary Wind Tunnel Plan Act of 1949

After the construction of the aviation game-changing Variable Density Wind Tunnel (VDWT) at Langley Research Center (Hampton, Virginia) in 1921, the National Advisory Committee for Aeronautics (NACA) built a variety of technical research facilities upon which the modern American aircraft design and manufacturing industry was based. These research facilities enabled the American aircraft industry to rapidly dominate the skies in both commercial and military aviation.

But by1945, America's lead in the field of aviation seemed to be evaporating. The technological achievements of German missiles and jet aircraft, as well as then-current Russian aircraft technologies, suggested a lag in American aeronautical research. President Harry S. Truman and Congress believed that such a lag could seriously harm America's ability to defend itself against future Soviet threats.

Learning from this lesson, Congress passed the **Unitary Wind Tunnel Plan Act** in 1949, under which the Federal government coordinated a national plan of facility construction encompassing NACA, as well as the Air Force, private industry and universities. The Unitary Plan resulted in the construction of a new series of wind tunnel complexes to support the American aircraft industry, including the incredibly important Ames Unitary Plan Wind Tunnel Complex, located at Moffett Field, California.

It is unarguable that without these bold agreements and investments between government, private industry and universities; advancements in aviation that are critical to everyday life in

America (and the world) would not have happened. It is equally likely that America's aircraft industry (think… Boeing, Lockheed Martin, Northrop Grumman, Cessna, Gulfstream, Bell Helicopters and Sikorsky) would not be the envy of the world, and that substantially fewer citizens would be employed in this defining industry. Again, bold non-incremental ideas coupled with public/private partnerships, can and do shape futures that positively impact every American.

4. A Bold Plan – The Federal-Aid Highway Act of 1956

On June 29, 1956, President Dwight Eisenhower signed the Federal-Aid Highway Act (FAHA). The bill created a 41,000-mile national system of interstate highways that would, according to President Eisenhower, *"eliminate unsafe roads, inefficient routes, traffic jams and all of the other things that got in the way of speedy, safe transcontinental travel."* At the same time, highway advocates further argued that in case of atomic attack on our key cities, the road network would permit quick evacuation of citizens from target areas. **For all these reasons, the 1956 law declared that the construction of an elaborate expressway system was essential to national safety and security interests.**

Without government's involvement, and without construction company incentives, this strategic national asset would not exist… and our economy would certainly be smaller. Can you imagine life in the U.S. without the interstate highway system? Again, we see an example of how legislative-boldness and non-incremental solutions can reshape the fundamental day-to-day lives of American citizens.

What has historically made America so great, has been its ability to exploit the operational advantages of BOTH public and private sectors boldly and collaboratively for the common good. To this end, it is equally clear that solving the healthcare crisis in America will not occur until federal legislators can accept that the problems facing America's health are no more and no less complex than:

- Electrifying the entirety of America.
- Focusing many domestic manufacturing capabilities toward winning a war… a war that could not be lost.
- Giving a global competitive edge to American aircraft industry in support of national safety, security and defense.
- Building 41,000 miles of highways to supercharge American industry and provide for national defense.

Members of our current congressional bodies need to acknowledge that historical Congresses have (arguably) solved bigger problems than our current-day healthcare problem. Members of Congress need to accept that to solve our current healthcare problem, a non-incremental solution that is equally BOLD and equally BIPARTISAN will have to be shaped.

There are no incremental solutions for this problem… only BOLD and BIPARTISAN solutions will work. We only have to look toward presidents Roosevelt, Truman and Eisenhower to learn how "*bold*" must take priority over "*incremental*" when *real and sustainable* solutions are demanded.

Summary

The beauty of this proposed model is that we get to a single-payer model for essential services, but one that is run by private sector companies who operate as for-profit, (or not-for-profit), regulated public utilities. This model represents a hybrid of the private company model that has worked successfully in

other industries where a service is necessary to society, but where no company can operate successfully without some level of governmental partnering.

A variation of this model has also been successfully applied at NASA and the Department of Energy to run their national laboratories. And just as the federal government can replace a private sector management company in any of the Department of Energy's national labs, so can the government replace an unresponsive, poorly run and low-performing healthcare provider.

The proposed model does not "*blow-up*" anything. Instead, it is inspired by the strengths of many of the existing healthcare players by engaging them in activities they are best at, and removing them from activities that others could better provide… for example, this proposed model:

- **Preserves the best aspects of the insurance industries:**
  - Super-large risk pools mean more effective risk management.
  - "*Bulldog*" price control capabilities.
  - Management of massive amounts of data.
  - Identifying and monitoring performance of providers.
  - Modeling and management of risks.
  - Allows for supplemental insurance for non-essential, *"vanity"* services.
- **Preserves the best of healthcare service providers:**
  - Uses profit motive to encourage innovation and invention.
  - Adopting technologies to improve diagnostic and delivery performance.
  - Uses competition to drive healthcare providers toward preferred status.
  - Utilizes existing facilities and delivery processes.
  - Focuses HCR contractors on patient care instead of administrative and reimbursement justifications. Encourages doctors to be *"doctors."*
  - Allows fee-for-service models for non-essential services.
- **Preserves the best of government:**
  - Establishing performance standards, codifying and measuring program providers' performance against pre-established benchmarks.
  - Defining desired aggregate outcomes.
  - Collecting taxes to pay the health delivery suppliers.
  - Stays out of delivery! Utilizes the best of governance capabilities.

Issues to Be Resolved

There are plenty of issues to be resolved with this proposed utility-like healthcare delivery system. And while it is not about blowing-up the existing model, it surely will require a deeper view of specific technical, organizational, cultural and behavioral issues. Tangential issues, including essential service definitions, new-drug patent life issues, states' responsibilities, contracting regulations, delivery performance expectations… and many more critical issues will have to be worked out. **Nevertheless, this model SHOULD be thrown into the pool of ideas and should be explored further as a potentially viable and innovative solution to the current healthcare provisioning crisis in America**.

Something must break the partisan bickering over incremental solutions to the healthcare crisis in America. In my opinion, congress, and particularly Republicans, should have started thinking "*bold*" many years ago, perhaps after the first declaration that something better than ACA was needed. We have wasted too many years.

I hope this proposal in some manner, moves the dialogue from incremental to bold. I hope this proposal moves legislatures to think big, take appropriate risks and LEAD our country to a new, more effective, more democratic, and more moral healthcare delivery solution.

Contact

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Before founding GDI, Mr. Dunn was a Vice President at **Gemini Management Consulting** and a Partner at **Coopers & Lybrand** (now **PricewaterhouseCoopers**). In both positions, Mr. Dunn was responsible for leading large teams of technical manufacturing consultants in innovative productivity enhancement projects. For the ten years prior to joining Coopers & Lybrand, Mr. Dunn was President, (and Founder) of **ADI**, a successful systems implementation consulting and training company that Mr. Dunn sold to Coopers & Lybrand in 1990.

In addition to his 38+ years of technical and management consulting experience, Mr. Dunn has several years of line management experience in manufacturing environments. He has extensive background in most functions within manufacturing companies and has participated in over 150 manufacturing and distribution consulting projects in over 100 companies. Mr. Dunn has consulted in more than 23 countries and across most manufacturing industrial sectors.

Mr. Dunn regularly presents executive workshops at the **Center for Technology & Management Education (CTME)** of the **California Institute of Technology (Caltech)** in Pasadena, California where he has presented multi-session leadership and technical courses. Mr. Dunn also manages **CTME's Next-Generation Global Supply Chain Leadership Certificate Program.** This is a multi-year leadership program that targets large multi-national manufacturing companies that want to develop their geographically dispersed young high-potential talent into world-class global supply chain leaders.

Alan is also a regular instructor at the Manufacturing Executive Institute (MEI), where he presents numerous workshops and web-enabled training programs. Over the duration of his career, Alan has developed and presented more than 800 single and multi-day executive workshops at venues worldwide.

Mr. Dunn also has substantial experience in organization governance; having served on numerous private, public and non-profit Boards of Directors. Mr. Dunn currently serves as an independent Director on several Boards. In 2007, Mr. Dunn was honored in Washington D.C. by the National Association of Corporate Directors (NACD) as the "*Director of the Year*."

Alan holds a BA degree in business management from **California State University in Fullerton**. He is also qualified by **ASCM** as a Certified Practitioner in Inventory & Production Management