

The Cure That Costs Less:

Interview with Professor Sean Flynn

Interviewer: Dr Randall Bock | **Guest:** Professor Sean Flynn. On [YouTube](#).

Randall Bock: I'm honored today to have Professor Sean Flynn. He is economics professor at Scripps College which is one of the Claremont colleges in the eastern part of LA County, it's a beautiful spot out there. And he's talking about a amazingly important issue: our overpriced health care system, our bloated healthcare system.

There's probably ... no bigger domestic strategic issue for the USA today than the high cost of health care. The fact that the USA spends four times more than Singapore – which is something Professor Flynn has noticed – on health care in comparative terms, yet achieves four to five years fewer of life expectancy, is a sign that something is fundamentally wrong with our health policies.

I came across your work recently through Sanjeev Sabhlok – a friend of mine, health economist in Australia – and I'm delighted to have you explain why the USA performs so badly and how Singapore has managed such an effective and efficient system.

We know that Lee Kuan Yew ... the late Singapore leader and president and frankly interesting thinker, consciously rejected both the British and the American system. Singapore thereafter designed its own system from scratch. Clearly they have the right incentives both for consumers and market participants, enabling a stupendous performance.

We don't want to copy their system but surely there are some useful principles we can adopt. And to wit, you have an excellent book on this topic of which I've read a good part but not in full.

So that's a kind of a long intro. Tell us a little about how you landed on Singapore and what are your interests both economically and in the healthcare system.

Sean Flynn: Thank you doctor. Great to be on. Just to jump right in.

I accidentally became maybe America's biggest expert on Singapore's healthcare system because a Rotary Club in Claremont asked me to do a presentation. It was about 6 months before Obamacare got passed, the Affordable Care Act. This would have been November of 2009 and I needed a topic because I was asked to do this on short notice. There happened to be an op-ed in the Wall Street Journal the day before the talk I was supposed to give and it argued that both political parties both the Democrats and the Republicans should look at Singapore as the optimal guidepost – you know thing we could learn from – rather than the normal suspects which are Canada and England.

Even today, if you go into a school of public health, if they're teaching first year master students or even the undergrads they'll only usually usually talk about Canada and the UK. Maybe a few words on Germany, or South Korea does something nice with billing, but this

guy said Singapore. And he also said they were delivering the best care in the world at the lowest costs and of course that's not a combination an economist normally believes, right? You don't get a Rolls-Royce at a Honda price, right? That's not what you're expecting – highest quality and lowest prices – but I went online. The World Health Organization has a huge huge database of comparison statistics for every country in the world and everything I could get online said that it was true.

Singapore really was running the most efficient, lowest cost and best outcome healthcare system in the world. Usually, and I've now seen 20 years – decades – of statistics, but usually in they're in the top three in life expectancy, maternal mortality, infant mortality and they're by far at the lowest cost.

So whereas – I'm sure your audience is aware of this – we're spending about 18% of national income on healthcare, Canada, England, France – they're usually in the 12-13% [range], sometimes 11, if they're doing well. Singapore has been under 5% throughout its history and I think it's at maybe 4.6% right now.

And what's even more shocking about that, [is that] they have mandatory health savings accounts which means they've got so much money in their health savings accounts. They're the only country in the world that will not have to unplug granny in 20 years because their, you know, Medicare system is going to run out of money like ours is, right? And so they've got both a secure system, a sustainable system, and the most efficient in the world.

And over the subsequent five or six years, Dr. Bock, I ended up, you know, even being a guest of Singapore's government and having a three-hour talk with the Ministry of Health and seeing all their different levels of health care systems from the basic public health up to the top. And it all checked out.

I love Singapore's healthcare system, they're very honest. They send you experts out every year to go see best practice around the world. And so everything they've done there, they borrowed from somewhere else. And they'll admit that they just put it together properly. And a lot of it was from the United States, whether it's price tags because they've got really competitive healthcare.

An American invented price tags, you know, back in about 1850. You may have had John Goodman on, the economist – he invented health savings accounts. He's still alive. He invented them in the early 70s. Basically, all the key components of Singapore's system we have here, we've just never put them together properly.

And so that that makes it even more of a tragedy that we are spending so much to so little effect. As you pointed out, you know, our life expectancy is five, six years less than Singapore and Japan. We could do so much better. And we could free up about \$3 trillion a year, every year, forever. That could pay down the federal debt, that could fix the deficit, that could [fund], you know, any public program you want to spend money on, whether you're on the left or the right, or just lower taxes. Some people on the right just want to lower taxes. Yes, there's money for it if we fix the health care system in ways that are known to actually work and which we invented, which is the really embarrassing part.

Randall Bock: So, in the green room we were like making a reference to the Beatles and as you were talking I was thinking not about the Beatles but the Rolling Stones and the great

philosopher Mick Jagger in "Satisfaction" said you can't always get what you want. You can try. Sometime, you just might find you get what you need.

It's not quite apt, but obviously if Singapore is paying a quarter of what we are paying, they're going to be fewer things purchased, I assume, on some level. What are the things – getting to the "Satisfaction" lyrics – you might "just can't always get what you want, but you just might find you get what you need". It sounds to me as if that is the general economic proposition we have for all kinds of other products. I might want to have, I don't know, a coterie of five different cars, more sports cars, an SUV, I don't know. But I have to pick up one because I only have a certain amount of economic bandwidth to do what I want to do. If Singapore is paying a quarter, what are the things that they're not getting, or are they just getting everything at a more efficient price?

Sean Flynn: OK, so that's the latter, or more so the latter than any of the things you said earlier.

Let me let me try and unpack that a little.

We normally think – and the following is true in a competitive system where things are competitive like the price of wheat. If you're in a competitive system, then price will be almost identical to cost. And by cost, what you mean is how much does it take to actually get something done or to purchase something or to grow something or to build it.

But there's often big gaps between price and cost. A monopoly is the closest thing, right? Does it actually take \$1,200 to make an iPhone? No. Apple has 40% margins, right? They can do this because they've got a great public brand and stuff, but the price of an iPhone is well above the cost. Now, flip that around to supermarkets.

A typical supermarket has a 1% margin, right? Their prices are only about 1% higher than their cost. So, there's certain industries in which there are these big gaps between price and cost. And there are these other industries where there's almost no gap. If all of healthcare were more like supermarkets where there's these really thin margins, then you'd have to say, well, if you're spending less at a supermarket – in one supermarket than in another – or in one country than another like, say, supermarkets in Singapore, supermarkets in the United States, then yes, the only way to spend less money – if the price equals cost and the costs are basically the same everywhere – is to actually buy less. You have fewer apples, right? You have fewer pounds of beef at a supermarket. But if you're going from Whole Foods to Walmart, you can actually – because the prices at Walmart are lower than the prices at Whole Foods, and you know, the quality is basically the same (nothing's going to kill you, and you can get organic stuff at Walmart), but the markups are so much higher at Whole Foods that you could take your hundred bucks at Whole Foods, go over to Walmart, and actually come out with more food. Another thing you could do is only spend \$50 instead of a 100 at Walmart and still maybe come out with almost as much food as you did at the Whole Foods.

So what Singapore has done basically is set up a highly competitive healthcare system where competition - like with supermarkets. The supermarkets – it's not that they're being nice by, you know, only having 1% markups: they're forced to do that because there's such intense competition between the supermarket chains. Singapore's basically got that same

level of intensity of competition in its health care system, so that the markups are very small. And so when you see the price lower over there, you really could take a bunch of money from the United States, go over to Singapore and buy more stuff than you can in the United States. It's not that the only way to get the lower expenditures in Singapore is by cutting back on the actual number of surgeries and, you know, bottles of aspirin or something like that; because they've eliminated these massive up-markings; ... they've got a system where the price and the cost are nearly identical, highly competitive, the prices are low down with the cost level rather than, you know, the cost being low and the price is high - like going to Whole Foods Market or something like that. And because of that, you really aren't cutting back.

And ... there are some places where they are more efficient in the sense that they've got fewer doctors per capita than the United States, they've got fewer nurses per capita, they've got slightly fewer dentists per capita. But it's not like ... , you know, people there are can't find a doctor. Actually, the wait times are shorter in Singapore than they are in the United States for all those things. There is no nurse shortage or something.

It's just they've got a system that works really efficiently. So, for instance, doctor [Bock], my mother retired from Kaiser Permanente as an eye surgeon. One of the things that drove her out - I don't know it's been 16, 17 years - but they got "Epic", right which is this coding billing system. And when they first got it in, there were like 140 pull down menus so anytime she saw a patient - and you know these are routine patients - they're just coming in nothing's actually wrong, she would have to fill out 140 different things, including for the men whether they were pregnant or not, right? So within six months Kaiser had to hire what are called scribes which are people whose only job is to ... do the pull down forms while the doctor talks to the patient, right? Massively inefficient. And yet when all these electronic data systems were rolled out, it was claimed by the advocates, "Oh, with all this information science and data informatics, the healthcare system will save a huge amount of money", right? That wasn't true - because you had to hire all these other people just to do the pull-down menus.

And so we've managed to run; and here's the key part - largely because we've created a system where the prices are so far above the cost - a system where nearly every hospital administrator, government public health person, you know, someone running Indian medicine for the Department of Interior, everyone can be massively inefficient, because they've got don't have the pressure of actual competition, and having to keep prices down. And so I would argue the exact flip of what you set up there, doctor [Bock], ... which is that we have created a system where we are so inefficient, right, in spending money, ... and we've so forgotten that the prices are way above the cost - that we think as a public policy thing whenever, you know, say (it's usually the Republicans), we're going to, instead of having 4% per year Medicare growth, we're only going to have 3; everyone starts screaming because they think, well, the only way to reduce the expenditure is to actually reduce the number of surgeries and the number of doctor visits and this and that: the actual quantity of stuff purchased. But that's not true when you have a vastly inefficient system like ours.

And quite frankly, if you take Singapore as the comparison point rather than Canada or England, we're spending about three times as much as we should be on nearly everything in

the system: just massive waste, fraud, and abuse – incredible, like 10,000% markups on generic drugs, because ... we've set up a monopoly system for distributing the drugs.

So it is not the case – and I want to be very emphatic about this – it is not the case that you would have to cut back on services 75% if you cut back on expenditures. If you cut out the 10,000% markups on certain drugs and all these other things where we've gotten really inefficient, you could have both lower expenditures and just as much and perhaps even slightly more actual medical services being delivered, especially to the poor.

You know, if we have time later, Singapore has created the world's greatest social safety net for health care. And no wait times for the poor. Same access, same doctors. It's absolutely amazing. But they could afford to do that because they created a competitive system where the prices were driven down to the cost level. Here in the United States, when Medicare or Medicaid goes in to pay for ... an indigent person, they pay the almost identical outrageous “market prices” – these chargemaster prices that we have in our system, these bloated prices.

[In] Singapore, since all prices, both public and private are kept low by competition, the government goes in and can buy stuff for indigent people really, really cheap without the 10,000% markup on the generic drugs and things like that. And so that's how you do it. You actually need the intense competition. But – and the real trick here with Singapore – they also built the world's greatest safety net. They didn't create a two-tiered system where the rich get stuff for cheap and they can afford it and the poor get nothing. It's not like that at all. everyone gets the same level of service. The government steps in. There's actually ombuds people hired by the government with like sociology degrees at every hospital to actually guide people through all their benefits and make sure they get everything and that the government will pick up the bill. [Clarification: In his book, Sean notes: “At the entrance, there are greeters as well as medical social workers. The medical social workers act as ombudsmen and advisors, making sure that each person knows which government benefits he is eligible for and how to apply for them”.] It's absolutely amazing.

Randall Bock: So, there's a lot there. I'm going to have to relisten to this video later because there's so much to unpack. But obviously, the book is there as well. We're going to get into the book and how people can find it and find you and so forth. On a personal note, I mean obviously I'm a physician and I've had some thoughts about this stuff. I substack away and I write and YouTube and all that kind of stuff.

There was a point about a decade ago I was at a healthcare conference sponsored by a law firm in town in Boston. And it's ironic and or interesting maybe, or coincidental, that Boston's sort of the medical mecca. People come here, you know – there's a you know famous book by Samuel Samuel Shem [pseudonym of psychiatrist Stephen Bergman] that labels MGH [Massachusetts General Hospital] as man's greatest hospital [Man's Best Hospital (MBH)—a satirical name for it] – it's tongue and cheek. but they often feel that way here. And so, all those hospitals – you know, all the Harvard hospitals – are basically annealed into one system.

And so you basically got this huge thing it's mass general bighgam da da da, and so you know they have kind of a monopsony. I don't know if they have a monopoly – I mean they have a monopoly to a certain extent for a lot of the tertiary care that filters through, and

they probably get some monopsony aspect where they can be a single big purchaser of items and get some benefit on the on the short end. But the prices keep marching up because I don't think we have that much competition within our own systems. We're not free individual kind of atomized purchasers as we are for shoes or raincoats or pencils or whatever it happens to be which can come in and out of. I would probably short the pencil market these days because people don't – I mean I have a pen in hand right now – but I don't really buy pens very much anymore. I might get one here and there at the bank but I used to buy pens. I don't really do that anymore because I got computers and dictation – all kind of stuff. So the markets changed ... and we see some of that in medicine. So anyway, getting back to this conference I was at, I was probably one of the few physicians there, mostly lawyers and they were talking kind of how to game the system in a sense – not game it, but you know, be aware of what are the regulations, all the kind heavily regulated place.

We'll get to that later, but I got up and I said, you know, what's really amazing and great about the American health care system is the way, you know, things have gotten so much better this last decade and provided so much better care at so much ... lower cost, more efficient and all that kind of stuff. And everybody just kind of looked at me puzzled like what planet is this guy from? You're saying, ... everything got better and cheaper and more efficient at the same time.

I said, "Oh, ... I forgot to mention. I'm talking about LASIK surgery, dental implants, hair transplants, and veterinary orthopedics. OK, so if your dog needs a new hip (I swear I've looked in these things – somebody brought a startup to my angel group). You know, they they've just gotten so enormously better. They're willing to experiment. There's a huge market. Everyone pays with cash for their dog because ... we don't have doggy Medicare. We don't have doggy Medicaid. All that kind of stuff. So, people want something for their dog, they have to go buy it. Or they can conversely not buy it and let you know – Rover – go around on one bad hip or whatever. So you know –ditto with all these other things which are elective items – plastic surgery and dental implants whatever. At some point they might be incorporated in the general ... kind of medical pharmacopeia whatever, but at that point. So, ... my point was that things that are ... freely marketed ... wind up finding their own equilibrium and people compete. And even you know, with hair transplants for instance, you know [it's] not just here you're competing. People are going on these medical vacations to Turkey and whatnot and they're getting their hair transfer and they probably can get certain things like you ... certain surgeries in ... Mexico or wherever, ... cosmetic surgeries in the Caribbean, Armenia blah blah blah. So, they can ... travel. So it winds up having a marketplace for those elective things.

Anyway, there are certain kind of innate inefficiencies we have in our system. ... So, what would it take to redesign, Professor Flynn, the American system in terms of time and effort. Obviously, there would be resistance from insurers, hospitals, pharmaceutical companies, and medical device manufacturers. Is there any way by which stakeholders could also win during the reform process? So, I don't know if you want to tackle that one or anything I mentioned earlier.

Sean Flynn: OK. Now, is the stakeholders everyone? Does that include like the big pharmacy benefit managers and United Health and things or do you mean the American people sort of the primary stakeholders?

Randall Bock: Well, we just had a barbecue the other day. My in-laws came over so we were holding some steaks ourselves. They were quite delicious.

Sean Flynn: [laughter] I like that joke.

Randall Bock: The American stakeholder could ... you know somebody with high cholesterol and winds up getting cardiac issues. No, ... I would say those stakeholders in that case would be the ones listed – the insurers, the hospitals so forth, who have their ... GDP of their own individual companies are at stake by any kind of regulatory aspect. Because so this big lobbying. I mean I've been following the RFK Jr. MAHA story in DC and it's been hard to just kind of peel off a couple of the less necessary vaccines from that schedule. There's the NCVIA which is kind of a nice rent seeking blanket for companies to make vaccines instead of medications.

So I've spoken and followed all that stuff, but obviously there are going to be stakeholders who make it very difficult and put the feet to the fire of anybody who wants to think differently. So I've had on Robert Malone on my show maybe three or four times and you know physician and he was head of the ACIP temporarily, and he got out of it because it was ranker, too much pressure and whatnot. So anyway so those are the stakeholders I'd say but obviously the stakeholders are the recipients as well. So the people who would prefer to hold a stake than to listen to any of these things.

Sean Flynn: OK, and thank you for that clarification that makes it clear to me how I should approach this. So let's start from top down and get more micro.

Top down the biggest problems are philosophical in that 30-40% of the country and maybe 70-80-90% of academics of any discipline – not just medicine-related or economics – have a fondness in their heart for the English and Canadian systems. They don't seem to read the news and know that the wait times have been skyrocketing in both countries, they don't realize that there's a private sector safe valve in both countries. Yes, England has a national health service but anyone can afford to buy private health insurance and goes to private hospitals. They don't realize that 80% of the Canadian population lives within 50% of the US border and so that the safety valve there is people driving south to the US to pay cash for things. But that being said, though, their allegiance to that system call it national medicine, socialized medicine, you give it whatever you name you want, government-controlled medicine, government funded single-payer.

Actually single-payer is sort of the neutral term which actually hides some of the defects. But let's call it single-payer. Single-payer is a disaster for quality of care, drug development, innovation, you could go on and on.

I remember back in the 1990s, I haven't seen the new statistics, but at the time the US had 3,000 MR machines and Canada had three. They should have at least 300 because their population is only a tenth the size. They had 1%. Right?

So these systems also massively under-capitalized, by which I mean they make too few buildings, they have too few operating theaters. You will routinely, as a result, see articles in the British tabloids about women at public hospitals having to have their babies in the hallway because there weren't enough delivery wards. You know, it's very predictable when a baby's going to be born, right? There's no excuse for a system not having enough

personnel and building space available to deliver a baby after nine months of waiting, right? Yet, they goof that up.

And so the biggest problem is that there's probably 30-40% of Americans who think that single-payer is the solution to all our current problems?

It wouldn't be for two reasons.

A) the best it could possibly be is to look like Canada, England – [with] massive wait times and lower quality of care. But the real problem – if we tried to transition politically through an act of Congress signed by the President into such a system – that legislation would be completely gamed by the current powerful special interests. You'd actually end up with something worse than Canada and England if you tried to do it through our democratic processes because the lobbyists would be in there for big pharma, big medicine, big insurance the whole way. You'd actually get a less efficient and more expensive system. So, that's a that's a big problem we have to deal with.

On the other hand though, the [other end of the] political spectrum – the Republicans, and you know, libertarians and anyone who's not of the single-payer mindset – they don't really have any proposals that I consider publicly attractive. They say that we're going to wave – what looks to other people like this magic wand of free markets – and everything will just be fixed. And yes, it's true, and the examples you gave are spot on. Anything like LASIK that was not covered by insurance, the cost has gone down, the quality's gone up – just booming business. And actually, for those things very few people do medical tourism? ... Because they can get it for cheap right here in the United States.

And there have been other people like Keith Smith at the Surgery Center of Oklahoma – I don't know if you've had him on yet – but they've been posting prices since 1998. They do over 900 surgeries now and people fly in from Europe to go there. We have import medical tourism in this part of the healthcare sector where they decided not to take insurance because Keith Smith and his crew figured out how to do everything really efficiently, high quality and so on. They get lots of Canadians, they get lots of Europeans, they get people flying up from the Caribbean and stuff and Central and South America. So, we can do this stuff here.

But politically only one side – the single-payer side – has something that looks like an easy quick obvious solution. And you're probably aware of that old HL Menken quote about for every complicated problem there's a solution that is – what is it? like “simple, intuitive and wrong”, or something like that. [Actual quote: “there is always a well-known solution to every human problem — neat, plausible, and wrong”; but it is more commonly used in the general public as: “For every complex problem there is an answer that is clear, simple, and wrong”] So, single-payer is that HL Menken solution that's simple, intuitive and wrong.

But the other side doesn't have an attractive opposing thing to say, and many of them I think are too wedded to –you know, they read Atlas Shrugged at 19 and they just think if everyone read this book too, they'd fall in line, right? But that doesn't ... deal with people really being worried about, you know, “if I get into an accident or if I get cancer, if I roll my car, who's going to help me? Am I just going to die? Or, are they going to help me and then I'm going to go bankrupt?”

I have a neighbor across the street here. He works in warehouse distribution facilities. He got a gash on a finger. It went to the bone. He needed, you know, eight stitches on his finger. But, you know, no permanent nerve damage, nothing like that. So, not they didn't need like massive surgery or anything. He got an \$18,000 bill from the local hospital? And I'm Catholic and – you know – it's a local Catholic hospital. Wow! How charitable are these people? And that's what he's dealing with now, “how do I, as someone who makes \$20 an hour, figure out how to pay for an \$18,000 medical bill”? And so, people are terrified.

The political right and the libertarians have no good, no attractive-looking solution. And so, as I said, I really think if we did get single-payer, our version would be worse than Canada and England because the special interests here would make sure they could still get to a trough filled with lots of cash that they could feed at.

And so the only way forward I really think that could work here so that we don't end up with single-payer and we don't continue just down the road we've been going on here with giant corporate health and stuff, is the little guys like Keith Smith. It's the direct primary care doctors who just checked out. They don't take insurance but they'll charge you a flat monthly fee for virtually unlimited ... and I've got a direct-care doctor, and so is my wife. And then the fact that we are getting more and more cash-price surgeries, cash and carry specialists, imaging, lab stuff. And unfortunately, most people don't know this.

And you know, obviously if you're Tiger Woods and you just rolled your car for the third time, you need emergency care, you're going to get medevac [medical evacuation], but the vast majority of healthcare spending, you actually have time to think about it ahead. Even things for like heart stents, right? Unless you're really about to die, the cardiologist said, “Oh, you can get it done next month or in six weeks; we'll just schedule you” There's emergency surgeries and then there's basically everything else.

And the vast majority of stuff is everything else – where there's delay, where there's time to shop around. And we're finally getting an ecosystem in the United States where there are – you know, I could not just call Keith Smith and ask him for his price on a knee surgery, I can call around to local hospitals, there's websites like MDsave.com where doctors [have] already pre-arranged bundled surgery prices, and you can just use their search bar and your zip code and they'll find the ones near you – give you every doctor, and sometimes they're not the same, because the competition isn't that intense: sometimes some doctors are 10 or 15,000 more or less. But you can also look up [that] they're all board certified. You can see if anyone's been sued. You can find out if the quality is there, as well.

And so that to me is how we can creep towards actual authentic reform because entrepreneurs, business people – if they know they're operating in a competitive environment, they just naturally figure out how to do things more efficiency – which in medicine is the combination of higher quality and lower costs: which, if it's competitive, also means lower prices. Because there won't be much of a gap between the price and the cost if it's competitive. You've seen that with these surgery centers.

But let me let me just say one more anecdote here as an example of the push-back in the system – and I don't even mean malevolent, intentional push back. I talked to Keith once and asked him, “Wow, how many other surgery centers are in the country? Are you going to stand up a bunch of franchises?” He's like, “No, no, no. I think they should all be locally

owned by local doctors." And he said, he'd advised on a whole bunch. And I'm like, "Wow, why can't I find them on the internet?" He's like, "Oh, they don't post their prices".

I'm like, "Why is that?" He said, "Well, a lot of these surgeons. they also do surgeries at – like, a local big hospital – and those local big hospitals have non-compete agreements and also these things where they shouldn't be undercutting anyone else's prices, right? So, they they've got the hospitals-negotiated reimbursement rate for ... stent implant or something. If anyone finds out that doctor is doing the stent implants at a lower price than the hospital charges, then the insurance company can get mad at the hospital because they're not offering the lowest available price in the area. So, the hospitals actually don't want the doctors out somewhere else in a different facility, doing them. So, we've actually created a system here where ... the incentives in the system are such that everyone wants to keep it quiet if they've actually got lower price and higher quality. You kind of have to do it clandestinely, which is just completely ridiculous. [Sanjeev: The cost of price discovery – the transaction cost – must be lowered via regulation. To operate efficiently, markets need publicly available prices. Singapore's great reform was to force this disclosure on everyone.]

But there are doctors who know they could make plenty of money setting up their own surgery centers where they control the rent, they control the cost, they don't have to deal with the insane insurance company – in network, out of network, higher cost, lower cost. Like Dr. Smith told me ... in his local area in that county there are five different Medicaid reimbursement rates, so depending on which hospital a Medicaid patient goes to, the government will get charged more or less even though it's identical service. That's our crazy system here, and ... to defend that [everyone] has to keep all the prices and the costs completely opaque. Because someone would end up asking: "Well, why is the government spending twice as much at that hospital as at this hospital? Isn't that unfair to the hospital? Isn't that unfair to the patients? Could that be dangerous for private care?" And the private insurance do the same thing. Depending on what insurance you walk into a hospital provider with, that hospital provider will get paid more or less for doing the exact same thing.

And that gets back to that gap between price and cost. The cost is the same whether they treat you or someone else at the same facility, but the price they get paid varies all over because we don't have competition and everything's been game.

Randall Bock: I wrote down a few things as you were talking. , I'll give you a couple of these words and I'll try to string them together. I wrote down NATO (North Atlantic Treaty Organization), I wrote down detox, I wrote Milton Friedman, and I wrote college, I wrote NBA. I'll see if I can make sense of those scribbles.

Basically, **Milton Friedman** at one point said: look before you had Medicaid, Medicare, ... he said it's not like people were just sitting on the streets – like, you know, the image of Kolkata whatever back in the day – starving and rolling around with tuberculosis or leprosy or whatever. There were charity hospitals. The greatest flowering of growth of hospitals was in the late 18th – the Belle Époque, the gilded age – and into the early 20th century. So right here we have the Deakins hospital, a catholic hospital. You can find any number of Saint "this and Saint that" we have St. Elizabeth, which recently closed. There's Beth Israel.

Anyway, there there's no shortage of hospitals with, you know, some Catholic, Jewish whatever – the Shriner's Hospitals here.

The charitable impulse is a huge part of our society. I recently saw *The Odyssey* – the movie – and, you know, they talk about Zeus's rule. And it's also the ... kind of the golden rule ... people have had this kind of stipulation to care for each other one way or another because it's in our long-term best interest as a society. Maybe not individually in any given moment. I only bring that up because you know that's like ... sort of prehistory bronze age or whatever. Anyway, so for a long time we've had this idea of looking out for each other. It's probably in our best interest to take care of each other to some extent. So Milton Friedman points out that before we had ... enforced charity through Medicaid, Medicare, disability insurance, whatever, we had charities. It's not like people were starving.

So that's number one.

I brought up **NATO** because a lot of our [healthcare] pricing and our model, and the reason that the UK and a lot of places in Europe can get by with their unipayer system, is similar to the NATO: ... just the way we provide defense for Europe, and they pay far less of their own personal budget towards defense: frankly, they can put a lot of that towards medical care and socialize this and that.

So, we kind of have an umbrella [for Europe]. We've had an umbrella on pharmaceutical prices because we have more of an open market, so we've been paying higher pharmaceutical prices. We get more innovation. The innovation is all coming out of the United States as [the] place where people want to make the new Viagra, make the new this and that, because we will pay for it at top dollar – at least under the patent realm, 7, 15, whatever, 11 years. Whereas, Europe has this monopsony aspect and they will ... get lower prices by single payer (single purchaser) and all that kind of stuff.

I brought up **detox** for a couple different reasons. One is, I used to do some narcotic detox as an ancillary part of my practice with subox and outpatient whatnot. I ran into a lot of people who had been through literally – not even not joking – 20 detoxes within that calendar year. And why did they do that? Well, they could do it because it's like having a free ticket at Disney or a year pass at Disney. They could go in and out as many times they want and didn't matter, so they had no personal repercussions. They're on some form of public assistance and the detoxers are certainly happy to see the person come by again. They collect money every time the guy shows up and there's no ramifications, no repercussions, no reformation. There's no re- anything except rehab over and over again. So, the re- re-rehab.

But the other reason I wrote down detox is because the whole system in a sense is like a narcotic addict. The typical narcotic user needs to get his fix and so the system has to have its fix. It's hard to get something [that's] on a “system”, off.

And the reason I wrote **college** down is because I think the ancillary example is college. I think there has to be a college “fix”. There's a lot of college being provided that's unnecessary. I think it's bloated. Everyone stays four years whether you want to become a French professor, work on HVAC or cure cancer – what everything needs the same kind of Turing machine answer of four years. Because college can get four years of payment

through the grants and whatnot. They've managed to get that rent-seeking apparatus to get paid for four years – so the answer to everything is four years. And so how would you fix college? How would you fix the healthcare system? These are probably similar things.

I mean, YouTube can fix college. Peter Theil wants to get people away from college and give them a certain amount of money to go get their ideas right out of high school, and go pursue it rather than waste four years in college. We could probably do something. You weren't that fond of the electronic medical record and probably in initial permutations, not so great. But I think that there's a lot of stuff that can happen with AI with medical records and portability of our own so that we can source our knowledge not necessarily through the physician through the hospital [but] through other means, leaving the hospitals for those places that are [for] the catastrophic aspect that has to happen somewhere down the line. So when you do have your massive stroke, you don't necessarily go to Charles surgery center on the corner [but] need a hospital. [For] a massive aortic aneurysm ... you go to the hospital because you're going to need a lot of stuff going on – transfusions or transplant, who knows? So there probably a place for it, but probably it needs to be pared down.

Probably colleges are OK for certain things, but not necessarily for everyone to live in, have a four-year keg party and absorb the social milieu – while they're getting a little bit of stuff that they're not really paying attention to. They get the AI notes they pass [with]. A lot of people pretending to teach, people pretending to learn, and people get these pretentious degrees after the fact. So, you know if you want to get rid of colleges, I don't think you can like tell the college to stop doing that. They're there for the long term and Harvard with it “Harvardiness” is able to sell that as a as an actual credential, and hospitals have that same kind of thing in people's mind, at the very least. So, I think it's a kind of a slog.

Anyway, so that's a diatribe, not a question, but you can attack any of those things I've just said or we can go to do either one.

Sean Flynn: OK, well, I like diatribes. People being frank is something that we have a little bit of a problem here in America unless we're actually doing an attack ad or something. So, let's run with the college example, because I think that's another great place here, where we need to point out that prices are set by demand and supply.

The supply – at any moment in time – you can't control much of. It's based on your current technologies – how many trained people you have, like in a hospital – or a college you could teach a physics class or something. But you could have very pernicious and very large effects on demand.

So, if supply is fixed and demand increases – if you're thinking of a supply and demand graph, that would be supply curve not moving but the demand curve being shifted to the right or you could think of it being shifted up. You get higher prices, and if the supply curve is nearly vertical which it is in the United States, it's hard to get a license to start a new college or anything. It's nearly vertical, at least in a short period of time. Then any rightward shift of the demand curve or anything that increases the demand – and demand, remember, in economics is defined as both willingness and ability to pay for something. I am willing to pay for a Ferrari but I am not able to pay Ferrari. So, my willingness just shows up as zero movement in the Ferrari demand curve. But if someone gives me subsidized student loans,

now my willingness to pay – because now I can spread it over the next 30 years – my willingness goes up.

There have been two major public policy goofs. which is why college now is not just this dumb ritual where no one gets educated – which is largely true: there's tons of evidence for this objective evidence, a lot of students do not walk out any more educated, better thinkers, or even with technical knowledge in a field after four years, and they get their bachelor's degree, [to] the one they went in. It's a travesty.

The two big things. Accidentally a Supreme Court case – and forgive me, I can't think of the name of the case around 1972 – where I think IBM got sued basically for racial discrimination or some kind of discrimination, might have been gender, because ... maybe ... whites were doing better on the exams, the IQ test that IBM gave to 18 year olds. IBM used to be perfectly willing not to insist on bachelor's degrees. They took people out of high school. They'd test them and the really smart ones would be put on an electronic track where they learn all these electronics first as a workman, but then they'd actually be sent to college by IBM. IBM would pay for their college. They'd come back with master's degrees, PhDs, and this and that. And if you didn't test so well, they might put you on a track to be a janitor. Now, part of testing was, as an 18-year-old – is did you get to go to good schools? We have a legacy of bad schools for African-Americans in this country, especially around 1970. Clearly, you're going to get a few or smaller portion of African-Americans being able to do well on those tests. Absolutely fine, disparate impact, I'm with you there.

But we ended up with a pernicious effect of the Supreme Court ruling that tried to fix that – because they basically said it was illegal for any employer to use IQ tests or even tests of technical skill and ability to sort workers out into different career trajectories. Now, the US Army does this, right? They make everyone take the ASVAB test, the Armed Service was a vocational aptitude battery test. And yes, if you do really well, even if you wanted to be a trigger puller in a special forces, no, they send you to intelligence. They just put you someplace where you're an “electronics” guy. And so, jokingly

within the military, and my friends who were in the military would joke about this: “Yeah, I ended up a grunt, I did bad on the test”. But they're happy with that because they wanted to be a grunt.

But we switched to this system and here's the weird thing. Businesses could no longer do their own testing. So, they basically outsourced it to colleges and universities. And this is when the SAT took up. So the schools could sort kids on ability. The schools could sort on. And so basically you now in order to get sorted into the career track at the high end of IBM, you needed to go through a bachelor's degree. You needed to go to the big state school or MIT because then as a 22-year old, someone had done the sorting for IBM and all the other corporations hiring.

So that massively increased the demand for a bachelor's degree. It became the official certification of elite success, especially, obviously, if you've gone to a highly ranked college and a lower ranked college. Also, you create this war among middle-class parents to suddenly make sure their kid goes to the high-ranked school rather than low-ranked school so they can get the job at Goldman Sachs. Goldman back in the '20s, they didn't they actually hated people with bachelor's degrees. They thought they were overeducated and would be

terrible traders on Wall Street. They actually look poor kids with very bad formal training but who had street smarts. That's who they wanted to train. We got completely away from that. By the end of the financial crisis 2008, 60% of Princeton's graduating class was going to Wall Street. This is a complete misallocation of resources in the economy. And also, most of those kids probably didn't even need to go to Princeton for four years. They would have been just as well at Goldman Sachs as 18-year olds. Total waste of resources for society.

The next thing, Randy, was in 1978 or 9, Jimmy Carter as payback for winning in '76 – he barely, barely beat Ford. Anyone my age or younger can't even remember that election. But he just squeaked it by, despite Watergate and despite Ford falling down the staircase and being mocked on Saturday Night Live every night. He barely won. And the only reason he won was because the teachers unions went out and knocked on doors for him. So, the payback was creating the federal department of education, which immediately massively expanded the student loan program. We'd had a teeny-tiny one only [for] engineers since Sputnik because we were freaked out by the Russians in the '50s and wanted more engineers, and the only student loans we gave were for technical things. The Carter administration opened it up to every major, every school in the country. And ever since then, we've had this massive increase in willingness and ability to pay because you could take out the loans for it.

And so, we screwed that up and it's very similar to healthcare with Medicare and Medicaid stepping in, in 1965 with the Great Society. Suddenly there were all these billing codes and anyone who could game the billing code or set themselves up as the highly marked up middleman like United Health or CVS Caremark could make a ton of money, because another way to put this: the user and the payer are different people.

I have a textbook with McGraw Hill. It's a good textbook but it is marketed to the faculty because the faculty choose the textbook and then the students pay for it, the users are different. And healthcare's got a lot of those aspects: what gets purchased for whom is basically a government money, or a CVS caremark decision, or a committee at a state capital for "certificate of needs" to build a new hospital: "Oh, do we really need a new hospital? That might ruin the profits of the existing hospitals. Couldn't allow that. We need them to keep their giant monopoly hospitals". And so, we've set up all these dumb systems where we massively increase the demand for health care because there's third party payers that really don't care about the cost. Any private business – if 20% of your money was going to fraud like it is Medicare and Medicaid ... (the higher-end figures). It's at least 5%. It's probably 10. It might be as high as 20. Any private sector company would figure that out and they call the police and get people arrested, fire employees. Medicare, Medicaid, no, everyone keeps their jobs. They're all civil servants. It doesn't matter. And so, we have this system where the demand is really, really excessive because we've set up a bunch of bad policies. And of course, the cost is high. And, of course, there's this giant gap between the prices and the actual cost of service.

Randall Bock: It's incredible. I used to be a disability exam doctor. And for various parts of my life, I got the nickname Dr. No for the James Bond villain. (Some people, you know, called me "Dr. No it at all." That's separate. That's with a K.) And so, the Dr. No aspect was actually for a lot of people in pursuit of narcotics before I started the detox thing the decade before that.

They'd come to me, you know, with a bunch of ailments, you know, theoretically, and they were explicitly allergic to every low-level narcotic. They only wanted the high-grade ones. I would sus that out. But I'd called a few pharmacies and you know ... so I got this nickname, epithet, or whatever (compliment in my view, a curse in theirs) that I was Dr. No. But that that kind of carried over, because I told them to get detox or rehab or whatever. I didn't not care about them, or not care for them. I cared for them a different way from what they came for. They were actually there, again – sort of to your point – they were there on somebody else's dime to get something that they wanted, and you're going to pay for it. But it's so diffuse, you know, the hundreds of millions of taxpayers have no idea that this one guy is going to, you know, 13 doctors a day and getting prescriptions and selling them, having a whole separate business. [A] kind of a fraud-on-the-run. It's like Door Dash you know, Drug Door Dash anyway. And it's dashing to his own door for the most part.

But as a disability doctor, I worked both for the Commonwealth of Massachusetts and also for the VA and so, two separate channels of people complaining of disability. Frankly, the VA ones were a lot easier and nicer because they had been in the military and they endeavored to serve the country and their stuff was kind of fixed. The state one was for people who wanted to get on [a] kind of long-term disability and payments. So, they were aggrandized. If they had a bad pinky, it meant they couldn't work at all. ...Their view of what this really was, and mine, differed.

I tried to look everything objectively and I would write things up. I couldn't out-and-out deny people but I'd say: "Professor Flynn has a bad pinky, has horrible gouty arthritis. We should fix that. But that's not going to really interfere with his job, which is economics professor. So, he's going to use either left or the right side of his brain or either one. Nothing to do with his pinky. I don't think he's disabled. He doesn't need to be on our money for now. And so he can probably go back to work tomorrow". I didn't write it as explicitly as that but wrote things that were, if you could read through it, you'd say, "Oh, this guy's pretty much OK."

And people would come back to me. I thought they'd come back angry, but every now and then, repeatedly, people came back to me, "Thank you, Dr. Bock. I really appreciate you gave me that disability." And I'd be like, "What happened?"

You know, the disability team, through UMass, university, they would approve everything. Their business model, working for the disability unit, was to keep themselves employed. And how do they do that? By handing out more disabilities. So, their model is not the same as yours. You know, college administrators don't have the same interest in keeping costs down as you and I might.

Sean Flynn: OK, one quick anecdote to follow up on that? So, in ancient China allegedly – I've never been able to verify this – it used to be the case that rich gentlemen of means would pay their medical doctor, but only when they were healthy. If they ever got sick, they cut off the money because that way the doctor would have an incentive to keep them healthy.

And let me bring this to something modern in America. There are these direct primary care doctors. They get paid a fixed amount per month, I think the national average is about \$75 a

month. Talking to one of them – maybe you should have him on your show – Dr. Josh Umbehr, Wichita, Kansas – runs an outfit called [Atlas MD](#) there.

He likes to joke that he loves getting some older fat guy as one of his patients, because Josh has the time as a direct primary care physician. They only have patient panels of maybe 600, to actually text the guy every day till he's taking his metformin and he's actually doing what he should, and then in Josh's perspective – just like the Chinese doctor who got paid when someone's healthy – Josh gets 75 bucks a month for doing nothing. Because that guy is healthy. Josh makes his profit when that guy's healthy. And that's the kind of health care system we need to set up.

Randall Bock: That's a business model thing. Last couple questions, how would consumers be involved and engaged in demanding reform? If you were Trump's health secretary, what would your elevator pitch be to the people of the USA to get them on board, and/or to Donald Trump, etc., to get him on board and wanting to do what you want to do?

Sean Flynn: Well, one thing you know – the idea of Trump RX – not the cheap drugs, but the government website with trusted information where you could find the lowest cost providers, that would be great. Singapore's government does a similar thing with the hospitals and surgeons. You could look up which hospital has the lowest rate of complications on surgeries, and stuff like that. And so, there's all this quality and price information out there. If there were a trusted national source – of course, everyone's going to try and game this trusted national source – Randy, so I'm not naive here. But if there were something where consumers could actually just type in their own zip code, and ask: “Hey, where's the lowest cost provided for X or Y or Z”, that would be amazing.

Similarly, letting doctors, you know, continue to practice across state borders.

There's a lot that could be done to lower the cost of care because very often, you know, someone just needs to see you for two minutes because you're such an expert. Doctors can figure out what's wrong with you, make the right diagnosis. The treatment plan is usually very standard. If there's a standard treatment plan for millions of people, with the same diagnosis, this is the country that invented the assembly line and the Model T Ford. That's something we can do. But most people think of it as a bespoke thing. They got to go talk to a doctor, it's things individual, the treatment's going to be different.

But I think the starting point is the price comparisons. Price tags on everything and quality metrics that can be trusted.

Randall Bock: Well, I like that. So, if you could if you could get Congress to do one reform during this term of government, what would it be?

Sean Flynn: You'd switch all the ACA [Affordable Care Act] subsidies and not just the tax subsidies to the individuals, but the whole darn system is subsidized. You just give people the money. It would look like what Milton Friedman wanted with school vouchers, which have turned out to work really well. Give people the money, put it into their health savings accounts. Then the government would just create a catastrophic backstop. Have it administered in the private sector. When people are given the money themselves.

In Singapore, they've got health savings accounts and every baby gets \$3,000 just for being born into a health savings account. People spend that money very carefully due to something called loss aversion which got a couple guys the Nobel Prize, Daniel Kahneman. So, give the people the money and then let them decide when and where to spend it rather than some bureaucrat who, as you said, thinks they need to shovel money out the door in order to keep their job.

Randall Bock: Well, thank you so much, Sean Flynn. So, give us the name of the book and how people can buy it and find you.

Sean Flynn: The name of the book is "The Cure That Works", and the subtitle is "How we can have the world's best healthcare for a quarter of the cost". It's on Amazon. If you need to remember my name, I also wrote Economics for Dummies, one of those yellow and black things. So, first look up Economics for Dummies, get my name and then get the Singapore health care book.

Randall Bock: I got to say I like the Dummies series. And I have not seen yours, but I probably will go buy a copy if you will venture to autograph it for me. I've been called worse myself and you know so I very much appreciate your being here on the show. Thank you so much, Professor Flynn.