Dr. Richard Kerbavaz

How to Reform the Health Care System

Recorded May 2, 2008 on luver.com

"Kerbavaz is a rare guy! He knows practically everything, enjoys life/people, and is available!" – Frank Moore

Frank first met Dr. Rich Kerbavaz when Frank was a patient at Rockridge Medical Group in the early 1980s. Twenty-five years later, they had become dear friends, Frank was running for president of the U.S., and Rich came over to discuss Frank's health care plan and to compare it with the plans of the "major" candidates.

Two years later, Frank went into the hospital for a routine operation, and instead spent six weeks in intensive care, and almost died. Rich Kerbavaz was there following Frank's care, and was his unfailing advocate. Frank said, after surviving this hospital experience, that if he did not have Rich, who was "willing to go against the prevailing expectations, it would have been much harder for me to beat the curse of their expectations, judgments, projections." This gives you an idea of who Rich Kerbavaz is.

With 30 years as a highly respected ENT doctor and surgeon, Rich knew the medical and medical insurance systems. In this interview Rich and Frank work together to develop an alternate, more humane model for health care in this country.

(Frank's complete presidential platform can be found in Appendix 1.)

Frank: ... is what they don't want.

Richard: Ah, the bigger cross-sections kind of things.

Linda: Gathering together like that.

Richard: Yeah. I guess there is a certain amount of just resistance to having any kind of a gathering at this point.

Linda: Yes, it seems so.

Frank: Other than corporate-sponsored events.

Richard: Yeah. And that's OK. But if it doesn't have that kind of sponsorship and a narrow goal that they can justify somehow, they don't want it to happen. I think the fear is loss of control. And it's just sort of the issue of controlling a lot of actions and behaviors.

Frank: I think that they is a big part of why we don't have universal free health care.

Richard: Ah, what a segue! (laughing) Good point, good point.

Frank: The rich don't want to be in the same system as the rest.

Linda: As the unrich.

Richard: And there's just a lot of obstacles or things that keep getting thrown up that are just not really true, but are the way people believe or the way people react to things. It's really interesting in all the big surveys, if you just ask Democrats the question about some sort of health plan or national health plan, it's overwhelmingly popular. And if you ask Republicans the same questions, it's overwhelmingly negative. And if you phrase the exact same question the same way to two different groups it just is totally polarized. It's very interesting. At almost every level asking it, whether they're in favor of a plan or opposed to the plan or whether they think it would be good for them or good for the country ... there's all these different ... the same kind of a survey's been done a half a dozen times and each time they ask slightly different questions, and it still comes out a big divide right along party lines! And those who are not declared in either major party, it sort of splits 50/50. So it's interesting.

Frank: Why is that?

Richard: I think that it's just how people frame the internal discussion or the internal dialogue. They're using their political filters to look at a bigger issue. And so it's a threat in some way to the Republican party or to the Republican ... the people who support the Republican party. And so people who are either a little bit more liberal or more of a Democrat, more of a social Democrat or aren't really involved with any organized party, tend to be in favor of the universal health plan. And that's across the board, however you ask the question.

Frank: Like if the rich were in Medi-Cal, Medi-Cal would get better fast.

Richard: Yeah, it would. (laughing) It would make a big difference. Actually, the ones that you want to get in Medi-Cal are the politicians. (laughing)

Frank: Because they would not stand for it.

Richard: No, they wouldn't stand for those kinds of things. And clearly they would not be eager to keep doing all the cuts that they seem to keep doing now to the Medi-Cal program. Just every year, anytime there's any kind of a budget crunch, the first thing that goes is health care! The easy thing ... actually there was another survey not too long ago that, in California, people were more in favor of cutting health care than cutting K through 12 education. I'm not sure exactly how they asked the question, but there was more support in the budget crunch time of cutting health care than cutting educational expenses. Tough choice, but nobody was really eager to raise taxes.

Frank: (making sounds) It is not really a choice. We need both.

Richard: Yeah, right, right. And then the trick is coming up with some sort of a funding mechanism that's a little more fair across the board. Which is one of the things that's nice about some of the tax proposals that you put out there, is that it eliminates a lot of the very strange, skewed tax codes that we have now and tries to make it a little more fair to everybody.

Frank: And the 7 ...

Linda: The 75% tax over $1 million per individual and $5 million per corporation ...

Frank Moore and Dr. Richard Kerbavaz (video capture)

Frank: Would take the greed out of the picture.

Richard: Right, right. And that would be a very good thing to do as well. 'Cause clearly we've got an awful lot of issues at the very top. That most of the people who make that kind of money aren't paying taxes, at all! They manage to find shelters for everything. So where's the justice in that, where the bulk of the tax burden is being carried by the middle class.

Frank: But I get: that is discrimination.

Linda: That's what you get? Yeah, that's what people criticize: that he's discriminating with that.

Richard: Discriminating against the wealthy?!

Linda: Yes.

Richard: (laughter) Interesting concept.

Linda: And I'm sure it's not rich people saying that, either.

Richard: That's an interesting concept. That there are ... I guess there are enough people that aren't in that tax bracket or in that income bracket who want to be, but they view it as a threat to their dreams or their aspirations, somehow.

Frank: But they don't see box seats as discrimination.

Richard: That's an interesting point. (laughter) Well, you see, box seats are to give them

something, and taxes takes something away.

Frank: And the rich need some perks (laughter) to be rich.

Richard: (laughing) That's true! Otherwise you stop being rich! It's terrible! It ruins the whole point! So maybe what you should do is just allow that for everybody who's in that tax bracket, that they get a box seat some place. (laughter)

Frank: And my policy on patents would help medicine.

Richard: Yeah, because it would eliminate a lot of the profit margins and in terms of the patents for like drugs and devices which creates a total monopoly on a lot of the product. That's actually an important way of cutting down costs. That if now suddenly there's not that big premium on all those products, they could be sold at a much more reasonable price, closer to the cost of production. And still allow a profit margin for the companies but not such an obscene profit margin.

Frank: Also royalties to the public on anything that is based on something that was developed in the universities.

Richard: It would give the public a return on the investment they've made in these universities so that the products can actually be back to the public domain.

Frank: Or by the government.

Linda: Or developed by the government.

Richard: Yeah. So if it's created by the government dime, why should some individual then be given the reward for that?

Frank: Yes. So that would be part of how we can fund the health care system.

Richard: Yeah. Health care and education. So we can have it all! Right. There's lots of places there where savings can be had and earning go plugged back into the public domain or the public good.

Frank: And medicine for the non-profitable diseases.

Richard: Yeah, and then you could treat things, so that if profit margin is not the only driving force, now there could be access to care for people who have things that don't happen to be fashionable or don't happen to have high profit margin. Thus, primary care. You know, all the things that don't have a big payoff immediately, but in terms of public good, make a huge difference. Things like immunization. Things like basic health care.

Frank: I just saw that smallpox is coming back because people don't get immunized because they don't trust it.

Richard: Yeah. And even measles. There was a thing in the paper I think today that measles is having a come back. This is the worst year for measles for years. It was just because people aren't getting immunized. Some of it is immigration, people weren't immunized where they were born. But a lot of it is people don't trust the vaccines. They're afraid of the potential side effects.

Frank: Autism.

Richard: Oh yeah, autism, yeah. And I'm not sure that that's as big of a risk as people are afraid of, but it's pretty scary for a parent thinking about it.

Linda: And that is one of the risks of some of the vaccines? And that's always been the case or is it more so now?

Richard: Nobody really understands it, which is the problem. It's just that it's scary. It's become ... it's easy to sort of demonize the industry because you don't trust the drug industry for anything else, why would you trust them for this? On the other hand, things like smallpox and measles still kill people. And the danger of not getting immunized ... when you look at all the old data, before there were these vaccines, a lot more people died from all these diseases. And there was a lot more disability and a lot more death absent the vaccine than there has been since the vaccine is around. Perhaps if we had a better system for taking care of kids who had autism there would be a lot less fear about having that be the outcome.

Frank: And if we took greed out ...

Linda: ... of the picture maybe people would be more inclined to trust the medical companies.

Richard: Yeah, and you can't really blame people for not trusting the drug companies because look at what they've brought us. And there have been a lot of wonderful drugs, but there have also been a lot of things that caused an awful lot of problems. And they've been sold equally with greed as the motive. It was all profit motive that drove the whole process. And now there's a lot of controversy about how some of the research was rigged.

Frank: Yes.

Richard: And how some of the FDA studies were not really being done with any kind of goal of finding truth but only promoting a drug. So, we've not done really well as a profession these days.

Frank: Science has been kidnapped by profits.

Richard: Yeah. Profits and politics. You know, it's scary when you look at how many even professional sort of public sector scientists feel like in the last seven years that they've been really limited in what they can do and told what to say. So the FDA, all of the big groups that are doing ... EPA ... all of the things that are trying to be good stewards have not been able to do their job in the last term, the last presidential cycle. So there's a lot of hope that some of the people who are in there who are trying to do a good job, will stick it out for a little bit longer in the hopes that the next administration, like yours, would maybe make the science part more of a priority and not the profit part.

Frank: Because science needs the freedom to explore.

Richard: And from that freedom and from that exploration new discoveries and new growth and new potential can happen.

Frank: Not to be funneled down to a search for what will make the most money.

Richard: Right! And I think that when you talk to people who are really scientists most of the

time what they're really interested in is the quest, is the knowledge, is the exploration! That's what drives people in science. Not the profit motive. It happens somewhere else along the way where they ... the only way to get funding is to go through some company or go to create a product for a particular purpose. But I think that that would really generate a whole new enthusiasm in the sciences. Not just medicine, but all the sciences.

Frank: That is one thing that the guaranteed minimum wage ...

Richard: Because that also then frees up people, totally removes the profit motive and allows people to do what they love.

Linda: The guaranteed minimum income.

Richard: Because again, that just changes the whole complexity of how people work for a living or what they do. Also, just the issue of the guaranteed health care, because so many people now work, not even so much for the income as for the health care. They're just afraid not to have insurance. And if you take that out of the equation it makes a big difference in terms of freeing people up to make choices of where they live and how they live.

Frank: And even if you have medical insurance, it don't cover ...

Richard: Right. And then the other ... yeah, that's the other part of the question, the things that it chooses to exclude. Or if you have a condition which they choose not to provide insurance for, you can just be kind of aced out of the whole thing now.

Frank: And they pay only a percentage.

Richard: Right. And the co-pays, the deductibles, all the things that they don't pay for like eyeglasses or dental care. It's not that those things are not important, it's just that they managed to carve that out. Or hearing aids! Another one that most of the insurance plans don't pay a nickel toward hearing aids. And as you know, it makes a huge difference in quality of life. And it's just one of those things that the insurance industry has been allowed to not pay for.

Frank: Teeth are not a body part.

Richard: (laughing) Only until you need to take a bite out of something!

Frank: They don't pay for dental.

Linda: Medi-Cal? Medi-Cal pays for dental, but good luck finding a dentist!

Richard: Right, that's the trouble.

Linda: Frank has never used his Medi-Cal for dental.

Richard: Because there are very few dentists who take it at all. And most of the dentists I've talked to say that the rate, even before the current set of cuts are actually less than the cost of the materials. So not only is the labor free, they're actually subsidizing the materials as well.

Frank: For a medical system to work, all doctors have to take all patients.

Richard: Right. And there has to be a system in place where that can happen transparently so that there isn't suddenly these issues of who has what kind of insurance and has access to

certain kinds of care. Because that's really the sort of de facto rationing that we have now. It's really not that health care isn't rationed, it's only rationed by who has money and who has insurance.

Frank: Michael Moore said if the insurance companies are a part of a medical ...

Richard: Are part of the medical health plan?

Frank: Yes. That plan is a con.

Richard: Right. You know, currently they just have basically the right to take as much out of the system as they can. And there have been all these different estimates about how much money we paid for insurance. Essentially it's at least 30% and probably a little more of all of the health care dollars goes strictly to the insurance companies, or go to the system that we create to pay for insurance. So there's the insurance companies themselves and their marketing, and the costs of all our offices dealing with all these different insurance companies. So right off the top you could probably save 30% by getting them out of the equation.

Frank: But neither Hillary Clinton nor Barack Obama will get the insurance companies out of the equation.

Richard: They pay an awful lot of money as fees to all these different people and they own all the lobbyists. And thus, they control huge parts of Congress. So it's going to be very difficult to get them out of the equation unless you have a major sort of a turn over as to how people think about insurance. There's already a lot of support in the public! The problem is actually convincing the politicians of that.

Frank: They would force people to get insurance.

Richard: So they're basically forcing everybody to subsidize the insurance companies to that however many billions of dollars they get. It's an interesting business model.

Frank: And just the big ...

Richard: ... big companies, because they're the ones who can compete. All the plans basically stack the decks in favor of the big insurance companies. And it's essentially a public subsidy. The other part, of course, is that they all would use tax dollars to buy insurance for the people who don't have the incomes to support it. So it's yet another way that the public is supporting the big companies.

Frank: Rather than directly pay.

Richard: Right, right. And it's for some reason more acceptable to pay the insurance companies than it is to just pay for health care. It's still a big government subsidy, it's still a big government system, it's still in lots of ways socialized medicine which is kind of a bugaboo. It's still money coming out of the public coffers to pay for health care but we get to pay more because we're paying the insurance companies to administer it for us. Instead of using an existing system to pay for it, like Medicare and all these other things that the government is already paying for. It's just an interesting model.

Frank: Doctors could be paid at a certain amount per patient.

Richard: Um-hum. And there are some systems that do that now in terms of the managed care where you get paid a certain amount per patient. Or there's models now where there's also ... you know, like the VA already exists where doctors are just paid a salary. The military system exists, where doctors are just paid a salary. So there are lots of ways in the existing system that you could do either a capitated model where you get paid so much per patient or continue like Medicare where you pay so much per service and just somehow control how the utilization works, like Medicare does. And Medicare already sort of controls how much we can charge for everything we do. And you still can do what you think is right for the patient. That's one model. Or you could have more of either capitations of paid per patient per month or just get paid a salary for what you do. And all those are already in existence.

Frank: A key would be the patient/doctor relationship as the base.

Richard: Right. Because ultimately that's where it happens. It's in the interaction between the doctor and the patient. And a lot of the other trappings that we put into the mix get in the way. And currently we're letting the insurance keep that relationship from being as effective as it can be.

Frank: The doctor and the patient decide what the patient needs.

Richard: Right. And that's the best solution, is to just have everything else pushed aside and really determine what the needs are. And figure that at an individual level where it's really between the doctor and the patient that that decision can happen. And that includes all the other kinds of ancillary services, like the dental stuff. That includes all the alternative things like acupuncture, Chinese herbs, which you guys have found very successful. And so those are all things that really should be accessible equally with everything else that's done.

Frank: And then patients could rate the ...

Richard: Rate the doctors? Yeah, see that would be great! (laughter) Another very interesting sort of way to turn things around a little bit. You know, if you could sort of have the salaries based on patient satisfaction or quality outcomes or all these other things that could be a very revolutionary way to model things!

Frank: So, there would be no pre-authorizations.

Richard: Right! Because if the decision is between the doctor and the patient you don't need to have the insurance company pre-authorizing things, if it's not an issue of what's going to get paid for, it's just an issue of what's the right decision is.

Frank: And then, if there is a question, then there could be a hearing.

Richard: A hearing or some sort of ... and the other thing that is I think really useful is a second opinion system whereby, if you're not sure, that you have a built-in opportunity to get a second opinion from somebody else. And either hearing ... the other way that they do sometimes with some of the managed care plans is they don't do pre-authorizations before the procedure, but they look at utilization patterns over time. And, so, if there's somebody who gets CAT Scans on everybody, that gets taken to some board or reviewed so you can actually look at it after the fact to just see how people are utilizing the system. And there may be a perfectly good reason, but you like to have somebody ask the question of why that's

happening, why are these higher cost procedures being done.

Frank: Before HMOs, doctors sometimes had cozy ...

Richard: Oh, cozy relationships with some of these ... actually, yeah, there have been all sorts of situations where the doctors were investors in some CAT Scan or MRI machine or ... so there was essentially some profit margin in ordering these tests.

Frank: That was a part of why HMOs came in.

Richard: Yeah. Actually the other part that controlled a lot of that was one of our local congressmen, Pete Stark, who did a lot of work with sort of Medicare and health issues in general. And he's the one who created most of the laws about what you can and can't do. And tried to put a real division between investments and practice of medicine so there wasn't sort of a kick back thing. As a doctor you can't own an interest in the MRI scanners or the nursing homes or something else that would be a potential profit margin that would interfere with your judgment clinically.

Frank: Again my tax ...

Linda: ... tax plan would take care of some of that.

Richard: Right! Again, because it takes the greed issue out. Once you have less issue of the greed, it solves a lot of problems across the board.

Frank: And hospitals should never be for profit.

Richard: Right. Because again that's ... it's a built-in conflict of interests. Although again, the high tax on corporate profits over a certain amount also takes of care a lot of that problem.

Frank: Exactly.

Richard: So mainly this kind of eliminates the greed motive.

Frank: Again, before HMOs some hospitals kept patients in longer ...

Linda: ... than they needed to be.

Richard: Right. Well, both HMOs ... the part that's interesting, of course, is that what shifts when you have all these HMOs is now the only people left who are allowed to make the money are the insurance companies. Because you know all these other things have restricted profits and cut back on some of these means that they had of getting more income streams, but they've still granted more and more to the insurance companies. So it's actually an incredibly regulated industry, both the hospital level and individual practitioners, and yet the group that has the least regulation makes the most money, that's the insurance companies.

Frank: And is in control.

Richard: And is in control. And provides absolutely nothing of any value. (laughter) Because at least the hospitals and the doctors, they're all providing something that the people value. I don't know anybody who likes insurance. Nobody likes the insurance companies. Nobody really ... but we pay them tremendous amounts of money.

Frank: Now they kick people out of the hospital before they should leave.

Richard: Exactly. Because now there's more profit in getting people back out on the streets.

Frank: Joe.

Linda: Oh, our neighbor, he's in his 70s and he has cancer. And he's getting all these treatments, which are just killing him. They're really killing him. But, he'll end up in the hospital for something and they'll send him right back. The woman he's with, he's been with for thirty years or so, she's old too. So she's, why are you sending him home? She can't lift him, she can't get him on and off the toilet. So it's like they call us and Corey and Alexi go down and are picking him up off the floor all the time.

Richard: Oh man!

Linda: But, they won't keep him in the hospital long enough to get him so he can stand up.

Richard: And they're probably also not providing any kind of home support or any other resources that might actually help him be at home.

Linda: Oh no, nothing! A walker!

Richard: A walker. Yeah, that's a big help.

Frank: I invented a mop.

Linda: Oh, for Joe?

Richard: A mop?

Linda: Well, it's because ... he's still who he is. So when he washes his hands he gets water on the floor. He likes to clean it up.

Richard: (groans)

Linda: So he leans over to clean it up and he falls down and he can't get up. So then Corey and Alexi run down the street. So Frank said, make him something with like a mop, some kind of a stick ...

Richard: Brilliant!

Linda: ... that he can dry the floor with without bending down.

Richard: Yeah! That's brilliant! That's great. (laughing)

Linda: He's not going to stop trying.

Richard: Does it work for him?

Linda: I'm hoping that that's happened!

Richard: That's great.

Frank: That is what the ...

Linda: ... doctors or medical people should be doing, dealing with things on that level.

Richard: Right! That's really getting to where the rubber meets the road. That's quality of life on a daily basis.

Linda: Yeah. And they're totally on their own with all that stuff. Nobody's dealing with that. We're dealing with it.

Richard: Yeah. Well, it's good that you guys are able to, because you have a little sophistication with this stuff, and you actually can think about these kinds of things and make something work for him. But just think if he were really alone. If he didn't have the support of the neighborhood.

Linda: If Betty and Joe were alone, yeah, I don't know what they would do.

Richard: That would be a terrible thing.

Frank: They would be in a nursing home.

Richard: Yeah.

Linda: Not together either.

Frank: Not a retirement community ...

Linda: ... but a nursing home.

Richard: And then the challenge there, too, is in terms of getting it paid for. You know, that's another big problem for people where a lot of the insurance plans don't cover long-term care at all. And so people who need to get nursing home level care are basically using up their resources, whatever they have and then they're stuck. So it's really a challenge for getting people into long-term care as well. I think it's better in general to be in a supportive community instead of the nursing home.

Frank: Yes.

Richard: And to have the independence to be in their own home doing the things they love to do gives him a much better quality of life, as long as he's able to do that.

Frank: And it would create jobs.

Richard: Right. Right. And you have better quality of life and an opportunity for people who are currently under-employed to do something really very personally rewarding and something that's very personal in terms of just the contact with somebody. And that would be great. And most people, as we have an aging population, most people really fear the nursing home. That's not viewed as something that's life, that's considered to be sort of an early death. And this is really something that we should offer better alternatives to our seniors.

Frank: Six months is the average.

Linda: Of what, of how long people live, last in a nursing home?

Richard: Six months, yeah. It's clearly better to be able to age in place and to have a structure where that happens is really kind of rare.

Frank: And cheaper.

Frank Moore and Dr. Richard Kerbavaz (video capture)

Richard: It's more effective, it's more humane and it's ultimately cheaper than comparing its infrastructure.

Frank: Preventative medicine would cut costs.

Richard: Because clearly it's cheaper to treat something before it becomes a big expensive problem, as well as kinder to everybody involved.

Frank: Meals in schools would cut medical costs ...

Linda: ... if the meals in schools were healthy.

Richard: Cut medical costs and also improve kids' performance in schools and change the entire environment of the school. Because now the school becomes much more of a community. And it's also a useful model for communities that aren't terribly interested in education.

Frank: But now Oakland is raising the cost for lunch in school.

Richard: How much are they raising it to, do you know?

Frank: No.

Richard: And again, it seems crazy that of all places to raise the cost, the kids and the parents are not in a position to really argue with that.

Frank: It should be free!

Richard: It should be part of the education. Because it's important for the education to happen.

Frank: And a part of the health system.

Richard: Because clearly it's not strictly educational, it really is part of health, health and wellness. Maybe instead of a health system we should call it a wellness system, and try to get everybody really healthier, more well as we go along.

Frank: Yes.

Richard: The other kind of school thing that I thought was interesting are the efforts to try to have the kids more involved with growing food and having school gardens and projects that are part of that so that they're connected to what the product of the food is, and it's not just something that comes on a tray, but they understand some of where it came from. That's another way to give kids options to not only grow and encourage them to do other things. But to show them how they fit into the universe.

Frank: And arts and music.

Richard: Yeah. Again, those are all part of what it is to be human and should be part of what we all learn.

Frank: All make you more healthy.

Richard: Right. So the question is, what things are not part of the health care system? (laughing) We've sort of got everything rolled in there now, and it makes total sense.

Frank: Prisons should be ...

Richard: ... part of health care as well. (laughing) Wow.

Frank: And education ...

Linda: ... should be part of the health care system?

Mikee: Prisons should be part of the education and health care systems.

Richard: So do you separate those out or do you try to have them sort of rolled together to try to create more of a cohesive concept?

Frank: Maybe in some way.

Richard: Yeah. And it makes sense. Because you really want to integrate it. And you want to have education part of whatever prison system you have. And you want to have the health care supporting across all those boundaries. That would be good. It would be an interesting idea. How to try to get it all together. What you need is to find a health care and prison and education czar to run the whole thing together.

Frank: How?

Richard: How to run it all together? I don't know. That's going to be a challenge because you really need to have it working from a similar basic premise of the individual and so clearly you need to get the prisoners involved in figuring out what happens in the prison. How is

this going to work to support their needs too, as well as society's needs? The students to some degree have to be involved in the education. How is it going to support their needs? Just as we emphasize the doctor/patient relationship in the health care system, we need to come up with some similar way to empower everybody who's involved in the other systems so that it becomes part of the same thing.

Frank: Yes.

Richard: But it's a major paradigm shift in how we look at all these different things to now, instead of splitting them apart, try to bring them together again and put them under one kind of conceptual roof.

Frank: Rockridge was a model.

Linda: Rockridge was HealthAmerica, it turned into HealthAmerica, but originally was Rockridge.

Richard: Oh yeah! That's right. Which is where I met you first actually, yeah.

Linda: Yeah! A model of bringing all the different, at least within the medical system, together.

Richard: And they made a real effort to bring in the social works side and all the home services and all those things.

Linda: Yes.

Richard: There's another group in Oakland, On Lok, which is a seniors organization. Again, the idea of aging in place. Providing home services instead of having people go to a nursing home. So it's again, kind of along that way of trying to bring other players that are not usually thought of in the health care system into the arena where they're working together to make things happen.

Linda: That's like a private organization?

Richard: Yeah. It's a private organization. I'm not sure exactly how they're funded but I know that they do a certain amount of Medicare, HMO stuff and a lot of home health services, including things like vans to take people to appointments.

Frank: Where Erika works is a model but it is only for people who can afford it.

Linda: We always think if it was like that, if everybody, anybody could move into a place like that, when they got to the point where they couldn't live alone or didn't want to ...

Richard: And when you look at the quality of life, all the things, the resources that they have compared to the average nursing home, it's completely different. And the level of support that really lets them be pretty independent within that construct.

Frank: And there is no reason why ...

Linda: ... everybody shouldn't be able to have that option.

Richard: Right. Right. And indeed there could be ways to try to convert some of the existing nursing homes into something that's more like that kind of a model. It should ultimately be

less expensive. When you think about the level of support services and people that it takes to run a nursing home compared to what you guys have, you get by with a very small staff comparatively speaking to the number of people that live there.

Frank: And if we had home care it would not have to be isolated.

Richard: Right. And ideally you could have more like what you guys have in this neighborhood. Where you are all supporting your neighbors. And you can really build on the neighborhood model so that the community itself supports other members of the community. That's one of the nice things about this neighborhood, that you guys are an amazingly cohesive community, considering how diverse the population is.

Linda: Yeah.

Frank: And Rockridge worked except for Medi-Cal.

Richard: Yeah, that was the problem, I guess. That they somehow or another either weren't making enough money or the Medi-Cal system cut them out. Originally they were being supported to some extent through Medi-Cal and I think they just restructured what they were paying for.

Frank: Crack.

Linda: It was a crack? Crack down? Oh, the drug, crack?

Richard: Oh!

Frank: They took everybody, so when ...

Linda: ... crack cocaine started to be a big issue, they had a lot of patients ... and that was a problem?

Richard: It started to cost them too much money or they couldn't really provide care anymore.

Frank: And Medi-Cal would not cover it.

Richard: Ah! Yeah.

Frank: On the other side, the corporations saw it as a money-maker so they bought them up.

Richard: They bought them out and totally changed the mode.

Linda: Yeah.

Frank: Promising the doctors they would still be in control.

Richard: But they weren't!

Linda: But once they took over, then that wasn't true.

Richard: So all those people who were so invested in Rockridge were so disappointed when that happened. An awful lot of people had really ... were very idealistic and altruistic and made that thing work and they just really felt like they were being kicked/shoved out the door.

Frank: But the model worked.

Richard: The model worked. And the whole thing worked well enough that they became a target of the profit ... and the corporate people took it over.

Frank: Exactly.

Richard: The funny part was they took it over and then completely changed it, and all the things that made it work stopped working! (laughing) Odd choice!

Frank: And they did not get it.

Richard: Right, they didn't get it. And I don't know that they ever really figured out why it stopped working. (Frank sounds, laughing)

Frank: Rockridge was a community.

Richard: It was, it really was. It was a fun place to work for that reason. It was really a lot of fun working with all those people.

Frank: That proves it does work.

Richard: Right, it does work, it really does. And also it shows that the importance of that kind of a community feel from the provider's standpoint, it pays a dividend that you don't get in other ways. There's just a pleasure to that working environment, the support that lets you do things you probably wouldn't do otherwise.

Frank: Is a hospital like that?

Richard: Not really. Not now. I suppose it could be. But at this point, it really isn't quite that same sort of a community sort of feel. There are individuals you find that you really do work well with and work kind of as a team, but there's also a lot more sort of division of labor, things get sort of separated out more than they did at Rockridge. And it's also because it's not as primary care oriented where you're actually taking care of a full spectrum of things. You're taking care of people who are much sicker. And because of the issue of getting people in and out, there's much more fragmented care. So you deal with one episode in their life and then you may never see them again.

Frank: And your regular doctor don't ...

Linda: ... is not involved in the hospital aspect of your care?

Richard: No, very few doctors now do follow their own patients in the hospital. More and more they now have people who are so-called hospitalists, the people who actually work in the hospital and take care of the patients while they're in the hospital. And most of the time, the way it's set up is that the primary care doctor sort of turns their patient over to the hospitalist and then picks them back up again after they leave.

Linda: Is there communication at all while it's going on?

Richard: Very little. Very little. So it's almost now that the doctor comes and does a social call, to visit and see how their patients are doing, but they're not really involved in the day-to-day decision making.

Linda: Wow!

Frank: That is scary!

Richard: It is! It is! And it's neither ideal for the patient or the doctor. I don't think the doctors like it as well.

Frank: So, why have a doctor then?

Richard: Well, because 90% of your life you'll spend not in the hospital. And so you still need someone to help coordinate all those other things that happen in the rest of your life.

Linda: Because I think it was like, a lot of times we'll think, well it's good to have a doctor in case something really happens. Then you have somebody who knows you, but now it sounds like that's not what happens!

Richard: Not so much any more. And there are still some doctors who follow their patients through the hospital, but more and more the primary care doctors don't. And some of them don't even have privileges at the hospital. They take care of the patients only on the outside and then just turn them over when they get admitted.

Frank: Why is that?

Richard: I think part of it is that it's hard to run an office practice and then also go to the hospital and take care of the patients. So I think that there was sort of a financial push on a lot of the small practices especially to have somebody else who's available to do rounds and do all these other things. And from the hospital standpoint, it's easier if they have a group of people that work there and that they can sort of control a little bit. I think in terms of getting people in and out of the hospital. Somebody who's in the hospital all day to make sure the tests are done, and the results are back. And when the results are back, you move them on or you get the consultants. It's just a more corporate model or a more like a factory model as opposed to the sort of hands-on thing.

Linda: So that's somewhat recent that it's been like that?

Richard: That's been happening more and more over the last few years.

Frank: Would our taking greed out ...

Linda: ... address that?

Richard: I don't know. It probably ... it would I think in so far as it removes some of the pressure on the individual practices. But I think that if you didn't have the issue of the practices needing to see a certain number of people to make a living, to do all the things that are necessary, and you had a more close doctor/patient relationship I think both the doctors and the patients would prefer that the doctor who knows you be the one who takes care of you in the hospital.

Frank: And most people don't know that we have a crisis in how many doctors and nurses and hospitals there are.

Richard: Yeah. It's actually ... it is a greater problem all the time. And there are a lot fewer

hospitals than there used to be, and a lot fewer hospital beds in the community. So that when there is a problem, or any kind of an epidemic or even just in the flu season, there aren't a lot of empty beds, so people end up waiting longer and longer to get in to the hospital or are not allowed to stay in the hospital. As soon as they start getting a little bit healthier they boot them out, because they need those beds for people sicker than they are.

Frank: And in the 1980s the HMOs did not think they needed that many doctors and nurses.

Richard: Yeah. It's interesting because just in the time that I've been practicing we've had that pendulum swing where for a while there was a big push to try to get more people through medical school and nursing school and more hospital beds and then the HMOs and all the other cutbacks came in and there were fewer and fewer nurses and doctors and hospital beds. And now they're trying to reverse it again. And especially in nursing there's an effort to build new nursing schools and they recognize that with an aging population we're going to need more and more health care, not less and less.

Frank: In fact, that would be a major hump we would have to deal with in the first years of a free universal health care.

Richard: Yeah. Another issue that sort of ties into that a little bit, that it should be addressed is that, at least in California, there's been these mandates that all the hospitals that are not seismically safe need to be rebuilt. And currently there's been no funding for any of that. So none of it's happening. So most of the hospitals in the immediate Bay Area are not really earthquake safe by the standards that the state has set. So there's going to be a huge need for new buildings, just physically new places for hospitals to be. And currently no one has quite the political wherewithal to make that happen.

Frank: Just to replace the existing buildings.

Richard: Just to replace the existing buildings. Like the whole thing with Children's Hospital. They had a bond issue to try to have funding tax-based, to try to build a new building for Children's Hospital, which failed. I guess people didn't really want to have more taxes. But the trouble is the building still needs to be replaced. And we still need to provide care for all the kids. And there is not currently a lot of support for raising taxes.

Frank: And we will need to train more doctors and nurses.

Richard: Right. I think that's going to be true over the next twenty years that we'll need to continue raising the numbers of people in training. Partly, I think, that there are people who would like to do it and we just have to create a system whereby that's ... that they're taken care of, that they're provided a good place to work. And I think that community issue of trying to build something that really offers sort of non-monetary rewards, but just the pleasure of doing that kind of work should get people involved.

Frank: And GP ...

Richard: General practitioners, GPs? Yeah! Because the more emphasis we put on primary care, the more GPs, nurse practitioners, primary care people we need to generate and train and have a system for them to work.

Frank: In the meantime, why not bring the military hospitals home?

Richard: Right! That's a good point! That saves a lot of money right there. And actually if you put all the military hospitals and nurses and doctors and put that whole system into place, that all already exists. Why not put it to good use? And actually, by the time you start eliminating some of the standing army, you'll have a lot of people who are currently under-employed.

Frank: And less crips.

Richard: Less crips? That's true. Because we're creating crips as fast as we can over there. (laughs) Very true! One more fringe benefit to the war plan.

Frank: And the VA could be for the general public.

Richard: Right! Because it's another federal system we already have in place, we've already paid for, the buildings are there, the people are employed. Just kind of broaden the mission and change exactly what they're doing. Because now, once you eliminate the issue of insurance versus non-insurance there's no reason why people couldn't choose what hospital they go to and doctors couldn't choose where they practice.

Frank: Yes. And the reason for the VA would not exist.

Richard: Right, right. So there would still be veterans for awhile, but we wouldn't be creating new ones quite so quickly.

Frank: But they would be covered by the universal health care.

Richard: Exactly!

Linda: So they wouldn't need special health care.

Richard: They would just be part of the health care system, as opposed to a separate system.

Frank: Yes. And that brings up why was the VA needed in the first place?

Richard: Well, because too many of the veterans were uninsured and they felt like that was an unacceptable alternative too! (laughs) So actually it was our ... one of the big pieces of our socialized health care system that we already have. So in that setting, the government already owns the buildings, employs all the people who work there and decides who gets care. So we already have socialized medicine, but only for certain people.

Frank: Why don't we ever hear this kind of discussion?

Richard: Well, you just have to look at the right places. It's out there. It's not new information. It's just that it's not something that people tend to talk about in that sort of way.

Linda: About what you just said about not hearing this kind of discussion? Yeah, it seems like that's a lot of ... that whole thing of this kind of thing not being available to people so it doesn't get their heads working in this way. That seems like a lot of ... that's part of the problem too.

Richard: And a lot of it is spin. Realistically, that so much of this is a politically driven process

Dr. Richard Kerbavaz (video capture)

that how you discuss things becomes how people perceive it. And as long as there's a push to demonize universal health care and calling socialized medicine as some sort of an evil thing when in fact we already have big chunks of our population under socialized medicine by any kind of standard. And the government already pays more than 60% of all the health care costs.

Frank: The VA is socialized medicine.

Richard: The VA is socialized medicine and the government completely controls the system. And yet people don't demonize the VA.

Frank: And the military is socialized.

Richard: And there's also the whole military health care system is strictly socialized, again like the VA. And the public health hospitals and all of the other government-run systems are already socialized health care.

Frank: In the past we thought the doctors were against ...

Richard: Against socialized medicine? But they manage to find lots of people to work in all of those hospitals! And they aren't opposed to that! Not everybody chooses to work at the VA, but they don't seem to have any trouble recruiting people. And the other part is some of these systems like Kaiser, in terms of the physicians, Kaiser is just a private version of socialized medicine, where there's an organization that controls the hospitals and controls the doctors and pays the nurses' salaries and structures the whole thing. The difference is that to get into

it you have to buy in, usually by where you work and what your employer offers. But in terms of the actual structure of the system, it's really not that different. It's just who's paying the bill.

Frank: And the difference between my system and Kaiser is the doctor/patient relationship being the base.

Richard: Right. Right. And ultimately instead of having people get in by virtue of where they work, that they would have coverage based on being here. By where they live. Being a member of that community entitles you to access to care.

Frank: What do the other candidates' plans offer?

Richard: Well, interesting you asked that! (all laughing) I just happen to have ... so one of the things that I, just in preparation for this, I tried to do my homework. And this is actually a whole list that I got off the internet that talks about a sort of side-by-side comparison of John McCain, Hillary Clinton and Barack Obama, but somehow they left off the Frank Moore plan.

Frank: I will give my ...

Linda: Frank will fill in his section.

Richard: I think you should fill in your section, right. We'll start out: the stated goal. John McCain: provide access to affordable health care for all by paying only for quality health care, having insurance choices that are diverse and responsive to individual needs and encouraging personal responsibility. (Frank screeches, all laugh)

Linda: Whatever that means!

Richard: Hillary Clinton: affordable and high-quality universal coverage through a mix of private and public insurance. (Frank screeches) And then Barack Obama: affordable and high quality universal coverage through a mix of private and an expanded public insurance. And the Frank Moore plan ... ? Universal access to health care.

Frank: When they say affordable (giggling), watch out!

Richard: (all laughing) Right, good point!

Frank: I will push for free universal pre-natal to the grave health care.

Richard: Very good. So, the overall approach to expanding access to coverage. John McCain: remove the favorable tax treatment of employer-sponsored insurance and provide a tax credit to all individuals and families to increase incentives for insurance coverage. Promote insurance competition and contain costs through payment changes to providers, tort reform and other measures. Hillary Clinton: every American required to have coverage with income-related tax subsidies available to make coverage affordable. Private and public plan options would be available to individuals through a new health choices menu operated through the Federal Employee Health Benefits Program, FEHBP. Coverage through employers and public programs like Medicare continues. Barack Obama: require all children to have health insurance and employers to offer employee health benefits to contribute to the cost of new public program. Create a new public plan and expand Medicaid and SCHIP (which is the

children's health plan). Create the National Health Insurance Exchange through which small businesses and individuals without access to other public programs or employer-based coverage could enroll in the new public plan or in approved private plans.

Frank: I will have free universal pre-natal to the grave health care. Everybody would be in the same system. Every doctor, nurse, hospital, alternative medicine will be in the same system. Preventative and nutrition will be important parts of the plan. I would pay for it by cutting the military and by cutting the pork and royalties for drugs and etc. that are based on research done by public universities and the government.

Richard: Very good.

Linda: We're going to get this transcribed!

Richard: Definitely! This is great! This is definitely relevant.

Frank: Why I am not in the debates.

Richard: That's right! There you go. (all laughing) Well, I think you can use all of this very well to your advantage.

Frank: I am right now! (all laughing)

Richard: Good! You are! (looking at the chart) Let's see what's another good one here ... here's the tax change, we already talked about that. Changes to private insurance although you're pretty much going to eliminate the private insurance issue, so that's not really relevant. And the cost containment, you talked about some of how that's going to work too. State flexibility. This is a national plan, this is not states' issues. It's all one thing for everyone.

Linda: (asks Frank) Is that right?

Frank: Yes.

Linda: Yes, it's a national plan.

Richard: And improving quality health system performance, that was the issue you talked about that's basically putting the primary relationship between the doctors and the patients is the major goal and the major tool for making quality happen.

Linda: Right.

Frank: Read their ... (Frank looks at the chart Richard is holding)

Richard: Oh! OK! For quality control. (Frank screeching)

Linda: To make you look good!

Richard: For quality control, this is the John McCain answer: to change provider payment to encourage coordinated care. That is pay a single bill for high-quality health care rather than individual services. Provide Medicare payments for diagnosis, prevention and care coordination and bar payments for preventable medical errors or mismanagement. Require transparency by providers with regard to medical outcomes, quality care, costs and prices. Establish national standards for measuring and recording treatments and outcomes. Promote

deployment of Health Information Technology (HIT). Where cost effective, employ telemedicine and clinics in rural and under-served areas. And then the Clinton plan: provide federal recognition to physician-driven maintenance and certification programs that promote continued education about latest advances in care and procedures. (I'm not sure what that means.) Invest in independent public/private consensus-based organizations to certify performance for enhanced reimbursement, identify gaps in existing quality measures, set priorities for development of new quality measures, and disseminate cost effective protocols and treatments through a best practices institute. Fund improvement of web-based tools to provide consumers with user-friendly information on provider performance and development of tools to promote informed patient choice about treatment options. Incentivize quality through increased federal payments for excellence in care.

Frank: She is a lawyer.

Richard: Yeah. (laughing) Yeah, you can tell. (all laughing) Well, so is Barack Obama. Let's see what his says. Support an independent institute to guide comparative effectiveness reviews and in required reporting of preventable errors and other patient safety efforts. Reward provider performance through the national health insurance exchange and other public programs. Address health disparities, promote preventative care and chronic disease management and require quality and price transparency from providers and health plans. Require health plans to collect, analyze and report health care quality data for disparity populations and hold plans accountable.

Frank: The patient should know how much was charged.

Richard: Under these plans (gesturing to the charts)? Or under your plan?

Linda: Under your plan the patient should know how much was charged for the service?

Richard: Right. That seems a good way for patients to kind of control what's happening. To understand the costs and charges.

Frank: Like I get chux. I don't know how much ...

Linda: ... is being paid for that?

Frank: Or how often?

Linda: We're completely out of the loop with that. And we kind of get a sense that there might be stuff going on that maybe isn't honest?

Richard: Yeah.

Linda: But we're not in the loop at all.

Richard: Yeah. And it seems silly that in your own health care you can't actually figure out where the money goes. It's even worse actually at the hospital level because the bills are just incomprehensible. And there's just layer upon layer of charges for aspirin and anything that possibly gets used generates a charge, but by the time you've been in the hospital for a few days, it's just page after page after page of charges for things you don't even remember happening. So, it's a very strange system. And most of the time, since insurance picks it up, the patients

either never see the bills or never actually look at it carefully enough to understand what it was that they were being charged for.

Frank: So they don't get outraged.

Richard: Outraged, right. Because they don't really see it. They're insulated from it. It's not real money.

Linda: I remember ... like when we go on the road, we rent a hospital bed and a commode. And there was one time when we went and we just really couldn't afford it so we asked the Regional Center if they would pay it. And I knew how much it all cost because we did it all the time. And I saw the bill. And I saw the same people that we were renting it from, when they knew that somebody else was paying it, they charged them way more money. I called them and I said that's not how much you charge us and they had to then charge the organization the same amount they charged us because ...

Richard: Oh, they did actually reverse it because you noticed!

Linda: Yeah! Because I talked to the organization too! I said that's not how much we pay for this. I know that and I have the bills to show them. And so they had to pay them what they were charging us. But it was like that was a case where we got to see how that worked. Whereas if we got a bill every month for the amount they're charging Medi-Cal for the stuff that Frank gets, we would be the quality control! Because we would say, wait, that's not right!

Frank: You don't have to pay ...

Linda: ... someone else to do that if you just kept it simple.

Richard: Right. Let the patient actually be their own kind of watchdog to make sure the system isn't being taken advantage of.

Linda: Because all of that just seems like it is way out there. And you kind of feel spaced out when you hear it. It's like, oh, OK. Whereas when Frank talks about stuff it's like right here. It's like, oh, right!

Richard: Yeah, and if you actually had that bill in front of you and you understand where the money is going you can actually make some real choices about where the health care dollar gets spent.

Linda: Yeah.

Richard: It's actually a very good quality control thing too, in terms of making sure that the costs are being contained.

Frank: And you respect the people by doing it that way.

Richard: Right. Right. Because it's a little patronizing, really, to say you don't need to worry about this. Don't worry your little head about this. But yeah, putting people back in charge of their own health care consumption.

Frank: We got a lot out.

Linda: During this show.

Richard: Yeah, I think so! That's good. Covered a lot of bases.

Frank: What else do they say?

Richard: Oh, on this thing (gestures to the chart)? I should have mentioned, actually, the source of this is from a survey or a project that was done by the Kaiser Family Foundation. So it's actually trying to be as impartial as possible. And they actually give links to all the different quotes from articles and from talks that the various public candidates have said. So that they actually vet pretty much what exactly they're promoting. So it's actually a fairly good, fairly objective and not particularly partial issue. So one of the things here: other investments. So again, this is the McCain one to start with: support federal research related science-based care and cure of chronic disease. Promote education of children about health, nutrition and exercise. Support public health initiatives to stem obesity and diabetes and deter smoking. (Frank giggles) So Hillary Clinton: provides federal funding to address nursing through new training and mentoring programs linking nursing education and quality to encourage diversity and cultural competency in health care workforce. Support initiatives to reduce health care disparities, including funding for more accurate data collection, development of quality measures target at reducing racial and ethnic disparities and prioritizing the development of medical homes designed to improve quality for minorities. And strengthen consumer protections for long-term care insurance. And then Barack Obama: expand funding to improve the primary care provider and public health practitioner workforce including loan repayments, improved reimbursement and training grants. Support preventative health strategies including initiatives in the workplace, schools and communities. Support strategies to improve the public health infrastructure and disaster preparedness at the state and local level.

Frank: Well free education would do more than any of that.

Richard: Right. Well, we've covered it pretty well. The rest of the page is more just the quotes. And then the issues here, they talk about all the premium subsidies to individuals, all related to the health care side, or health insurance side rather than the health care side. By eliminating the health insurance part you don't have to deal with who's paying what premiums. It all becomes a federal mandate or a federal funding program.

Frank: As a doctor would what they say make your job easier?

Richard: Somewhat in that if they could really come up with something that did provide more universal health care there would be fewer barriers to taking care of everybody. And that would be a good thing, a good outcome. My concern is that it's a really expensive way to do things.

Frank: Yes.

Richard: And basically you're just moving 30% of the health care dollar into the pockets of the insurance companies. That's not a good investment to my mind. I don't think that's where we should be putting our tax dollars. I'd rather have it go directly to taking care of people.

Frank: Yes. And take corporate control out.

Linda: And take corporate control out of the picture.

Richard: Yeah. And I think that the more you do that, the more you basically empower the individuals, the patients to help to figure out how they want their health care to look. What sorts of resources they want to use. Do they choose to go to an acupuncturist or somebody else? And I like the transparency where if you know what all the pieces of your health care cost, you can use that money the way you want it spent. And sort of see that it's actually going toward something productive.

Frank: And get paid at a reasonable rate.

Richard: Yeah. And I think that's again definable based on relative to other things and how things ... what do things cost? The tax structure takes a lot of the sort of the greed element or the need to be higher paid out of the equation. I think that would go a long way toward leveling the playing field.

Frank: So every doctor would see anyone.

Richard: Yeah. Or they could. And that basically I think that it's up to the patients to choose who they see. And that's going to be the tricky part, educating them about what the difference is, what different doctors do and what their style is like. But I think that that could ... you'd learn that as you came along.

Frank: Like now if I did not have you and John Good.

Linda: Frank's GP.

Frank: I would ...

Linda: You'd be out of luck! (all laugh)

Richard: That would be a challenge! That would be a challenge!

Linda: Yeah!

Frank: Because no ...

Linda: Nobody takes Medi-Cal anymore.

Richard: Right. Right. And they keep cutting reimbursement on Medi-Cal so it gets to be harder and harder to find people to take it.

Frank: Under my plan everyone is equal when they go to a doctor.

Richard: Yeah. And that would be a very powerful switch. That would be a very powerful switch. And you mentioned earlier, the thing about how to make things change would be to have all the rich people have Medi-Cal, and I said no, you really need all the politicians to have Medi-Cal. And so now you can actually level it in a better way, or more positive way, so that you can have a system where everyone really has equal access and has equal chances to get the care they need.

Frank: On the level that the Congress and the president now have!

Richard: Exactly! And that indeed would be a perfect system if everyone had equal access, everyone had the same insurance that the president had.

Frank Moore and Dr. Richard Kerbavaz (video capture)

Frank: So why are not Obama and Hillary talking like this?

Richard: Well, again, it's a matter of how much power and clout the insurance industry has. And how unwilling to rock the boat the other political candidates are. And you have no fear of rocking the boat. And I think that gives you a great deal of freedom to say these things.

Frank: Yes. Things like most doctors will not take Medi-Cal is hidden.

Richard: Yeah. Because unless you have Medi-Cal or know someone who has Medi-Cal you don't appreciate that that's an access disparity. And people who have insurance don't really think very much about people who don't have insurance and what the implications would be. But more and more people find themselves without insurance for at least part of every year. And I think what that ends up doing is giving a little bit more sensitivity to the issue to the people who are employed most of the time or have their coverage through work most of the time.

Frank: People say if you are rich or on Medi-Cal you are covered.

Richard: Hmmmm. That's interesting. Yeah, but Medi-Cal's not really covered in quite the same way. (laughter)

Linda: That's the point that people don't really know what it's like to be on Medi-Cal.

Richard: And even with insurance, there's getting to be more and more disparity between the insurance plans and how restrictive some are. And more and more doctors are not taking

some of the insurance plans that are just too much trouble to be worth.

Linda: Like we had ... the thing that we have, Alameda Alliance, through being home care attendants, we had one eye coverage that was great. We kept going to our optometrist. It was covered. It was every two years, and that wasn't that great, but still we kept going to the same person. And then they switched it out and the only place that would take the new coverage is like a quickie place. It was horrifying. You'd go in and boom, boom, boom, boom. And it's like you see the eye doctor for like 10 minutes maybe. I'm used to a 45 minute eye exam. It was horrifying. It was all about product. You felt like they were trying to get you to buy the newest kind of thing in eyewear ... this is covered but, you really want this!

Richard: Yeah. For only so much more ...

Linda: Yeah, yeah. The optometrist was here on this part of the room, and then they were on the other part of the room. And they were clearly in control, the people selling the glasses.

Richard: The sales pitch was the biggest part of being there.

Linda: Yeah, yeah.

Richard: Right. Even people who have private insurance ... or some of these insurance plans, like United Health care is the biggest health insurance company in the country ... their recently retired CEO had to give back 400 million dollars of his severance package because it was shown it was one of those illegal post-dating or stock deals. But that was OK because he still took more than 400 million home. So this is where a lot of the profits from these insurance companies end up going, is to pay these guys off.

Frank: You can cover most Medi-Cal with their retirement packages.

Richard: Right. You could cover an awful lot of health care with that. Just by itself, taking some of those back would take care of some of those disparities.

Frank: Like Erika has a good job with health care but each year she pays more for less.

Richard: Just be grateful you didn't get sick, because then you might not be able to get any at all. (laughs) No, it's just a very strange system we have now.

Frank: And in Europe and Canada they ...

Richard: ... they have a different system again. Well, pretty much every other country has some sort of a universal health care system. We're really the only major industrialized country that doesn't have it. Each country has their own way of paying for it and some are more like true ... more like an insurance plan, more like Medicare, and some are more like ... the English model is more like the VA where the hospitals and doctors are all employed by the government. And then there's other models in other countries that are more like private insurance but sort of paid for by the government. So everyone else has come up with a way of doing that. Somehow we've never organized it in a single system, or had any kind of a comprehensive approach.

Frank: And our health system shows it.

Richard: Yeah, we pay more than any other country per capita and on an absolute dollar

amount, and yet don't do that well in terms of infant survival or overall longevity. On most of the parameters we're way down into the middle of the pack, except in the one of cost. Because we currently are paying almost twice as much as the next vocal competition. It's just interesting how much we pay for how much less we get.

Frank: Why?

Richard: Why is that? Oh! Well, a whole bunch of reasons, but largely it's that so much of the money gets taken out of the system and put into other things. Like advertising. Like collecting health insurance premiums. And then we have a system where people who can't afford to get care delay care until it becomes a crisis. And then the most expensive and inefficient way to provide care is through a hospital emergency room. And for many people it's the only way they can get care at all. So we have a very silly system. It's not really thought-out or organized in a way to either save money or to really provide care to people. But it does provide a great deal of profit margin to large insurance companies and large drug companies.

Frank: Greed.

Richard: Greed. A lot of it comes down to greed. Because we pay more for drugs. We pay more for all these other things than every other country in the world. They all have some sort of organized buying plan. We choose not to put any restrictions on the profits that the drug companies can make in the name of trying to promote more research. But all the other countries with their health insurance plans have some sort of a savings plan built into it that limits how much the drug companies can profit. We've chosen not to do that.

Frank: Why?

Richard: Just like those insurance companies, they pay an awful lot of bills to the politicians.

Linda: But it's not ... I wonder why that's not the case in other countries.

Richard: Well, because once the government is in control and determines ... has to pay the bill ... once the government is picking up the tab, they're not willing to allow those insurance companies or those drug companies to make those profits anymore. So they're trying to capture back some of the profits as savings to the insurance plans. Since we don't have the government nominally in charge of all those things, we kind of don't notice how much money comes out and goes other places.

Frank: We should do this again before the election.

Richard: Not a bad idea. Not a bad idea.

Linda: Because the time is up and it feels like we're just really getting going here.

Richard: Yeah. Well, we covered a lot of ground. I think you got a good chance to kind of make your platform known.

Frank: A special.

Linda: This will also be a special, yes!

Richard: Good! (laughing)

Linda: And you are ... ?

Richard: Oh, I'm Rich Kerbavaz. (laughs) Ear, nose and throat doctor in Berkeley. And trying to take good care of Frank's ears for many years now.

Frank: And one of my electors.

Richard: That's right. I'm officially an elector for Frank Moore's campaign.

Frank: And I need more ...

Richard: ... more electors.

Linda: Frank needs a total of 55 electors.

Richard: Yeah. And having done it, it's very easy. All you need to do is find someone to notarize your signature, get the form, and it's very simple.

Linda: You can get all of that off our website.

Richard: It's all on the website.

Linda: frankmooreforpresident08.com.

Frank: Or email.

Linda: Email Frank. fmoore@eroplay.com. That's it? Alright!

Richard: Alright! That's good.