Article

Achieving moral, high quality, affordable medical care in America through a true free market

DAVID MCKALIP

St. Petersburg, FL, USA

The basis of a just and moral economic model for health care is examined in the context of Catholic social teaching. The performance of the current model of “central economic planning” in medicine is evaluated in terms of the core principles of the social doctrine of the Catholic Church and compared to freedom-based economic models. It is clear that the best way to respect and serve human dignity, the common good, subsidiarity, and solidarity in medicine is through the establishment of a true, free-market health economy.

Lay Summary: This article reviews the impact of recent healthcare reforms as well as traditional “third party payment” models for healthcare financing in America (insurance). Impact on patients and doctors are evaluated in the context of Catholic social doctrine and the *Catechism*. The many shortcomings and negative consequences of an economy planned centrally by government are compared to the benefits of a true free-market medical economy with empowered individuals. The analysis shows that interference in the patient–physician relationship and the centrally planned medical economy itself violates Catholic teachings, harms patients and doctors, and create morally evil outcomes and economic structures.

Keywords: Catholic social doctrine, Free market, Central economic planning, Health care, Pay for performance

INTRODUCTION

The means of providing medical services to patients in America is the subject of intense political and social debate. Division around the issue is mainly based on the best economic model for delivery of care that achieves the best access, quality, and affordability for all Americans. The predominant model since the 1940s has been based on a third-party payer model with insurance provided through place of employment by private insurance. Since that time, the rise of government-funded

and -controlled healthcare financing has become more common through Medicare, Medicaid, and State Children’s Health Insurance program (SCHIP). In 2010 the Patient Protection and Affordable Care Act (PPACA, commonly called “Obamacare”) has created a new and highly intrusive level of government involvement in the financing and delivery of health care. Despite this history, there are still many who call for a single-payer, fully nationalized economic model while others advocate moving toward a free-market model of care.

Patients, physicians, and citizens continue to express concern that the current delivery models are not delivering on promises and may be causing harm. The nature of the current socio-economic models of health care must be compared to the traditional standards of the profession, patient and societal expectations, and a sound moral foundation. This review seeks to reconcile the record of current models of healthcare delivery to other obtainable options. Such a reconciliation can reveal systems that are most compatible with the dignity of the individual, freedom, life, and the means to achieve the greatest possible access to high quality, affordable, and moral medical care in America. The Magisterium of the Catholic Church, its *Catechism*, and its social teachings are important benchmarks to guide Americans and all people towards the best economic model for health care.

CATHOLIC MAGISTERIUM

The teachings of the Catholic Church serve all mankind, and all are referential to the *Catechism of the Catholic Church* (CCC 2000). Pope St. John Paul II (1992) wrote of the *Catechism* that it is a “sure and authentic reference text for teaching Catholic doctrine and particularly for preparing local catechisms.” The *Compendium of the Social Doctrine of the Church*, often referred to as Catholic social teaching has as its object the “human person called to salvation, and as such entrusted by Christ to the Church’s care and responsibility” (PCJP 2006, no. 81). The *Compendium* advises that it is a complete and systematic Magisterial reflection of the Church’s social teaching but cautions that it is derived from a variety of documents of “different levels of teaching authority” (PCJP 2006, no. 8). As such this evaluation of the healthcare system will be carried out within the context of the

Compendium but will subject itself to the larger Magisterium of the Church, especially the *Catechism*.

The *Compendium* provides four permanent and essential principles at the “heart of Catholic Social Teaching.” These are (1) dignity of the human person, (2) the common good, (3) subsidiarity, and (4) solidarity (PCJP 2006, no. 160). These are all defined in the *Catechism* and will be used to analyze the current situation with US health insurance and medical economics below. The *Catechism* also offers a basis for moral decision making. Man, including the political authority it creates, can choose good and evil acts. The morality of those acts is judged based on: the object chosen; the end in view or the intention; and the circumstances of the action (CCC 2000, no. 1750). The morality of a human law is judged based on whether it conforms to the natural moral law or contradicts it. Unintended consequences can make laws evil as can evil intentions or circumstances that violate the core principles of the *Compendium*. While many laws have been established to improve health care based in good intentions, the results described here will demonstrate that evil has occurred which negates these good intentions (CCC 2000, no. 1756).

HISTORIC PERSPECTIVE

Americans have become accustomed to a third-party payer (such as a health insurance company or government agency) paying for the majority of their health care. Patients generally seek to pay an insurance premium and then small co-pays and other out-of-pocket payments for most care. This system became the mainstay of financing beginning in the World War II era when President Roosevelt imposed wage and price controls on

businesses. In order to attract employees, laws allowed companies to provide health insurance as a benefit not subject to taxation; but this tax exclusion was not available for the purchase of insurance outside of employment. After decades of battles, Medicare was passed in 1965 as a means of government-funded health benefits for those aged sixty-five and older. Medicaid was also created for those of low income followed by the SCHIP in the 1990s. These government-run programs have continued to be challenged by spending far beyond that predicted, while the trust funds for Medicare require a draw on general tax revenue outside of payroll taxes (Yood 2016). As a means of cost control, the government has implemented many programs to more centrally plan expenditures based on complex formulas and fee schedules that have been constantly subject to heavy politicization.

In the early 1970s, managed care companies were promoted through federal law with the HMO model achieving substantial market penetration in the 1990s. However the tightly controlled model was heavily criticized by patients and physicians. Ultimately, with the passage of PPACA: (1) non-Medicare health insurance was subject to strict federal standards, (2) a method of “pay for performance” (PFP) was established, and (3) a massive federal subsidy scheme was created along with transfers of premiums directly to insurance companies for qualified plans. In March of 2016, the Congressional Budget Office estimated the projected ten-year total net federal subsidies for health insurance accounting for direct spending, tax-free income, and penalties for non-purchase of insurance for those under 65. The CBO estimated \$8.9 trillion of federal subsidies for those under sixty-five alone from 2016 to 2026 (Congressional Budget Office 2016a) and has estimated an additional \$8.5 trillion

for Medicare (over 65) from 2016 to 2026 (Congressional Budget Office 2016b). Despite President Obama’s promises that PPACA would produce lower health insurance premiums, retained patient choice of physicians, market improvement in insurance coverage, and lower costs of medical care, the opposite has proven true (Furchtgott-Roth 2016).

CENTRAL ECONOMIC PLANNING VERSUS MARKET-BASED CARE

While critics of healthcare delivery and financing frequently point to a “failure of the free market,” it is clear that the system in place since the 1940s has borne very little resemblance to a free market. Economist Murray Rothbard described “free market capitalism” as “a network of free and voluntary exchanges in which producers work, produce, and exchange their products for the products of others through prices voluntarily arrived at” (Rothbard 1972). Rothbard sought to distinguish “free-market capitalism” from “state capitalism” which “consists of one or more groups making use of the coercive apparatus of the government—the State—to accumulate capital for themselves by expropriating the production of others by force....” The distinction is critical since the health insurance programs present in America have been marked by implementation through the use of government force (through taxation and regulation enforced by jail and fines). In fact, in the 1945 McCarran Fergusson Act, insurance company regulation was handed largely to the states and exempted from anti-trust law, allowing collusion for price fixing and other activities banned for most other businesses including private medical practice. Now purchase of health insurance is mandatory and directly subsidized by the

government—a *sine qua non* of “state capitalism.”

It is clear that the delivery of health care, and its economics, is governed by a philosophy of central economic planning, rather than by the natural action of a free market. Under a central-economic-planning model, elite groups and politicians create rules for fees, delivery of care, the medical practice of physicians, and care provided by hospitals. Central economic planning is a hallmark of socialist economics and has a history of failure economically and socially (e.g., see [Hayek 1944](#)). Centrally planned economies usually require price fixing (price controls) by the state which results in shortages, as seen in the long lines for gas from Nixon’s fixed prices in the 1970s ([Morton 2001](#)). In medicine, the fees paid to doctors are largely subject to the relative value resource based value system, which produces price controls that are arguably a source of shortages in primary care doctors, especially in certain geographic areas. Congressional reports have pointed to price fixing as a significant partial cause of intravenous drug shortages present since about 2009 ([Issa 2012](#)). The drug shortages are also largely due to another hallmark of central economic planning—regulation. The FDA chief appointed by President Obama went out of her way to indicate there would be “aggressive” regulation of drug manufacturing ([Sheppard 2009](#)), and Congress indicated this slowed and stopped production of IV drugs within the borders of America. When it comes to the economics of healthcare delivery, the unifying theme of government has been one of central economic planning, albeit in different degrees based on the political party in power.

Centrally planned economic models place the power in the hand of the planners and those who have been granted

control of spending. In this case, those responsible for the vast majority of spending are third parties outside of the patient–physician relationship. This third-party control of spending has broken the bond between the patient and the physician as the constant influence and interference of the outside agents often dictates the nature of the provision of care. Doctors now take “assignment” of the benefits of the patient’s third-party payer, deliver services, and then must have “reimbursement” approved by the outside agent. This disconnects the patient from the true costs of care and removes incentives for patients to question the necessity and cost of the care they seek. The third-party system incentivizes a gaming of the finance structure, directing physician decisions toward those things that get them paid by outside agents, at times at the expense of the patient’s best interest.

A further weakness of a central-economic-planning approach is the influence of politics and the desire to advance social and other agendas by special interest groups. In an effort to control costs, insurance programs are often subject to “community rating” whereby the cost of insurance premiums is kept artificially low for older and sicker patients and artificially high for younger and healthier patients. This is a hallmark of PPACA that by law limits premiums at only three times higher for older and sicker patients than younger and healthier patients effectively redistributing wealth between different groups (sec. 2701). The purchase of health insurance is mandated (enforced by a tax penalty) to ensure fulfillment of the political slogan “Everyone in, no one out.” Those in lower income groups receive taxpayer-funded subsidies for health insurance, even if their income is at 400 percent the federal poverty level. Those in higher income groups do not enjoy this economic benefit—redistributing their

wealth from them by force. Those purchasing health insurance outside of employment enjoy no tax benefit, thus subsidizing those with employment-based health insurance. Benefits are mandated for hair prosthesis, motorized wheel chairs, chiropractic care, birth control and abortion and dozens of other items often under the influence of special interest groups seeking their forced payment through government action. Rationing, the most concerning type of central economic planning, manifests in the intentional, overt denial of care to certain patients based on economic reasons compared to the perceived “value” of the life of the person seeking the care. Central planners (e.g., Ezekiel Emanuel, an architect of PPACA) even compare treatment cost to the value of a life as represented by a “quality adjusted life year” (QALY) to make utilitarian decisions on whether those with QALYs lower than set by the state should receive treatment (Prasad 2009). The corollary to rationing is the imposition by central economic planning of physician-assisted suicide and other means designed to end the lives of sick and injured patients as quickly as possible.

In a true free-market system, consumers would purchase health insurance directly in a competitive market. These consumers would also pay for medical care out of pocket for average, routine medical care received throughout the year and reserve the use of insurance for rare, expensive episodes of care which would then cover such services as greatly as the market would demand. There can be shortcomings in the delivery of health care through the market, but these can be overcome through charitable action and the use of temporary, high-quality government safety nets for medical care. Further the actions of a vigorous free market would help drive down the cost of care and increase access for all—even those in lower income

groups. The absence of government payment for Lasik and plastic surgery provides an excellent case study in the value of a market-driven system benefitting the general public (Herrick 2013).

PAY FOR PERFORMANCE

The chief mechanism of imposing rationing and other denial of medical care is the “pay for performance” model, often called “value-based purchasing” (VBP). In a PFP model, complex schemes are established by remote, political bureaucracies to penalize doctors who do not comply with the central economic plan for delivery of health care. Agencies such as the Centers for Medicare and Medicaid Services (CMS) create practice guidelines and withhold payments from doctors should their compliance threshold fall below that set by government. The thresholds are altered based on the available government budget to ensure that enough money from penalties will be available to fund so-called “incentive” payments for those who comply. The budget neutral nature of the penalty/incentive paradigm demonstrates that the preservation of money is the primary intention of those controlling the program. More overtly, the PFP programs also incorporate “resource use” or “efficiency” into their quality ratings. Doctors must ensure that spending on a patient falls below artificial thresholds set by the bureaucracies, or they will suffer a penalty. Furthermore, penalties are applied to doctors who do not utilize electronic medical records (EMR). The doctors who do use EMR receive a penalty if they do not do so in ways that are considered a “meaningful use” by regulators. Doctors are also subjected to penalties if they do not comply with certain “clinical practice improvement activities.” This onerous command and control system through

PFP and VBP has been integrated into the private insurance system after being developed in earnest beginning in the early 2000s under the Bush administration in collaboration with large corporations and insurance companies (Leavitt 2008). The Obama administration embraced the PFP model for its cost-control agenda and both political parties proudly celebrated the overwhelming bipartisan votes to implement these programs in Medicare through the Medicare Access and CHIP Reauthorization Act (MACRA) legislation in 2015 and the subsequent 962 pages of proposed rules in 2016.

Multiple studies have found a lack of significant improvement in patient outcomes after implementation of PFP programs. While compliance with guidelines increases, the actual benefit for patients was lacking. For instance, the Premier Hospital Incentive Program famously failed to show any benefit for patients, yet was still used as a model for massive implementation of PFP through Obamacare and MACRA (Jha et al. 2012). Thirty-day mortality failed to improve for acute myocardial infarction or coronary artery bypass grafting in the Premier program despite good compliance to avoid penalties. Korenstein et al. (2016) report that improvements consisted mainly of compliance with process and not outcome measures (e.g., ensuring more hemoglobin A1C testing without improvement in HbA1c results) or in finding ways to cut spending for alleged “overuse.” Surgical wound infection rates failed to improve despite excellent compliance with Surgical Care Improvement Project (SCIP) protocols to prevent wound infections including the limitation of antibiotic use in certain post-operative populations (Stulberg et al. 2010). This failure prompted Hawn (2010) to ask “Should performance measures have performance measures.” Reporting of compliance with PFP measures did nothing to

help life expectancies (Osborne 2015), the complication rate, or the hospital re-admission rate (Etzioni 2015) among surgical patients. PFP has failed to improve surgical mortality or complications from coronary artery bypass grafting and hip and knee joint replacement surgeries (Shih 2014).

Penalty-enforced compliance with so-called evidence-based medicine standards (PFP) have also been associated with actual harm to patients. Continuity of care (loss of “usual doctor”) was worse in a diabetes PFP program. Deaths increased in congestive heart failure patients when beta-blocker compliance was imposed on them for four years before the government stopped use of the “quality” measure AMI-6 (CMS 2008). Infection rates increased following hip arthroplasty as compliance with required deep vein thrombosis chemo-prophylaxis increased due to clot accumulation—a measure still enforced with penalties (Wang 2012). Patients were inappropriately receiving pneumovax to meet performance thresholds (McKaliip 2009).

As these PFP programs achieve maximum penetration in the profession of medicine, doctors are leaving private practice in large volumes to become employed. The percentage of doctors employed was reported at 64 percent by a major physician recruiting firm compared to 11 percent ten years prior (Florence 2014). Employed physicians, especially those who are part of large health systems, face increasing pressure to comply or they will not receive their incentive payment. Nurses and doctors are spending far less time with patients as they instead spend time in front of computers and on compliance activities.

Markovitz (2016) evaluated the impact of PFP on patients, hospitals, and physicians (Fifty-eight studies covering twenty-one unique PFP programs). They found very little evidence of a meaningful benefit

for patient outcomes stating “P4P [pay for performance] has largely failed to realize substantial quality gains.” More importantly, they found that hospitals were re-directing substantial resources away from patient care to support compliance activities. Even with good compliance with imposed goals, hospitals still often suffered financial penalties. Safety-net hospitals and those serving larger populations of poor and racial-minority patients were more likely to see penalties, threatening the viability of these service centers. Physician practices serving predominately low-income and racial-minority populations also were unable to achieve improvement in compliance and bonuses in the PFP scheme. All practicing physicians will recognize that this will lead to de-selection of black, Hispanic, and poor patients from medical care in private practice—harming the patients in the process. Even doctors who dutifully complied with a precursor of PFP—the Physician Quality and Reporting System (PQRS)—were far more likely to see penalties than avoid them, with \$1.3 billion in penalties applied to 79 percent of the 600,000 physicians involved in the program (Fiegel 2013).

The PFP measures themselves have been found to be invalid for patient safety indicators (PSIs) and hospital acquired conditions (HACs) in nearly every case. Winters et al. (2016) found that only one of eight measures used in the PSI-90 composite score was potentially valid in reflecting actual medical care (positive predictive value >80%). Yet this score is currently used to determine penalties for hospitals failing to meet government-set thresholds of care. They advise that the role of PSIs and HACs in PFP need to be re-evaluated and state that their inappropriate use can result in “unwarranted financial penalties and damage to reputation” as “unintended consequences.” For example, use of razors has been banned in

hospitals, and penalties are applied to physicians who shave with them based on no valid data supporting this practice (McKalip 2013).

Despite ample evidence showing the failure of the PFP approach, government has continued to implement even when warned not to do so. Winters (2016) pointed out that PSIs were not originally intended for PFP, yet the CMS used the Agency for Healthcare Research and Quality composite PSI for its PFP program. Scott (2011) cautioned that there was insufficient evidence to support PFP in health care and stated that “implementation should proceed with caution and incentive schemes should be more carefully designed before implementation.” Writing for the Rand Corporation, Damberg et al. (2014) pointed out that studies on PFP with stronger methodology were less likely to identify improvements and only those with weak study designs showed improvement. A reading of the literature will reveal that these “improvements” are often merely related to compliance with measure requirements and not necessarily with better patient outcome. The Rand study described PFP and VBP as “natural experiments” conducted on populations of patients without any control groups. It is obvious that there has been no consent for participation in the social experiments by patients or physicians. McKalip (2009) evaluated dozens of preliminary studies of PFP and pointed out they failed to improve care, were associated with patient harm and led to loss of care for high-risk patients, and gaming of the system, and recommended cessation of PFP in medicine.

Rather than heeding valid studies of PFP showing failed improvement, as well as severe negative unintended consequences, and despite a paucity of scientific support for these endeavors, policy makers have embraced and accelerated implementation. Unfortunately establishment, organized-

medicine groups like the AMA and their partners in the Federation of Medicine have endorsed congressional acts to implement PFP (American Recovery and Reinvestment Act 2009, Patient Protection and Affordable Care Act 2010 and Medicare Access and CHIP Reauthorization Act 2015) despite clear policy in the AMA and other associations to oppose such programs (personal observation). As a former ten-year member of the AMA House of Delegates and seven-year board member and officer of the Florida Medical Association (FMA), it is clear to this author that the interest in “being at the table,” having political influence, and brokering political power was the main motive. This motive was also influenced by a preference for central economic planning by key leaders and colored by the notion that physician organizations can somehow control and improve a PFP system that appears to be beyond hope in achieving purported intended gains. It was also clear that some physicians and medical organizations believe they could benefit financially by selling services related to PFP and participating in medical models that would redistribute funds from non-compliant doctors to themselves [e.g., through accountable care organizations (ACOs), EMR support, and through measure development for PFP programs].

The most logical and rational conclusion for the continued growth of PFP programs by Medicare and private insurers relates to the motives of each third-party payer to save money at any cost. The data have clearly shown no benefit and many harms, even before implementation in Obamacare and Medicare. Hospitals and doctors are complying yet still suffer financial loss and loss of autonomy in the process. The fact that the policy makers continue to implement their centrally planned incentive and reward plan can reveal only one intention: they must find

excuses to spend less money on patients to bolster their profits (insurers) or prop up their failing government health programs (Medicare, Medicaid, SCHIP, and Obamacare). The preferred method of saving money is to ration care by turning doctors into rationing agents for the state or attempting to punish all non-compliant doctors out of existence in the process. This fails all tests of Catholic social doctrine resulting in a loss of social justice.

It would be difficult to find a more clear case study of the violation of every fundamental principle of Catholic social doctrine than PFP. Human dignity is violated as doctors are incentivized to put the survival of the system and their own financial gain over the interests of the patient. The common good is violated as rationing is imposed through the PFP and VBP systems. Subsidiarity is violated as centrally planned economic models are imposed through a massive command and control scheme right into the doctor’s examination room with the patient. Solidarity is violated as a collectivist society seeks to withhold care from patients, save money for the government, and allow the ill and the vulnerable to suffer or die early for the benefit of the government, private insurance companies, private corporations, and doctors themselves who get a bonus.

THE CATHOLIC BASIS OF A MARKET-BASED MEDICAL ECONOMY

The *Catechism* assertively rejects socialism and central planning as acceptable economic models and provides a framework for a moral, market-based economy as an ideal to achieve. The *Catechism* offers:

The Church has rejected the totalitarian and atheistic ideologies associated in modern times with “communism” or “socialism.” She has likewise refused to

accept, in the practice of “capitalism,” individualism and the absolute primacy of the law of the marketplace over human labor. Regulating the economy solely by centralized planning perverts the basis of social bonds; regulating it solely by the law of the marketplace fails social justice, for “there are many human needs which cannot be satisfied by the market.” Reasonable regulation of the marketplace and economic initiatives, in keeping with a just hierarchy of values and a view to the common good, is to be commended. (CCC 2000, no. 2425)

The Magisterium of the Church rejects “centralized planning” and calls for “reasonable regulation of the marketplace and economic initiatives” and Catholic social doctrine “excludes socialism as a remedy” to social ills (PCJP 2006, no. 89). The Church embraces subsidiarity stating “neither the state nor any larger society should substitute itself for the initiative and responsibility of individuals and intermediary bodies.” The Church further states: “Excessive intervention by the state can threaten personal freedom and initiative” (CCC 2000, no. 1883). The Church calls for respect for private property (CCC 2000, no. 2401) pursuant to the seventh commandment. It is clear that the PFP cost-control and wealth-redistribution mechanisms violate the Church’s call for subsidiarity, protection of private property, and rejection of centralized planning as a primary economic model.

Rather the Church has called for a legitimate free-market system of care. She does call for the political community to ensure the “right to medical care” (along with the right to private property and free enterprise) (CCC 2000, no. 2211). However, the Church does so within the context of her warnings about central planning and her respect for free-enterprise, and specifically states that the right to medical care should be “in keeping with

the country’s institutions.” The American ethic is one of free enterprise and not one of centrally planned economies, so it is clear the Church’s Magisterium must call for the American medical economy to be conducted in a just, moral free-market system. Thomas Woods provides an outstanding discussion of the Church’s call to support free markets in his book *The Church and the Market* (2006).

The Church offers an uncanny parallel echo of Rothbard’s differentiation of the morally good “free market capitalism” from the morally evil “State capitalism” (Rothbard 1972). Catholic social doctrine differentiates a “free economy” from those that are not free (table 1) (CCC 2000, no. 2431). The Church has indicated that it is the responsibility of the state to ensure stable currencies and efficient public services and to protect individual freedom and private property. This will ensure that “those who work and produce can enjoy the fruits of their labors and thus feel encouraged to work efficiently and honestly” (CCC 2000, no. 2431). The *Catechism* continues, “[the] state must oversee and direct the exercise of human rights in the economic sector,” but it cautions that the primary responsibility in this area “belongs not to the state but to individuals and to the various groups and associations which make up society.”

A full reading of the *Compendium of the Social Doctrine of the Church* and the *Catechism* makes it clear that the ideal economic system for healthcare delivery is a “market economy” or a “free economy.” The practical means of establishing true social justice for health care in America requires the tearing down of the centrally planned healthcare economies now in America and substitution by freedom-based economies that respect individual human dignity, the common good, subsidiarity, and solidarity. So far neither existing political party is offering a plan to

Table 1 Catholic doctrine on true free markets. The Church defines a free economy as moral and the basis of the Church's social doctrine

"In the perspective of an integral and solidary development, it is possible to arrive at a *proper appreciation of the moral evaluation* that the Church's social doctrine offers *in regard to the market economy or, more simply, of the free economy*... In this way a Christian perspective is defined regarding social and political conditions of economic activity, not only its rules but also its moral quality and its meaning" (PCJP 2006, no. 335).

True Free Markets

Capitalism with "free economies" (PCJP 2006, no. 335)

"Free Market Capitalism" (Rothbard 1972)

"If by 'capitalism' is meant an economic system which recognizes the fundamental and positive role of business, the market, private property and the resulting responsibility for the means of production, as well as free human creativity in the economic sector, then the answer is certainly in the affirmative, even though it would perhaps be more appropriate to speak of a 'business economy', 'market economy' or simply 'free economy'."

False "Free" Markets

"Capitalism" without freedom (PCJP 2006, no. 335)

"State capitalism" (Rothbard 1972)

"But if by 'capitalism' is meant a system in which freedom in the economic sector is not circumscribed within a strong juridical framework which places it at the service of human freedom in its totality, and which sees it as a particular aspect of that freedom, the core of which is ethical and religious, then the reply is certainly negative."

Note: PCJP (2006, no. 335) is quoting Pope John Paul II, encyclical *Centesimus annus*, no. 42.

establish a true free-market medical economy, but a plan of action is exceedingly simple if we put the person at the center of the economy, with money as a bystander.

A FREE-MARKET MEDICAL ECONOMY

Describing a free-market system is surprisingly easy, but modification in light of other social needs and within the reality of the current healthcare system is required. At its most primal, a market-based system would be based on a sound currency, with no central bank controlling its production and would be part of a larger free economy. A basic, functioning, and socially just free market would mean that a patient would pay for his or her health care with his or her own funds, and the doctors, pharmacies, ancillary testing, and point-of-care sites would provide their services to them. In such a free market, there would be no government intervention, and the consumer action with choice and competition would ensure the lowest price, most open and timely access, and highest quality. In such a market-based system,

the ease and low overhead of providing care would make it easier to provide charitable care (without incurring financial losses) and would be supplemented by the innate charitable nature of enough participants on the provider side that there would be near-universal access to care. That is clearly a utopian dream that is unlikely to be easily attained. It is also true that universal access to high-quality, low-cost care through a centrally planned, collectivist (socialist) approach is also a utopian dream that has never and can never be attained (despite every earnest attempt). So how best to implement a market-based healthcare economy within the current reality of the American healthcare system?

Establishing a free-market economy in health care means dismantling the barriers that currently exist to such and instituting the hallmarks of a free economy as quickly as possible. Transitioning to a free-market economy will have its own costs and must be accompanied by charitable actions by the provider community and a respectful response from the patient community to embrace their rights and responsibilities. An integrated approach toward this

market economy in medicine was developed under this author's leadership as the Chairman of the FMA's Council of Medical Economics from 2007 to 2008. The Florida Health System Improvement Plan was embraced by the FMA and served as the basis of their advocacy activities up to 2015 (table 2). Unfortunately, political changes in the FMA led to an embrace of the current PFP plan in MACRA in 2015 and an effort to implement the ACO approach of central economic planning. Such is the case of establishment, organized medicine, like the AMA and FMA, where sound policies often are ignored or suffer at the hands of political expediency and aspirations (personal observation after 15 years of intense service to both organizations) (McKalip 2016). Nevertheless the market-based plan developed by the FMA involved two years of intensive work by knowledgeable leaders in organized medicine in conjunction with thought leaders in medical economics and stakeholders throughout the entire industry. The key elements of this market-based plan are presented here by its author and reconciled with Catholic social teachings.

Patient Empowerment

When the consumer (the patient) is empowered economically and in other ways, he or she is in the best position to provide for his or her own needs. Multiple consumers, through their collective economic power and action, are able to improve cost, quality, and access for all. The current tax and subsidy structure severely impairs the ability of patients to be economically empowered for their own health care. The tax code picks who is favored and who must sacrifice by unequal tax treatment for health financing in and out of employment and through

redistributive effects of tax payments and tax subsidies based on income brackets. An equitable tax system provides the same benefit to all, not just those chosen by politicians who are subject to majority pressure. Unequal tax treatment of a person's income violates their right to "enjoy the fruits of their labor" and harms the solidarity with their brothers and sisters as they receive a disincentive to "work efficiently and honestly" (CCC 2000, no. 2431). For instance, to keep subsidies for health insurance at a higher level, people have been shown to avoid seeking work that pays more but would mean loss of their subsidy. In addition, hundreds of companies have laid off workers or cut people from full-time to part-time to avoid penalties under Obamacare (Johnson 2013). The Congressional Budget Office indicates that the Obamacare subsidy structures will discourage enough people from working to create the equivalent of 2.3 million "full-time-equivalent workers" by 2021, an increase from the previous estimate of 800,000 (CBO 2014). It is clear that the current tax structure should be changed to one that provides the same tax benefit for all citizens and that does not create other unintended consequences that harm workers, businesses, and the common good. The practical policy position supported by the *Compendium* would therefore be for each person to get the same tax break for health costs—regardless of social class, income level, or other differentiating factor. A socially just treatment of citizens requires fair and equal treatment of each under the tax code, rather than a progressive code designed to redistribute wealth. Wealth redistribution through government action is fraught with a history of failure, unintended consequences, and abuse. However wealth growth of all through a free market, charitable action, individual

Table 2 *The market-based health system reform plan of the FMA since 2009*

P 235.005 FMA HEALTH SYSTEM REFORM POLICIES

The FMA adopts the following health system reform policies:

1. Supports the following health system policies to increase access to affordable and high quality care:

A. *Promote patient rights:*

- (1) Ensure patient can receive medical care in their best interest within the patient–physician relationship from a physician they freely choose.
- (2) Ensure that the law prevents third parties from creating direct and indirect rationing of medical services.
- (3) Ensure that third parties refrain from creating cookbook and evidenced-based medicine protocols designed to help patient populations that do not help individual patients.

B. *Increasing affordability of medical services and health insurance.*

- (1) Limit guaranteed issue and community rating for health insurance products.
- (2) Allow the interstate purchase of health insurance.
- (3) Promote growth and expansion of health savings accounts and high-deductible health insurance products and ensure that covered medical expenses are broad for these accounts with 100 percent first dollar coverage for proven preventative tests and treatments.
- (4) Minimize state and federal health insurance mandated benefits.
- (5) Encourage competition in the health industry by ending Certificate of Need laws, Stark rules and self-referral laws, and allowing physician ownership of healthcare facilities.

C. *Promoting tax fairness for healthcare financing.*

- (1) Allow tax deduction for individuals who purchase health insurance outside of work.
- (2) Expand contribution amounts for tax-free HSAs and ensure rollover of unused funds each year.
- (3) Create refundable, advanceable tax credit (a voucher) for all Americans who purchase health insurance—at same amount regardless of income level.

D. *Encourage private control of healthcare spending.*

- (1) Reinstate right of Medicare and privately insured patients to privately contract with their physicians for medical care.
- (2) Create a choice for younger workers to contribute payroll taxes to an individually owned Medicare account or to keep money in the Medicare system.
- (3) Allow Medicare beneficiaries who opt-out of Medicare the right to continue to collect other Social Security benefits.

E. *Ensure economic sustainability of government financed health care.*

- (1) Encourage transition of Medicare to an individually owned account for younger workers and subsidize cost of older workers who choose to transition to an individually owned account.
- (2) Establish means testing for Medicare recipients for benefits and premiums.
- (3) Prioritize public financing of health care for those of lower incomes.

F. *Guarantee access to medical care.*

- (1) Pass tort reform by capping payments for non-economic damages at \$250,000 per incident and protect patient rights by creating special courts and tribunals for physician professional liability cases.
- (2) Pay physicians and hospitals fair market value for services delivered to patients covered by publicly financed programs.
- (3) Minimize regulations that increase cost of care with no benefit to individual patients and anti-trust laws affecting physicians.
- (4) Support activities of the Medicaid and CHIP Payment Access Commission that increase access to medical care.

G. *Ensure high-quality health care and protection of patient and physician rights.*

- (1) Ensure fair and strenuous board certification and state licensing laws for physicians.
- (2) Promote fair, unbiased peer review as the basis of quality, protect such through federal law and reserve reporting of de-identified physician quality measures to occur directly to individual physicians only.
- (3) Ensure that only physicians practice medicine and that physician extenders are adequately supervised by practicing physicians.
- (4) Allow access to courts and full judicial review for patients and physicians participating in publicly financed health programs and ensure full payment of attorney fees to prevailing party.

2. That the FMA opposes the following as health system reform policy:
 - A. Creation of expanded public financing of health care through a “public option.”
 - B. Individual and employer mandates to purchase health insurance supported by tax penalties.
 - C. Value-based purchasing and PPP programs that are not compliant with the AMA’s Principles and Guidelines on PPP.
 - D. Mandated use of EMRs or Electronic Prescribing.
 - E. Reducing physician and hospital payments to fund incentive programs for value-based purchasing.
 - F. Bundling of physician payments with hospital payments for medical practice reimbursement.
 - G. Financial penalties to physicians and hospitals for non-participation or non-compliance with government cost control and medical practice control programs.
 - H. Economically undermining physician practices or hospitals by providing incentive payments for competitors in certain programs such as pay for reporting and ACOs.
 - I. Increasing payments for medical home physicians by cutting payments to specialists as suggested by the Medicare Payment Advisory Commission.
 - J. Public reporting of physician and hospital practice data.
 - K. Forced compliance with cost-control protocols established by the Federal Coordinating Council on Comparative Effectiveness.
 - L. Expanded scope of practice of non-physicians to practice medicine.
 - M. Mandatory participation in professional liability insurance for physicians.

Note: The FMA is now reconsidering all of this pursuant to new policy adopted at their annual 2016 meeting to adapt to the changes of PPACA and MACRA. This demonstrates the transient adherence to principles commonly seen in establishment organized medicine and the primacy of political ambition and expediency.

enterprise and work is less subject to the shortcomings of centrally planned economics using unjust tax policies to force citizens toward certain political goals. Thus if the government has assigned \$15,000 as the value of a tax break citizens should receive for their spending on health care, that would apply to each and every American citizen.

Another key toward patient empowerment is to ensure that citizens have money in their hands to spend on health care. A market-based system would ensure that the patient is spending money for their routine, regular medical care out of pocket, from their own funds that are owned in a tax-free manner. Ensuring full tax deductibility of healthcare financing would allow more people to place a greater amount of funds into a health savings account (HSA are now held by nearly twenty million people) (AHIP 2015). Patients can self-fund their care through an HSA, a process that more fully involves them in their care (Effros 2009). Patients who use HSAs are more likely to ensure that the recommended care they receive is necessary, and they have the power to drive down costs by negotiating the price of services, such as outpatient laboratory and radiology studies, and are just as likely to receive preventative care (Agrawal 2005). Obamacare substantially disables the use of HSAs by requiring health plans to meet “minimum essential requirements” in addition to including a financial formula that does not allow people to spend as much out of pocket from HSAs without tax penalties.

Health Insurance as Protection—Not a Benefit Plan

The popularly accepted view of health “insurance” in America is of a product that pays for 95 percent or more of medical costs, while the patient pays small

amounts out of pocket. Under this model patients are led to believe that they will be provided a great deal of medical care for their regular annual premium cost. The insurance companies work on the other side of the equation to avoid spending on health care for patients. With the passage of PPACA, this system of third-party payment (and cost control) has been strengthened. In a 2012 Congressional Budget Office estimate, insurance companies were projected to receive about \$1.07 trillion (over ten years) for purchase of health insurance as result of direct subsidies paid to them by the government (Anderson 2014; CBO 2012). In addition these insurance companies now enjoy a government-created and -enforced cost-control regimen (PFP) to enable lower spending on patients.

When patients buy health insurance, they often act as if they must get as much spending from the company as possible. If a doctor orders tests and treatments, there is no cost trigger for the patient to question the necessity of the tests and treatments—the insurance company will pay most of the cost. This leads to an escalation in cost for these tests and treatments as the consumer price trigger is also removed for them. The response of government has been to institute cost-control measures such as PFP. For medical care, insurance is no longer viewed as a hedge of protection against rare disasters. In the auto, home, and other insurance sectors, the benefits are accessed rarely. This keeps premiums lower and encourages insured consumers to work within the market to obtain routine minor services (e.g., car and home repairs) leading to more consumer control of costs, access, and quality. A market-based health economy would allow health insurance to naturally revert to an indemnity plan that would be used for rare events in life (such as cancer, a heart attack, a major trauma). Those consumers

who want a plan with lower deductibles and that pays their benefits directly can opt for that, but history does show that consumers rejected HMOs in the 90s when other choices were readily available (McQueen 2013). Unfortunately, with PPACA and the predominance of government control of insurance products, their subsidization, and their mandated purchase, choice and competition are markedly diminished in the health insurance market. As a result, even those who do not receive subsidized insurance are facing less choice and markedly higher insurance prices (Coleman 2016).

A market-based approach with health insurance as an indemnity plan would allow lower insurance premiums for all and allow them to be coupled with HSAs. High-deductible health plan (HDHP)/HSA models serve almost twenty million Americans now. If society insists on using government as a tool to promote health-care financing, a lower-cost and more sensible approach would be to allow people to fund HSAs to buy HDHPs tax free. This should be coupled by policy action to promote education on their use. Medical societies and other advocacy groups can work to build networks of doctors who will work with patients in these plans.

HDHPs generally are far more affordable as their lower premium costs reflect less usage by consumers. Unfortunately, the health insurance plans mandated through PPACA function as HDHPs—with required out-of-pocket spending of up to \$13,292 for a family on the lowest cost Bronze Plan in order to access the plan's full benefits (Coleman 2015). Yet these high-cost, PPACA HDHPs do not have associated HSAs or low premiums, with a 2010 estimate for the actual premium for the Bronze Plan family policy to be \$12,500 in 2016 (with most of the cost covered by subsidies paid

directly to insurance companies through the federal government) (Elmendorf 2010). The affordability of HDHPs is being altered by the subsidization of these plans by the federal government to insurance companies. A true market creates far lower prices for high-deductible health plans. A 2014 study (Lenardson 2014) of national HDHP usage found that approximately 90 percent of people with HDHPs spent under \$7,100 annually for premiums, with over 50 percent of families spending less than \$2,000 on health care and about 70 percent less than \$3,000 annually. This is with HDHP deductibles that can range as low as \$2,500. Thus of the 30 percent of families spending more than \$3,000 on health care, they are likely to have 100 percent of coverage above their deductible. This market-based HSA/HDHP model would obviously have a much better affordability profile for Americans than the low-coverage, high-cost, subsidized, and highly limited Bronze Plan HDHPs of PPACA.

Health insurance can also be made far more affordable if mandated benefits are limited (such as pregnancy coverage paid by men and vasectomies paid for by women). In addition there are many states that offer health insurance with much a lower cost of health insurance than others based on their regulatory policies. Allowing insurance to be purchased across state lines would create a new level of competition that would drive down health costs. Finally, health insurance is most commonly linked to the work place. This creates a job-lock as plans interfere with opportunities for new careers by covered workers. It also creates a more pernicious effect on “pre-existing conditions.” A better, market-based approach would allow health insurance to be tied to the person throughout his or her life, regardless of jobs. Thus, if a young

person buys health insurance at a low premium in his or her 20s, he or she would be covered for life even if he or she develops a medical condition later on. There would be no more worry about a “pre-existing condition” exclusion if the person developed the condition while he or she carried his or her insurance throughout his or her life. The cost would change based on true free-market conditions, taking into account consumer choice, competition, age, and life-style risk factors (e.g., smoking) rather than government mandates, regulations, and central economic planning.

Physician and Patient Freedom

Currently physicians are paid predominantly through third parties based on contracts they sign for services. These insurance and Medicare contracts require adherence to cost-control and practice-regulation requirements, such as PFP that interfere in patient care and drive up practice costs. In addition, the physician is limited to taking in payment only what the insurance company allows and often must deal with ever-changing rules and onerous appeals processes. PFP has made this even worse as the appeal rights for physicians have been removed by law (PPACA). Doctors participating in PFP programs are denied access to the courts to dispute ratings, payment decisions, and factual matters relating to them, such as what care was actually provided.

Patients are also denied the right to pay for care they prefer. For instance Medicare patients may only receive their Medicare benefits to pay for care provided by Medicare-contracted physicians. This limitation makes it very difficult for physicians to escape or remove themselves from the command-and-control system of Medicare

and offer their services directly. This is in contradistinction to specific Medicare law (that has been ignored by the federal government) that states that “Nothing in this [subchapter] shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine, or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer, or employee, or any institution, agency or person providing health care services” (Title 42, Section 1395, USC).

Doctors are now being coerced into ACOs that will pay a capitated amount to physicians for care. The more they spend on patients, the lower will be their revenue. They will be penalized and are “at risk” directly or indirectly. This creates an obvious conflict of interest for the doctor who must now choose to serve their patient’s interest or to serve their own financial interest. In effect, this arrangement and PFP works to convert the doctor into a rationing agent for the state.

Doctors of good conscience may want to leave the third-party system that seeks to control them and their care, but will not be able to continue to provide their services easily without third-party payer contracts. A way to enable the freedom of doctors to honor their patients first is to provide freedom for patients to take their health insurance benefit to the doctor of their choice. That means being allowed to see doctors who are “out of network.” However, Medicare will not allow patients to privately contract with their doctors to take their Medicare benefits with them to the doctor of their choice—denying them the ability to pay what they agree to pay to the doctor. Further, patients cannot have tests and treatments ordered by non-Medicare doctors, severely limiting the services

these doctors can provide. Likewise, private insurance companies continue to have legislation passed banning the ability to pay doctors out of network in certain circumstances, especially in hospital-care situations. A market-based solution would enable patients to take their benefits with them to the doctor of their choice who will provide them with care. If the bill for the doctor is \$120 and Medicare can only afford to pay \$80, then the remaining \$40 should be payable by the patient if he or she chooses. Lifting the ban on balance billing and private contracting would provide freedom for patients and doctors to compete in the system. Given the onerous PFP penalties and damage to reputation, doctors may be increasingly likely to take only what Medicare or an insurance company will pay simply to be allowed to escape from the interference in the patient–physician relationship imposed by third parties.

Charity

The obvious objection to market-based economics often is most soundly based on the loss of access by the poor. However, the discussion so far has shown how excessive government intervention and favoritism shown to insurance companies have only driven costs higher and resulted in rationing and other interference in the patient–physician relationship. There is obviously a better way; and while those who object to market economies may refer to “market failures,” there should instead be an objection to the obvious “government failures.”

Doctors, especially those in private practice, are finding it increasingly difficult to offer charity care. The increased demands on their time for compliance, increased overhead costs, and decreasing

payment for services leave little room for charity. In a free market doctors can ensure a lower cost of practice and a lower volume of care with a similar revenue profile, leaving more time for charitable action. In addition, large organizations can step forward and supplement charitable care outside of the government. However, with the government now a primary source of “indigent” care, citizens find little reason to donate money to charities for these purposes.

The presence of GoFundMe and similar crowd-sourcing tools for funding provide evidence of the charitable nature that remains amongst Americans, which would certainly grow if there was less impact on their income by the government. This author personally created, ultimately raised, and spent over \$16,000 through his own charitable foundation (the Pinellas Medical Foundation) and a GoFundMe campaign to provide care for his patient (McKalip 2015). Medicaid would not cover the costly stereotactic radiosurgery the patient needed for a recurrent brain tumor. Lack of coverage by Medicaid and low physician payment created a major access to care problem for this patient. The phenomenon of poor access to care for Medicaid patients based on low physician fee schedules is well known (Artz 2014). However, with the fundraising we performed together and the willingness of a charitable radiation physician and facility to cut their rate, the patient received the care she needed and did well. The community, the family, and the patient were all involved in finding funds for this patient, the doctors were more engaged with their patient, and the common good was far better served. Surely if one doctor can organize such an action and find care for a patient entirely outside the third-party system through the use of private contracting, it is not hard to imagine how easily this could be done through Catholic charitable organizations. The rise

of healthcare sharing ministries (e.g., Medi-Share and CMF Curo) is another example of the power and potential of charitable action for health care. Note that even with PPACA, twenty-nine million individuals (not all of whom are American citizens) are still not covered by this program as admitted by President Obama in his own piece in the *Journal of the American Medical Association* (Obama 2016).

CATHOLIC SOCIAL DOCTRINE AND THE MAGISTERIUM AS A GUIDE TO ACTION FOR HEALTH SYSTEM REFORM

Human Dignity

The current structure of third-party control of health financing is out of step with the principles of the *Compendium* and the Magisterium of the Church. Citizens, patients, and doctors are treated unjustly by tax policy that deprives them of private property for actions that are not just. Doctors are coerced into becoming rationing agents of the states, depriving patients of the health care they need and deserve. Patients are deprived of a sound free market for the purchase of health insurance at the lowest cost based on their moral view and their unique needs. All of these circumstances violate human dignity and freedom. There has come to exist an “intra-worldly ideology of progress” that is contrary to the integral truth of the human person and does not heed the *Compendium’s* warning that “The human person cannot and must not be manipulated by social, economic or political structures, because every person has the freedom to direct himself towards his ultimate end” (PCJP 2006, no. 48). In fact, “the whole of the Church’s social doctrine...affirms the inviolable dignity of the human person” (PCJP 2006, no. 107). The differential treatment of people based on the precepts

of central economic planning and the coercion to follow faulty guidelines for rationing and clinical practice contradict the warning that the “person cannot be a means for carrying out economic, social or political projects by some authority” (PCJP 2006, no. 133). Finally, PFP programs lead doctors to avoid a financial penalty or besmirchment of their reputation, and so they are coerced to put their own interests ahead of their patient’s interests. Thus doctors are led to sin as they are encouraged to lose solidarity with their patient, further violating his or her human dignity. The best means of promoting human dignity for health care will respect individual freedom and choice and will come through the implementation of a true free-market medical economy.

Common Good

The Church teaches that the common good is “the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily.” (CCC 2000, no. 1906). The common good must not be an “end in itself” and “has value only in reference to attaining the ultimate ends of the person” (PCJP 2006, no. 170), and (1) must ensure respect for the person as such, (2) must ensure social well-being and development of the group itself, and (3) requires the peace, stability, and security of a just order (CCC 2000, nos. 1907–1909). The current third-party payer system works against the common good by placing man as a utilitarian object: merely a bystander in a financial transaction controlled by entities concerned primarily with their own financial and political gain. The current centrally planned medical economy creates “social injustice” since it does not allow society to ensure “the conditions that allow associations or

individuals to obtain what is their due according to their nature and their vocation” (CCC 2000, no. 1928). The common good is best served by a free-market system where individuals can more easily reach their fulfillment through just use of their private property and their natural rights to free enterprise described within a morally good structure envisioned by the Church (Woods 2006).

Subsidiarity

The Church teaches that subsidiarity requires that higher authorities should not impose their will on individuals and lower authorities. The current third-party, centrally planned economic structure is as clear a violation of the Church’s core social teaching of subsidiarity as has ever existed in modern America. The *Compendium* instructs, “the principle of subsidiarity is opposed to certain forms of centralization, bureaucratization, and welfare assistance and the unjustified and excessive presence of the State in public mechanisms” (PCJP 2006, no. 187). A market-based system best respects the principle of subsidiarity by ensuring that people can justly interact in their best interest in a way that “strengthens the social fabric and constitutes the basis of a true community of persons, making possible the recognition of higher forms of social activity” (PCJP 2006, no. 185). Some may argue that the lowest “competent” level of authority should determine the course of the medical economy. However, in this argument individual men and women many times are not recognized as a level of authority. Yet men and women working in a market-based economy are the epitome of a competent authority. Efforts by central economic planning “authorities” claiming to be more “competent” have clearly failed and are far more likely to harm individuals and subvert social

justice than to enable individual dignity and to promote true social justice. It must be noted that the *Catechism* says nothing about “competence” in its definition of subsidiarity (no. 1894), while others have attempted to insert this concept into the definition of subsidiarity without a sound catechetical basis. In addition, those pointing to a need for a “competent” authority in the context of subsidiarity point to the economic model and laws of the European Union to justify the assertion (Evans 2013).

Solidarity

The patient–physician relationship is the most profound, professional representation of solidarity in society. Ideally, the two act as a unit with the doctor advising the patient on his or her options and recommending those actions that are in the best interest of the patient who seeks care for his or her fulfillment. The solidarity of the patient–physician relationship has been severely broken by the extreme and unnecessary intrusion by the state through PFP and the loss of the ability to privately contract between parties. Solidarity exists among brothers and sisters in a community when they can best act in true charity toward each other. This solidarity has been damaged by the top-down style of public financing and control of medicine and the empowerment of insurance companies into nationalized entities that serve the state and their own interests first. The ability and incentive to act charitably are markedly diminished when patient care is viewed as a collectivist duty of a centrally planned economic system, and not the act of neighbors loving one another as they love themselves. A true free-market based system restores solidarity by restoring the patient–physician relationship, fostering a sound business relationship

between patients, doctors, and insurance companies, and re-invigorating medical charity as a basis of neighborly love.

The current centrally planned medical economy is an immoral exercise. Its intention is to redistribute income as an end to itself. It seeks to control and ration medical care to save money for third parties, at the expense of patient care and in violation of physician conscience. It seeks to mandate the purchase of insurance products that are costly and transfer wealth to insurance companies by government actions. The current system is causing an unnecessary escalation of health insurance and medical costs, harming the poor and those who subsidize others by force. The centrally planned medical economy removes the right to appeal to the judiciary by doctors and patients who have been treated unjustly and creates harm through the bad medical care it imposes. In short, the centrally planned medical economy in place now can easily be defined as morally evil. The evidence is clear in many sectors of the economy that free markets can provide food, clothing, and housing with minimal central planning and supplemented by government safety nets and charity (although more central planning is entering these sectors as well). A true, free-market based system has the potential to be a morally good system when enacted justly and accompanied by charity.

Catholic physicians should search their conscience to determine if they are able to continue in solidarity with their patients under the current onerous third-party payment system. This author humbly suggests that doctors should reject compliance with PFP and other regulatory activities that serve anyone but the patient (including themselves). Doctors should work together to reaffirm their dedication to the patient first, which is really a reaffirmation of their calling to serve God first. The exact methods of establishing a just

free-market economy in medicine require careful thought on the proper, but limited roles of the state in assisting this common good. Catholic physicians, working in coalitions of their medical associations, should work together to re-establish a true free-market medical economy as the best means of respecting the Magisterium of the Catholic Church and the Trinitarian unity it serves for the salvation of souls.

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BIOGRAPHICAL NOTE

David McKalip, M.D., is a private practice neurosurgeon in St. Petersburg, Florida. He is the current president of the Florida Chapter of the Association of American Physicians and Surgeons, past president of the Florida Neurosurgical Society, past chair of the FMA's Council on Medical Economics, and a member of the Health Policy Committee of the Catholic Medical Association.