# Book Reviews

***The Price of Panic: How the Tyranny of Experts Turned a Pandemic into a Catastrophe,*** by Jay W. Richards, Ph.D., William M. Briggs, Ph.D., Douglas Axe, Ph.D., 256 pp, hard cover, $28.99, ISBN-13: 9781684511419, Washington, D.C., Regnery Publishing, 2020.

This book puts the huge human costs of the panicked response to the COVID-19 pandemic in realistic and thoughtful perspective. The authors appropriately label this unprecedented experiment "economic hara-kiri." The many dire effects will take a long time to work out. This book helps us understand what happened and what we might do to avoid repeat performances.

Compared with previous pandemics throughout history, the response this time was unprecedented, with several government mandates, such as lockdowns, wearing face masks and what I call "inverse quarantines" (healthy, not sick people, quarantined and locked in), without evidence that these measures would be helpful. The subsequent immense disruptions in jobs, education, commerce, medicine, and normal social functions cost many lives and other damages, vastly outweighing possible benefits.

Worldwide and locally, the people that could least afford it were the worst hit, as usual, again more by the panic than the virus. Number-crunching here is fraught, but tens of millions of people lost their jobs, more than 40,000,000 according to the new-jobless-claim-bean-counters. Even in healthcare, more than 1,400,000 people lost their jobs. The "executive director of the United Nations World Food Programme predicted that shocks to food supply chains could lead to 300,000 deaths per day."

As the authors report, the pandemic "models were wrong—way off—but they were wrong in [the] right direction. They gave politicians justification for taking over almost every aspect of citizens' lives. They gave the press clickbait galore. We're not assuming malice, here. We assume that many of these folks were moved by concern and even love for others. The issue is one of incentives and human nature, not bad intentions." Even so, "Political advisors took worst-case scenarios from highly uncertain models as if they were perfect. In the wrong hands, rough-and-ready tools became weapons of mass destruction."

Guidance goalposts shifted several times during the panic. For example, "The rampant spread of the virus, which the authorities had described as inevitable just a couple of weeks earlier, was now the thing to avoid." The goal of spreading out the inevitable and unpreventable infections over time morphed into the goal of wiping out the virus completely even though there was no known way to do so. The answer to the question, "to mask, or not to mask?" flip-flopped several times.

The idea to "flatten the curve" of COVID-19 hospital admissions was originally promoted to spread out the infections over time so hospitals wouldn't be overwhelmed with more sick patients than could be managed. This backfired when the measures adopted (e.g., prohibiting elective surgery, requiring healthy workers and businesses to "lock down") flattened citizens' lives and wallets more than the virus.

Panic proponents are even trying to change the meaning of words, e.g., a "case" has been redefined, now meaning someone with a positive test (false positives included) although asymptomatic, in addition to people seeking treatment.

There wasn't any evidence to suggest lockdowns would work. In the past, infected people were quarantined lest they infect others. The burden of proof that lockdowns would help should have been on the proponents, not the innocents. Countries with lockdowns suffered higher COVID-19 death rates than countries without lockdowns. Perhaps not surprisingly, the concept started as a high-school student's science project. The computer model was further modified, published, and adopted, without real-world testing or validation. Obviously, many important factors, such as the costs of job losses, social isolation, and common sense weren't adequately weighted.

Suicides became more frequent. Some credited Japan's policy against lockdowns with a 20% DROP in suicides, in marked contrast with increased suicides in locked-down countries. Also, panic about catching the virus apparently impeded many people with strokes from coming to emergency rooms, as stroke centers saw a "drop in stroke patients being treated, with decreases ranging from 50% to 70%." In addition, "Government was, in effect, rationing healthcare by fiat based on anticipated shortages." Even "when the shortages never came, and yet the restrictions continued."

In economic terms, how much did the COVID-19 panic cost, above the baseline costs which "would be costs of the virus itself plus a non-panicked response" such as the world has been through in previous infectious disease pandemics? Ballpark economic cost estimates of previous pandemics range from $10 to $100 billion. The COVID-19 response estimates start at $2,000 billion, 20 times as much.

Experts in various medical fields rarely have the experience or vision to balance the possible benefits and risks of various courses of public action in responding to pandemics against other possible uses of available resources. Accountable political leaders must "make the tough calls that require weighing competing interests and perspectives," the authors write.

"No one can master all of that. So we can only solve such complex problems with input from a wide variety of experts. It falls to our elected leaders to weigh their advice, mustering whatever wisdom and prudence they can." Inevitably, "we have to make choices, and every choice involves a trade-off. Anyone

who doesn't grasp this is not equipped for political leadership. Governing is all about making tough choices." The "tradeoff was never between filthy lucre and human lives. It was between lives harmed or lost from the viral outbreak and lives harmed or lost from our efforts to mitigate it."

We should have learned many valuable lessons. We need to pay attention to what we experience locally and not be blinded by global news-feeds. We need to balance expert advice with common sense, take care of the most vulnerable, take computer models and predictions with a pinch of salt, beware the overconfidence of experts, choose freedom over one-size-fits-nobody central planning, be cautious about traditional media, make social media accountable, and resist petty tyrants.

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***Overcharged: Why Americans Pay Too Much for Health Care,*** by Charles Silver and David A. Hyman, 555 pp, paperback, $19.95, ISBN 978-1-9442424-76-3, Washington, D.C., Cato Institute, 2018.

Public Service Announcement: If you are looking for a light, entertaining read, this is not the volume for you. However, if you are ready for a detailed, scathing review of the U.S. medical system and all its players, including the Patient Protection and Affordable Care Act (PPACA)—which the authors refer to by its common name, Obamacare—then you're in luck and should get this book in your hands. Its 500+ pages are full of well-researched arguments, more than 100 pages of which are references.

The authors do not pose the questions of whether Americans pay too much for medical care or whether the U.S. medical system has problems; these are given. Instead, the law professor authors set their thesis as early as the subtitle, and then reinforce it in the first sentence of their preface.

The authors go to the root causes of the state of current affairs in U.S. medical care. The first part of the book is titled "Problems Obamacare Should Have Fixed," and they touch on everything: political control of medical spending, third-party payment, enrichment of the medical sector at the expense of the rest of the economy, lack of transparency, and gaming the payment system by all involved: pharmaceutical companies, hospitals, public officials, lobbyists, electronic medical record systems, durable medical supplies, home health, nursing homes, hospices, physicians, and even patients. In other words, this book is filled with the awful truth that the high costs in the "medical industry" are multifaceted and deeply rooted. You will read of pharmacists watering down medications, the inflation of "average wholesale pricing" (AWP) of medications and supplies, cardiologists stenting patients unnecessarily, and obstetricians performing unnecessary Cesarean sections.

In Chapter 8, titled "Payment-induced Epidemics," you will read about something that may sound strangely familiar: hospitals widely coding secondary conditions for high reimbursements. Citing a study that was published in *JAMA*, they write: "Although admissions with a primary diagnosis of pneumonia fell from 2003 to 2009, hospitalizations with a primary diagnosis of sepsis and a secondary diagnosis of pneumonia rose by an almost equal amount." Why? The lead author of the study himself observed that "'there's a strong financial incentive for coding based on sepsis versus pneumonia' because hospitals get paid more [for] doing so." Hmmm. So, if hospitals get paid more for a certain secondary diagnosis, one might see an inflated number of admissions with that diagnosis?

Of particular interest to independent physicians, the authors feel that the reason why there are fewer and fewer of us is the tremendous referral base that hospitals get when they purchase practices and employ the referral base. "When doctors practice independently, anti-kickback laws limit what hospitals can do to reward them for referring patients. They cannot pay for referrals, whether directly or indirectly. But nothing prevents hospitals from ensuring future patient flows by hiring doctors or acquiring their practices and paying them handsomely. So that is what hospitals do. Once that happens, doctors send their patients to the affiliated hospitals for care." When hospital administrators claim that they lose money on primary care, realize they more than make it up in the referral base for ancillary services.

The crux of the matter can be summarized with this statement on page 340: "The health care cost crisis is a byproduct of the third-party payment system." In lucky Chapter 13, titled "Bad Business," one learns that incentives exist for poor outcomes. "Fee-for-service payment arrangements—the kind of payment arrangements that government encourages and that lobbyists for health care providers defend—reward providers for quantity not quality, including services that are unnecessary, ineffective, or even harmful."

Part Two of *Overcharged* is titled "Why Obamacare Failed and What Will Succeed." So, it is not all doom and gloom; these law professors have some conclusions that, if applied, should largely address the major problems. Understanding that "payers want health care to be expensive" (p 279) and that "the more expensive health care becomes, the happier payers are (p 280), they take on "Medicare For All," and—not surprisingly, considering the book is published by Cato Institute—conclude that 1) competition drives down cost, 2) hospitals don't like competition, and 3) the retail sector is 40–80 percent less costly. In other words, truly free market medicine is largely the answer, even for medication prices. "Having people pay for most medicines themselves would alleviate many of the abuses that pharma companies commit" (p 357).

Public Service Announcement #2: Nicely, both the Surgery Center of Oklahoma (in Oklahoma City) and Atlas MD of Wichita, Kan., are mentioned in Chapter 17 (titled "The Retail Sector Will Save Us—If We Let It"). I am pretty sure I shouted out loud "I KNOW them!" as I was reading. If you do not yet know them, you should.

Grab yourself a copy of this book, prepare to be depressed, but then refreshed, knowing that there are answers to the myriad of problems with the finest medical community on the planet, and that the answers are largely free-market solutions.

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