Health Care Systems And Local Cooperatives as if People Mattered

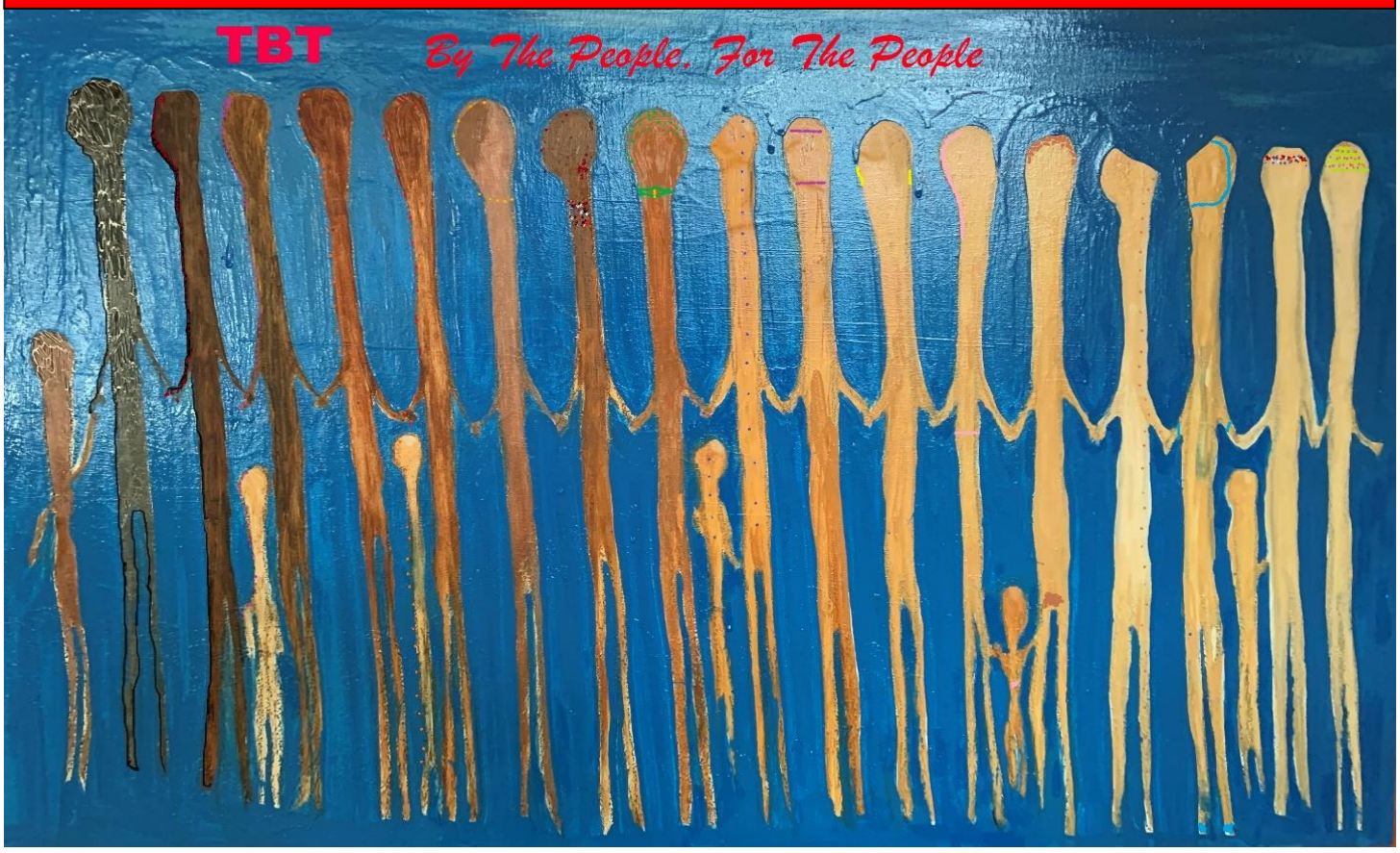
By

Don McCormick

with content contributions from

Tony McCormick, John McCormick

Blair Korndorffer, Michael McDermott, and Henry Ospitia



Health Care Cooperatives
& Complete Healthcare Systems

"This is the Evolution
People Want and Need"

By Don McCormick

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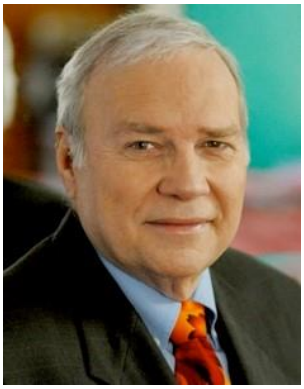


by Don McCormick, Director of Tomorrow's Bread Today (TBT)

TBT Entity started in 1994 and created Patient/Physician Cooperative in 2005

Incorporated Name: The Order of Love, Peace, Truth, Tolerance, and Cooperation,

DBA: Tomorrow's Bread Today (TBT) and Patient Physician Cooperative(PPC)

Charter Number: 01326463-01

Tax ID # 76-0446925 **Tax Exempt** 501(a) (1) under Section 501(c) 3 of federal income tax code

Extract: Exemption Letter from Department of Treasury

DLN 1705300903707

Membership

The Organization shall have members of both sexes, married and single, with or without families, in the following classes:

1. Permanent Community Members – People who govern the order and have a vow of poverty
2. Novices – People who are training to become permanent voting members
3. **Volunteers -People who share the burden of care and participate in health plans**
4. Guests of The Organization – People who are cared for by the Order

(Don McCormick is one of the 6 permanent members.

The expenses have been reported for 30 years in the 990s of TBT)

Contents

Foreword

This book seeks to offer guidance for the formation of local cooperatives designed to address fundamental needs in health, welfare, and self-governance. It is not merely a technical manual, but an invitation to reconsider the way we organize our societies—from the ground up, rather than relying on distant authorities. Central to this vision is a healthcare system where the locus of control resides with the patients and their chosen caregivers, rather than being imposed from above. Such a system, grounded in human-scale principles, is a manifestation of what could be called "economics as if people mattered." That phrase was taken from the economist, E.F. Schumacher's book, Small is Beautiful published in 1973. He was concerned about the exhaustion of nature resources but what he said was applicable to almost everything humans can to do cooperatively.

The activities essential to the flourishing of life—such as securing food, shelter, transport, education, and recreation—are, at their best, the fruits of local cooperation. As the essays, charts, and graphs within this booklet will demonstrate, these efforts arise naturally when people work together in mutual trust and respect, rather than as isolated, competitive individuals. The ideas presented in the first section are broad and foundational, followed by more specific discussions, which explore the power and potential of cooperation, trust, and mutual aid.

None of these concepts are new; they have been articulated by wise minds and proven in practice over generations. Small, resilient groups of people, often united by shared ethical or spiritual convictions, have shown how local, self-sustaining communities can endure the shifting tides of history, surviving oppressive regimes and unstable economies alike. These groups, diverse in age and gender, have spanned centuries and regions, often outliving the governments and economic systems that once loomed large over them.

Today, we live in a time of relative prosperity for many, but our economic and medical systems are increasingly disordered, leading to needless harm and suffering on a scale greater than many past wars, depressions, or pandemics. It is during such times that the need for humane, decentralized alternatives becomes more urgent.

We invite readers to engage with the ideas here, not only to critique or improve them but to join us in fostering a spirit of mutual aid and right action—principles that must underpin any sustainable future for humanity.

In the development of a cooperative health care system we have accumulated some positive experience which is in a slide show following the description of the foundation for the system. This experience is much better than has been done by either the public or private systems in the United States. It was dependent on the common monetary exchange and the sponsorship of employer groups and our Non-profit Association. If it had been done as we now propose, it would have had lower costs and better medical outcomes and less turnover of membership. We project the improvement to be about 25% less cost and a retention rate of about 90%. We are anxious to prove this is possible and an "economics as if people mattered."

TBT Patient Association

The volunteer members of TBT have made since 2005 and will make as needed "concierge" payment agreements between individual patient members and individual or group medical practice providers. Additionally, TBT Patient Association members purchase health care plans that are as limited or as comprehensive as they require to comply with the Accountable Care Act or any amended regulations. The purpose of these health plans is to fund the specialty and hospital costs that are beyond the funds available in the "concierge" payment plans with individual providers. The result for patients is to have all the resources needed to get health care without exclusions and for a price that is from 30% to 50% lower than current market costs.

Patients who are beneficiaries of Medicare, Medicaid, Employer Sponsored Trusts, or private insurance can combine the TBT concierge plan with viable health plans that pay for specialty and hospital services and the result is better access to care and lower medical loss ratios.

The main problem is about how to live a healthy life and not about how to trade representations of goods and services (fiat money) for health care advice and treatment. **Regardless of the outcry about excessive cost and bad outcomes in health care from the most knowledgeable people in our society, a top-down solution to health care problems has not worked**. The solution, if there is to be one, will come from the bottom-up, from the patients, their interconnections with each other and the inclusion of knowledgeable caregivers in small self-directed groups within each community. It is like the economic ideas expressed by E.F. Schumacher in his book, Small is Beautiful, Economics as if People Mattered.

TBT, which is our short name was incorporated in 1994 as **The Order of Love, Peace, Truth, Tolerance, and Cooperation.** The organization was inspired by Catholic Worker ideas and practices from our reading of the works of Dorothy Day and Peter Maurin. Dorothy Day expressed staunch support for cooperatives and often connected them to the Works of Mercy in her writings. As the co-founder of the Catholic Worker Movement, Day promoted a vision of society based on solidarity, mutual aid, and Christian personalism, where cooperatives played a vital role. She saw cooperatives as a practical means for fulfilling the social teachings of the Church and a way for people to organize their work and economic life in line with Christian principles.

Dorothy Day believed that cooperatives offered a more humane and ethical alternative to capitalism and large-scale industrialism. She often referenced the Distributist philosophy of thinkers like G.K. Chesterton and Hilaire Belloc, which emphasized small-scale ownership and cooperative forms of production as ways to empower individuals and communities and as an alternative to both capitalism and socialism.. In her view, cooperatives fostered personal responsibility, dignity in work, and a sense of mutual interdependence. She believed that through cooperative ownership and shared labor, the values of compassion, solidarity, and mercy could be lived out in a concrete, sustainable way. E.F. Schumacher, an economist who wrote Small is Beautiful, Econmics as if People Mattered in 1971 explained the Distributist ideas in enough detail to enable the creation of small medical cooperatives.

Trusteeship that can be seen clearly by the Trustor

Premises

1. Most healthcare services are less than the cost of other household expenses such as rent and food and transportation.
2. They can be included in the family budget in the same way as these other household expenses.
3. Common medical costs that fall within this type of budgeting are:
    a. Primary Health Care
    b. Lab
    c. Diagnostic Imaging
    d. Prescription Drugs
    e. Telemedicine
    f. Patient Advocacy
    g. Legal Defense against excessive charges and billings
4. Each of these services is available via direct payment agreements with each type of provider using retainer contracts and a monthly retainer payment system.
5. When these services are funded by insurance it increases the cost by 40% and delays payments and increases the administrative load of the practices and encourages false reporting of prices and procedures. Deductibles, Co-insurance, Quality Reporting, and managed care do not and have not corrected this problem.
6. Medical and Surgical expenses which are beyond the means of most people in their household budget allocations are:
    a. Hospital Charges
    b. Surgical Charges
    c. Complex treatments for diseases and injuries
    d. Long term management of disabilities
7. These expenses require both financing and cost sharing, which lending is not usurious nor are the claims funds be a profit center. The financing should be structured like a credit union among the members and the claims funds a mutual insurance pool in which the projected premiums that cover claims, claims expenses, and accounting are within the trust funds of the members to mitigate cost increases and lower premiums if projections were too high. There is no place for Profit Taking in a shared claims and claims expense fund of patients. The large employer groups have demonstrated that in the use of ERISA Trusts for funding of their health plans. Well managed plans of this type have equaled or bettered the experience of countries that have national health plans which have costs that are half of the cost experience of both public and private insurers in the United States.
8. There are no legal barriers to anyone having a plan that is structured on these premises.

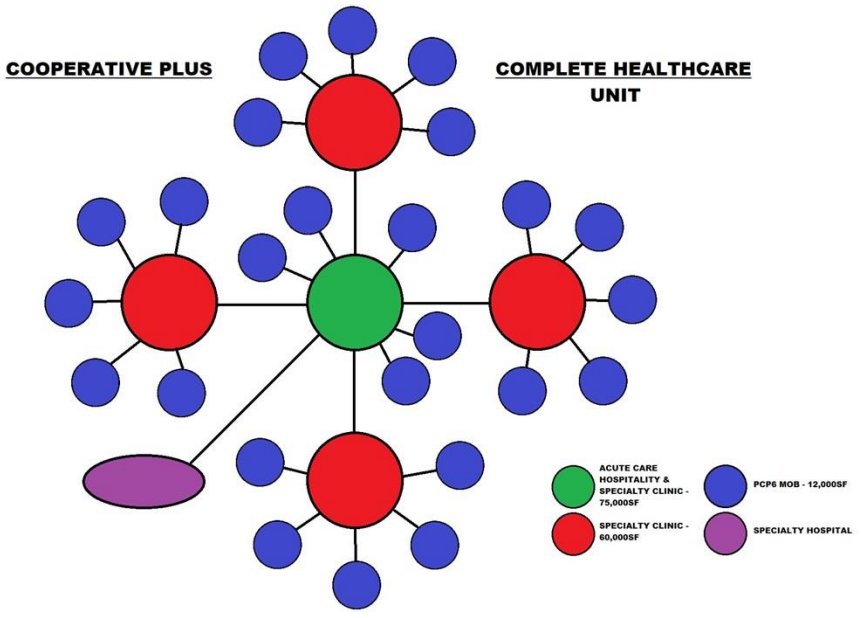
Process for creating the healthcare plan based on these premises

1. You must have a group of individuals who want to participate in a local healthcare program and are willing to pay directly for services listed in premises under #3.
2. This group should be in a specific geographical location relative to the Primary Care Services offered.
3. The Geographical location should have about 3,000 households to make possible the 300 needed to sustain a medical cooperative. In densely populated urban areas the number of households is within a radius of 1.5 miles from the center of a neighborhood. In the suburban areas the radius is about 5 miles and in rural areas about 25 miles. They must be helped to self-organize in order have the kinds of health care services their members will require. Such help will come from TBT and the selected Medical Care Practices.
4. The organizational effort must include comprehensive healthcare evaluations of each person so as to define risks and design the direct services, the financial structure, and the mutual insurance agreements.
5. Teams of volunteers must be trained in basic nurse's aide skills within each local group to responds to the acute and chronic needs of each individual within their Primary Group.
6. The ultimate size of the local group will be about 300 households but the initial requirement is about thirty adults to begin the local cooperative. Plan for a one-year development.
7. The role of employers and entitlements in this type of healthcare plan is to contribute to payments for services and insurance premiums as part of their payment for the labor of their employees. The Patient Association is the plan sponsor and administrator. While the plan can fall under the ERISA model, it is one in which the patient members participate democratically and control the trust and trustees and the plan design.
8. The retainer contracts are already in place or will be done by the patient physician cooperative (PPC) for the benefit of each member and represent the present cost of all the listed services (Premises #3) which can be in the household budget of each member. Such benefits are currently an out-of-pocket expense in the majority of employer sponsored and government healthcare plans.
9. The Stop Loss Coverage is in place through PPC from an A excellent rated national reinsurer at a cost of about $60 PMPM and covers 100% medical and hospital expenses excess of $50,000 per year per member to an unlimited amount without exclusion of preexisting conditions.
10. The cost gap to cover claims between the services that are paid directly by the retainer agreements and those that will be in excess of $50,000 paid by the stop loss reinsurance can be handled by either saving and borrowing or by gap insurance. The saving and borrowing method can be done without any usury and is the least expensive way to cover that expense. It can also be pooled and put into an insurance policy but such a tool necessarily cost about 20% more because of required reserves and administrative and claims expenses. The members will have a choice of methods.
11. The program is about transparency and trusteeship, which should be the essence of anything done for the benefit of others.

Development of the Delivery System from the Basic Unit to the Whole Community and Provider Group

The following power point presentation is of an orderly development of a complete health care system that will serve an enrolled population of 150,000 individuals. It begins with the basic unit of a Patient Centered Primary Care Practice of 1,000 and grows to serve 150,000 people with all the facilities needed.

Development of Complete Healthcare System
completecareppc.com



Basic Unit of Health Care – Patients and PCP

Patients Choose PCPs

1. Patient knows a PCP and has contact number.
2. Patient needs recommendation for PCP that fits their health care needs.

Health Evaluation

1. Comprehensive medical history including patient's own descriptions of problems.
2. Examiner's notes and comments recorded.

Patient Notebook

1. PCP named and contacted by Patient Advocate.
2. Referral list created.
3. Financial Plan Designed and enabled with all support information shown.

First Encounters

1. Patient Advocate sets up PCP Annual Exam and delivers patient created Medical Record.
2. Patient shares medical records with referred providers.

PCP Practice Composition

Patients Pay Monthly Retainers

1. Patient agrees to monthly retainer payment from Cooperative directly to practice via card, draft, payroll deduction.
2. Retainer is adjusted annually based on agreed published fee schedule.
3. Term is annual.

Practice Capacity

1. Assuming a workload of 20 patients per day and 4 visits per year average over 250 days the capacity is 1,000 patients
2. Based on fees and average gross incomes of PCPs of $420,000 that would require a retainer of $35.00

PCP Types are based on Patient needs

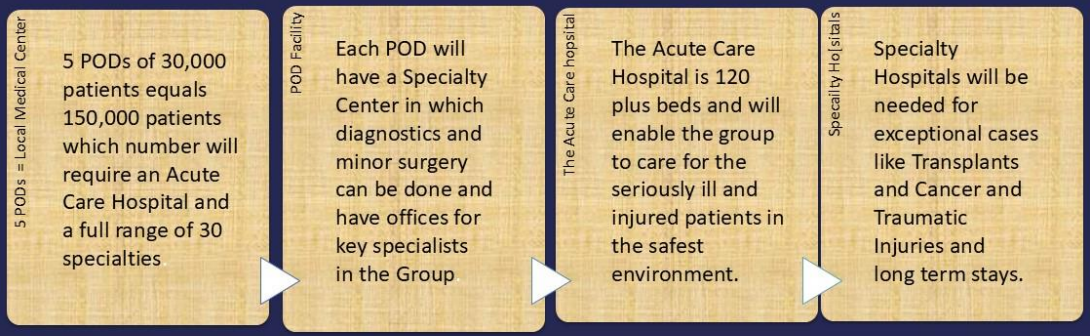
1. Usual PCP types are Family Practice, General Practice, Internal Medicine.
2. Physician Types that serve as PCPs include M.D.s, N.P.s, D.O.s, M.A.O.Ms, and Naturopaths

Team Participation

1. There are usually thirty PCPs serving Populations of at least 30,000 and are often in the same neighborhood
2. These PCPs will need the support and help of at least 11 core specialists to resolve their patients' problems

Provider Owned District (POD)

Local Medical Center and Specialty Facilities



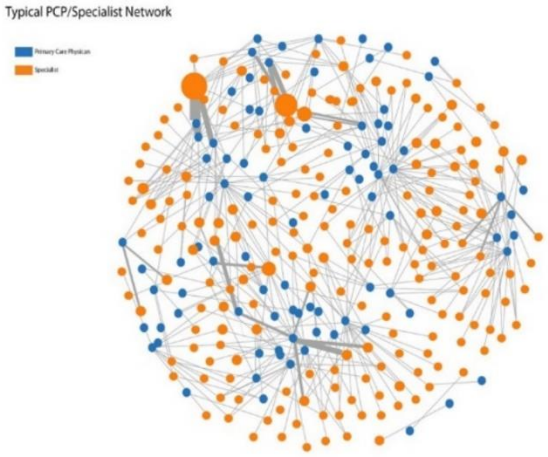
National Network of Key Support Services

Several Services that are key to the delivery of health care are available on an economical prepaid basis in every state. These include:

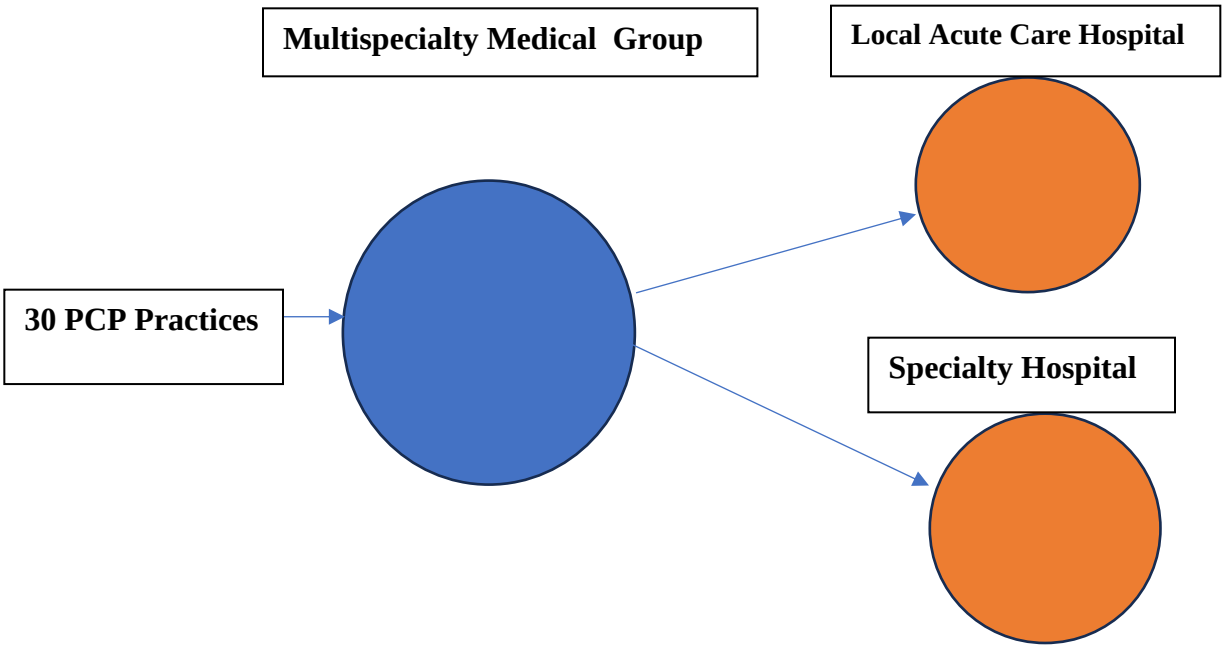
1. Reference Laboratory
2. Telemedicine
3. Pharmacy
4. Mental Health
5. Discounted Dental and Vision
6. Stop Loss Reinsurance

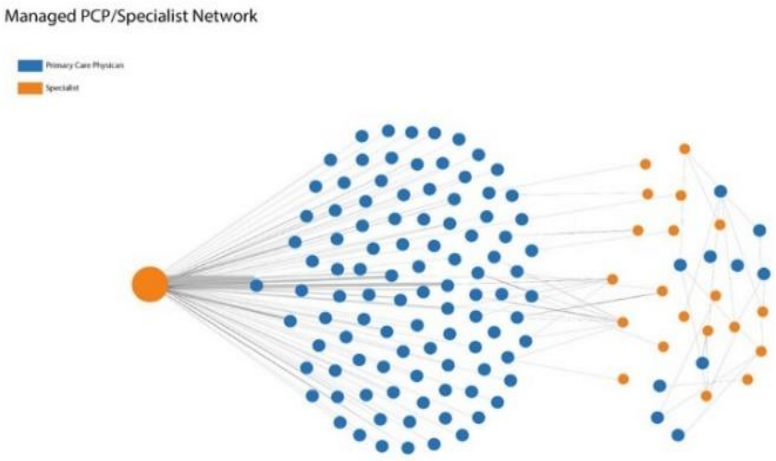
The combined cost of these services is far less than the cost when they are bought separately by groups or individuals. Consequently, when any are sold the marketing and administrative load is about 50%. People who are not in large group health plans that include these services at cost are unable to afford both insurance and these benefits. Often groups and individuals buy these services and fail to purchase basic health care and comprehensive health insurance coverage. Bundling them at wholesale is a way to reduce overall healthcare and health insurance costs as much as 40%.

Disorderly medical provider network usually seen in communities



An Orderly System of Relationships in Delivery of Medical Services





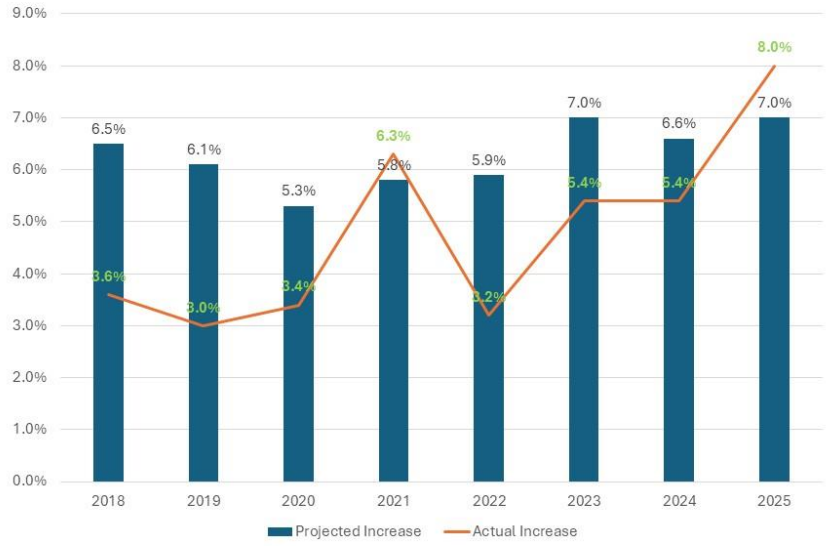
TBT Health Plan Experience Since 2018

The Difference

Healthcare costs continue to rise, and the monetary risks are consistently being shifted from the insurance plan to the plan member through plan designs that put a first-dollar burden for care on members, not carriers. These high-deductible plans offer catastrophic coverage but not the front-line care needed to keep people healthy and out of the hospital. Plans offered through TBT offer a combination of care and coverage and remove the additional burden of deductibles and coinsurance that put so many people into unexpected medical debt.

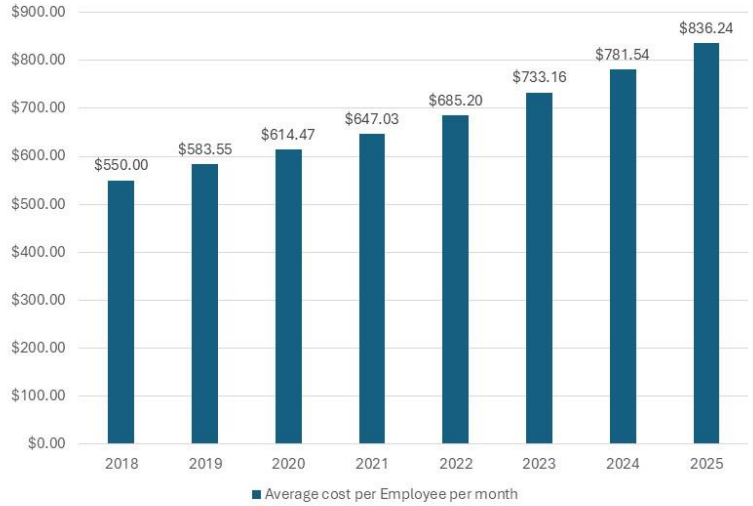
In the following slides we explore the market costs for healthcare and can track the rising costs from 2018 through the projected costs of 2025. We compare these rising costs and reduced benefits with the performance of sample groups managed by PPC through their Ovation Health product. Where the costs have remained very stable and there has ben NO reduction in plan benefits.

Health Care Cost Continue to Rise with a projected 7% increase for 2025



Data for 2018 to 2024 from a study conducted by Mercer reporting for employers with more than 50 lives. The actual rates are due to plan modifications driven by increasing deductibles, raising coinsurance percentage, copays, and maximum out of pocket exposure for the plan members
2025 Projected data is reported from Peterson-KFF that tracks the ACA marketplace. Actual increase reflects a limited sample of quotes from major carriers across the broader employer market this rate may adjust Downward as plans are modified to reduced rates and benefits for employer plans.

Rising cost translated to monthly premiums paid by the average employee for a Platinum Level Health Plan

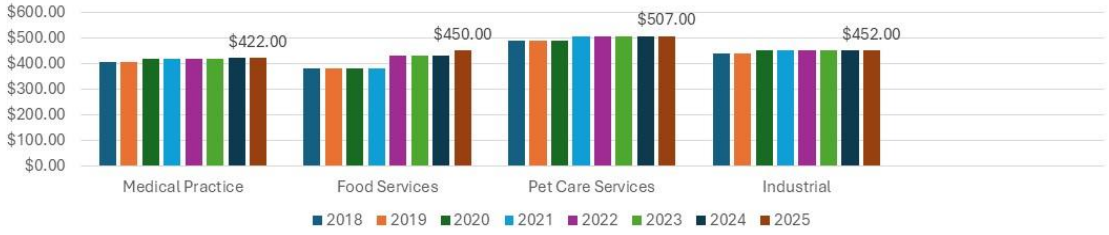


Data derived from market costs for platinum level health plans with zero or very low ($1,500) or less deductibles. Chart assumes no reduction in benefits year to year.
As noted on the previous slide employers have managed the rate increases by reducing plan benefits

Employers using commercial carrier retain no benefit for the good performance of their plan. Any savings realized from reduced claims become part of the commercial plans' profits

Ovation Health Platinum Plans

Self-Insured Plans – Monthly Premium Rates over time



Average Number of Employees Per Year

Funds currently retained in Trust Account by Group (Oct 2024) – Average Medical Clams cost per employee from 2018 to 2024 is $1,968.42 per year
Medical Practice - $490,141.79
Food Services - $20,570.07
Pet Care Services - $76,203.69
Industrial - $101,008.23

Data derived from actual costs for platinum level health plans with deductible and zero coinsurance
Employers using self-insurance retain funds in their trust to off-set premium increases while maintaining Platinum level benefits
Under the Ovation model group plan performance does not increase the profits of the TPA – funds are retained for the benefit of the employer/employee

Economic Barriers and Unnatural Links to Health Care

The relationship between economics and health care is a profound and complex one, which cannot be mended within the brief span of a human lifetime. Both fields, at their core, are slow, evolving processes shaped by the deliberate accumulation of knowledge and the persistent work of many generations. Yet, both have been hindered, not only by the slow progress of science but by the perpetuation of outdated ideas—entrenched by cultural norms, laws, and institutions that often resist change.

Still, hope remains. Progress, although gradual, is possible. The errors of the past can be corrected, both through the methodical inquiry of science and the expressive, often intuitive revelations of art. Science, rooted in doubt and experimentation, mirrors the efforts of practical individuals who, through patient exploration, discover what works. Art, on the other hand, vividly portrays the missteps and contradictions of human society. Together, they offer us the tools to reshape our world—but only if we begin at the level where life is most tangible, where relationships are personal, and where the functions of each part of the whole are understood and respected.

To reform both economics and health care, we must shed the baggage of outdated ideologies like capitalism, socialism, and communism. These 19th-century constructions have led us astray, imposing abstract systems on a world that operates at a human scale. In health care, the "assembly line" approach born in the industrial era has failed to nurture the personal relationships between patients and caregivers that are essential for true healing. The exchange of value between people must no longer depend solely on money—coins, paper, or electronic signals, which are merely symbolic representations of labor and resources. Instead, we must rediscover more humane forms of exchange.

History has shown us that all monetary systems, no matter how cleverly designed, eventually collapse. This cycle of boom and bust has left us with too many images of bread lines and too few of shared abundance. The global health care systems are tied to these failed economic models, making it difficult for many—especially the poor and marginalized—to access the care they need. While the privileged few, insulated by stable employment or government protection, may navigate the system with relative ease, nearly half of the population—those employed by small businesses or working in informal sectors—withstand the worst of this inequity.

When money becomes the primary means of settling all human affairs, those who control it dictate the priorities of society, including health care. The system becomes a trap, focused more on extracting wealth than on fostering healing relationships between caregivers and patients. This predicament has no easy solution, as the skills and knowledge required for medical care remain concentrated in too few hands. Furthermore, the medical profession itself is not immune to error—despite centuries of progress, harm is still caused. This is why the ancient medical oath begins with the directive, "First, do no harm."

To overcome these challenges, we must embrace a patient and practical approach. This includes advancing the science of medicine, improving step-by-step learning, and ensuring that more people are equipped with medical knowledge and skills. A promising step is to teach the basic

principles of anatomy and physiology from an early age, alongside reading and writing. While there will always be resistance from those who cling to outdated beliefs, it is crucial that we challenge the cultural and legal barriers that have kept such knowledge from being widely shared.

Our task is a long one, for human life is too brief to fully reform the economic and medical systems that now cause so much suffering. Both are rooted in intellectual arrogance and elitism—qualities that have no place in the natural, cooperative relationships of families and communities. It is in these close, personal circles that we see the truth: no individual can hide their ignorance or their need for help. This humble realization, that we are all interdependent, must guide our efforts to create a system where both economics and healthcare serve the needs of all people, not just a privileged few.

We can, of course, bring order to chaos in specific moments and places, much as nature itself does. But the chaos in economics arises from the abstract, artificial systems of exchange that distance individuals from one another. And the chaos in medicine stems from its entanglement with these very systems, as well as from the lack of medical knowledge among the general population. Even the most basic nursing skills are absent from many communities, despite the fact that they could be easily taught in small, cooperative groups.

This chaos benefits only a select few, creating monopolies of knowledge and power that hinder progress in both medicine and economics. Yet, the history of medicine shows us that reform is possible, if only we prioritize education and separate the practice of healing from the failed economic theories that have plagued us for centuries. Ignorance and abstraction should not dictate our future.

Having outlined the problems, we must now consider a path forward. The solution begins with each individual taking responsibility for their own health care while learning the science and art of medicine. Families and communities should form small, self-reliant groups—cooperatives that are independent of external medical and economic systems. These groups, united by mutual trust and shared purpose, should avoid monetizing the help they provide to one another. Oddly enough, such small groups can often solve their own economic and medical issues more effectively than larger organizations.

The steps are simple but profound:

1. Take charge of your own health care, learning the skills and knowledge necessary to maintain it.
2. Choose your medical team freely, selecting caregivers whose skills match the needs of your community.
3. Avoid opaque, profit-driven systems that hide prices and services. Instead, build transparent relationships with providers and arrange care in advance.
4. Keep detailed health records for each member of your group, ensuring that everyone has a personal advocate within the community.

5. Refuse to pay retail prices for medical services that come with exclusions and hidden costs—demand clear agreements on services and prices.
6. Above all, be together, learn together, and teach your children the importance of cooperation and right action.

This is the beginning of true reform. By coming together in small, supportive groups, we can transcend the limitations of the current systems and create a future where both economics and health care are once again human-centered, rooted in compassion, and aligned with the natural order of life.

A Low-Income Family's Struggle to Budget for Health Care

The cost of health care in the United States has spiraled far beyond control, driven by forces detached from the realities of those who use or provide these services. The issue lies not in the predictable aging of the population or even the diseases we face but in the unchecked technological escalation and an underlying societal belief that medicine can conquer death. The medical industry, much like other sectors of the economy, has become prey to a singular economic model that disregards the needs of the many for the enrichment of the few. What is needed is not merely policy reform but a complete rethink of our approach to health care, one that centers the well-being of individuals and communities over the pursuit of profit.

Our society has been led to believe that private insurance markets, shielded under the banner of free enterprise, will somehow provide affordable care for all. Yet, millions are left without insurance, unable to afford the costs despite the illusion of choice in the marketplace. For those struggling to make ends meet, health insurance is either perceived as a luxury or priced out of reach, even when artificially reduced by competition. Consider the example of a family earning $60,000 a year—already below the average in many areas. Their annual expenses, from housing to food, utilities, and transportation, leave just $3,000 for everything else. Health care, as it stands, costs at least $16,000 for a family of four—five times what they can afford. This stark discrepancy illustrates a simple truth: the free market has failed to address this fundamental human need.

Health care, like food, water, and shelter, is a necessity. It must be viewed as such if we are to create a society that thrives. To solve this issue, we must embrace cooperation at the community level. Local groups can pool resources and reduce costs in a way that no national insurance company or hospital conglomerate ever could. Housing, food, utilities, and transportation—expenses that consume over $37,000 of the family budget—are areas where communities can collaborate to reduce costs. By coming together, local cooperatives can save families between $12,000 and $15,000 annually. Applied to health care, this cooperative approach can reduce costs by 20% to 30%, making the impossible suddenly possible.

Take, for example, a cooperative health plan in Houston, Texas, where families pay a fraction of what they would through traditional insurance. With monthly costs for a family of four totaling about $1,085, the annual expense is just over $13,000—far more manageable than the $24,000 average cost reported across the country. By spreading risk and pooling resources locally, families can cover their health care needs, including catastrophic insurance, without facing crippling out-of-pocket expenses. And for those earning less, a small subsidy from within the cooperative ensures universal coverage, demonstrating that care can be extended to all without relying on the "magic" of the free market.

But this is only the beginning. Cooperatives offer more than just financial savings; they enable communities to regain control over their own health. Instead of being passive consumers of overpriced services, individuals become equal partners with their doctors, participating in decisions about their own care. The size of the cooperative—300 households, in this case—creates a balance of scale that allows for efficient management, strong relationships, and clear communication. As Schumacher rightly said, "Small is beautiful." In health care, as in economics, the human scale matters most. It is only by building at this scale that we can hope to create systems that are responsive, resilient, and rooted in genuine care.

The conventional methods of predicting and controlling costs through insurance companies and government regulators are fundamentally flawed. They are based on aggregate data from large populations, reducing individuals to numbers. A better approach is bottom-up budgeting, where the needs of each household in the cooperative are assessed individually. This requires time, attention, and trust—qualities that cannot be replicated by a phone app or outsourced to a faceless bureaucracy. By understanding the unique needs of each family, we can create tailored health care plans that meet real needs, rather than arbitrary benchmarks.

Health care costs in the United States are inflated by waste, inefficiency, and greed. In 2023, the average cost per person exceeded $11,500, with much of that money disappearing into the pockets of insurers and administrators. By contrast, cooperative models—grounded in community and trust—offer a far more sustainable path forward. Managed care plans in Texas have demonstrated that, with moderate price controls and a commitment to transparency, costs can be cut in half. This approach, scaled up through community cooperation, would bring the U.S. in line with the rest of the developed world in terms of cost and outcomes.

It is time to move beyond the failed promises of the market and embrace a new model of health care based on cooperation, community, and sustainability. In doing so, we can achieve what the current system never will: universal access to care, financial security, and a healthier society.

Why We Must Embrace Cooperative Health Care: A Declaration

1. Achieve universal medical benefits without the delays of politics.
2. Equal ownership and responsibility shared by patients and doctors alike.
3. Empower individuals to take charge of their own health care.
4. Create the most comprehensive and affordable plan in the nation.
5. Halve the cost of care while improving outcomes.
6. Reinsure through top-rated international insurers for security.
7. Allow patients to tailor their care teams to their needs.
8. Eliminate hidden fees and surprise charges.
9. Pay providers fairly through transparent agreements.
10. Maintain a simple, personal directory of trusted providers.
11. Cut out intermediaries who siphon off savings.
12. Foster values of love, peace, truth, and cooperation.
13. Prioritize education and support for long-term community health.
14. Ensure all costs and benefits are shared openly.
15. Guarantee that all benefits remain with the members.
16. Cut the waste and greed that inflate today's health care costs.
17. Regulate prices and usage through voluntary agreements.
18. Build a system that serves people, not profits.
19. Stop the insanity—work together and do the right thing.

In Schumacher's words, small, localized solutions are the key to true sustainability and well-being. We must build systems that prioritize people, not profit, and health care is no exception.

Patients: The True Stakeholders and Healers in Health Care

In our current age, many lay claims to the title of "health care provider," but few truly fulfill this role in the most meaningful sense. To understand who provides health care, we must first recognize who does not.

Insurers, though they manage the flow of money, are not providers; they are stewards of capital, driven by the imperatives of finance. Hospitals, while essential as physical structures, are not providers; they are places of maintenance, machines of administration, often beholden to profit. Pharmaceutical companies and equipment manufacturers, too, are not health care providers; they are inventors and merchants, engaged in the sale of goods, navigating the currents of the market.

True health care providers are those who have committed to the art and science of medicine—but even they, doctors, and nurses, cannot truly provide care unless invited by the most essential stakeholder: the patient. It is the patient who is the real provider of care. Whether through ignorance or wisdom, the actions of the patient determine their well-being. No amount of expertise or technology can replace the patient's unique role. Before any medical intervention is sought, before any diagnosis is given, it is the patient who lives with and responds to their condition.

In order to fix our broken health care system, we must first turn to those most deeply invested in it—the patients themselves. The power to heal, to improve, to prevent suffering, rests primarily with the individual. Health care is not something that can be delivered top-down from institutions or imposed through abstract policies. It must arise from the understanding and actions of each person, supported by the wise counsel of trusted advisors.

But to cultivate this understanding, empathy is required—not just from the professionals, but from all of us who live in bodies that are, for now, able, and functional. The real solution to our healthcare crisis lies in the wisdom and foresight of those who are not yet suffering. We must learn from others' experiences and apply that learning to our own lives. This is not naïve optimism. Some will neglect their health, some will succumb to long-term self-destruction, while others will tend carefully to their bodies despite all the negative influences surrounding them. The way forward is to observe what allows others to live well and to incorporate those lessons into our own lives.

Empathy, however, is not easy. It requires more than fleeting compassion or superficial understanding. It asks us to put ourselves in the place of those who suffer—imagining not just their present pain but the possibility of our own future suffering. The wisdom we need is to prevent that suffering by acting now, by cultivating a paradigm of health in our daily lives. As patients, we are the healers. We alone are responsible for our bodies, for the thoughts we think, for the relationships we cultivate, and for the actions we take. In this self-awareness, we see our own limits, and it is from this place of humility that we invite healers and advisors into our lives.

The key to a functioning health care system is to begin with the patient. Gather the patients, those who are the true stakeholders, and let them invite the professionals into their circle. The role of hospitals, insurers, manufacturers, and governments must be secondary—tools and

expedients that serve the needs of the patients, not the other way around. Whether resources are vast or meagre, it is the patient's life that must take precedence. Funding, equipment, and buildings are mere means to an end. It is not these material things that matter, but the lives and well-being of the people they are meant to serve.

We are all patients, each of us temporarily able-bodied, moving through life in a state of flux. Buildings, machinery, pharmaceuticals, money, and government are not patients. They are conveniences, mechanisms that support, but never replace, the vital role of the individual. If we are to rebuild our health care system, we must remember this truth: the patient is at the heart of all care. It is their life, their choices, and their understanding that shape the future of health.

Health care, like all systems, must be designed on a human scale—one that centers the individual and recognizes that the solutions to our deepest problems come from within, through cooperation, understanding, and a respect for life in all its forms.

A Local Cooperative

A starting point for a local cooperative that wants to establish a health plan can be created. It must include everyone that wants to be a member, have no pre-existing conditions exclusion. It can use a direct monthly payment model for primary care, specialties, lab, and imaging and have a discount medical plan for pricing of products and services not included in the direct monthly payments. It can have association insurance that will cover about 90% of the first $50,000 in hospital claims and stop loss insurance the will cover 100% of the rest of the costs in both professional and hospital expenses.

1. One such plan is offered by an Association enabled through TBT, a 501c3 organization chartered in 1994.
2. The Direct Monthly Payment Agreement is with the Local Multi-Specialty Group and is built upon the choices of the members in their local area.
3. The Discount Medical Benefits are from are from national organizations and include Dental, Vision, Hearing, and Drugs, all of which are at 50% to 80% discount.
4. Retainer plans for core medical services with national networks for Lab, Drugs, Mental Health enable the local Multi-specialty group to deliver care to patient groups controlled by large employers and government plans.
5. Health Plans from sharing ministries and ERISA Group Health Plans cover the gaps between Retainer programs and Association's Stop Loss coverages.
6. The Stop Loss is from an A-Excellent rated national company.

There are no deductibles and some small copayments in the plans, but a member could have out of pocket expenses if they use providers that do not have advance agreements with the Cooperative at prices close to the Medicare rates. The Patient Advocates in TBT work out the payments and prices with the providers for the members and have been doing so for many years with success in getting the fair prices for members. Other local cooperatives and sharing ministries can do the same kind of plans in the current market.

Peace, Cooperation, Equality, and Freedom: Building Society on a Human Scale

Our world, for far too long, has been dominated by hierarchical systems that elevate a few to positions of control while the vast majority must obey and conform. Yet is such a top-down model of governance truly necessary? What if, instead, we imagined society as a network of small, human-scale communities, where peace, cooperation, and equality are not merely ideals but lived realities? What if decisions could be made by individuals, acting freely, yet in harmony with one another?

In the present era, governments are built like pyramids, with power concentrated at the top, flowing downward. This model, inherited from centuries of authoritarian rule, assumes that a minority—those who control wealth, institutions, or influence—should dictate the actions of the many. The result is that people are not truly free, but rather subjects, their lives shaped by commands from above. By contrast, a horizontal structure, rooted in self-management and mutual respect, would allow individuals to co-determine their lives as equals. No masters, no subjects—just people, cooperating to sustain life and build a future together.

True freedom and equality have been scarce throughout history. The great powers, whether ancient or modern, have relied on coercion and violence to maintain their dominance. Wars, oppression, and exploitation are the hallmarks of such systems. The dream of genuine self-rule, of local communities managing their own affairs, has always been present in human thought. Philosophers and visionaries like Thomas Moore and Michael Bakunin imagined societies where people could live without the yoke of centralized authority. Yet, these ideas were either dismissed as utopian fantasies or actively suppressed by those in power.

Thomas Moore's vision of "Utopia" presented a society without private property, where all lived in peace, poverty was unknown, and each individual governed themselves with moral integrity. It was a dream of a world free from coercion and violence, a world of harmony and simplicity. Likewise, Bakunin argued that even in the most democratic republics, the people are still oppressed—only now it is done in the name of the "will of the people," a concept often used to justify the actions of a ruling elite.

We may not expect to see Moore's Utopia or Bakunin's ideal society come to life anytime soon. Yet, the desire for a more peaceful and cooperative way of living is deeply embedded in the human spirit. Like newly hatched turtles, we strive to reach the sea before we are devoured by the predatory systems of modern governance. The path to a better world lies in voluntary association—in the free choice to cooperate with others, rather than being compelled by force.

True cooperation cannot exist where decisions are imposed by coercion. It arises only where people have equal say, where decision-making is a shared process. A society built on voluntary association offers the best chance for peace and prosperity. It stands in stark contrast to the mechanisms of power we know today—mechanisms that rely on institutionalized violence, whether through the police, the military, or the law.

History has shown us that democracy, as it is often practiced, is not the answer to our problems. Even the much-celebrated democracy of ancient Greece was exclusionary, limited to a select

group of male citizens. Modern representative governments, too, have struggled to embody the true will of the people. Elections may be held, but power remains concentrated in the hands of a minority—politicians, corporate elites, and party officials—who often act in their own interests rather than those of the broader population.

What we need is not just a reformed version of the same hierarchical systems but a fundamental transformation. Small, self-managed communities can take care of their own needs, make their own decisions, and live at peace with one another. These cooperatives, when organized on a human scale, are capable of providing goods and services without the need for top-down control.

Of course, no system is without challenges. Cooperatives, like any group, will face differences of opinion. But such differences can be managed through dialogue, mutual respect, and, when necessary, compromise. In some cases, minorities may defer to the majority for the sake of unity. In others, they may seek to establish their own cooperative, creating a diversity of approaches that enriches society as a whole. The key is flexibility, the ability to adapt to changing circumstances, and a commitment to the well-being of all.

In the end, what we seek is not an impossible ideal but a practical vision for a society rooted in the principles of Peace, Cooperation, Equality, and Freedom. This is not a call for endless meetings or bureaucratic stagnation. It is a call for action based on the belief that individuals, acting together in free association, can build a better world. A world where decisions are made by those who are affected by them, where power is decentralized, and where the dignity of every person is respected.

The struggle for a just society will not be won through violence or coercion, but through experimentation, cooperation, and the quiet but powerful work of building communities that reflect the values we hold dear. The future belongs not to the rulers, but to those who choose to live in peace and harmony with one another. Let us begin by organizing on a human scale, and let the world take notes. The solution to our societal problems lies in decentralization and the empowerment of individuals within small, self-sufficient communities. Peace, cooperation, and equality are attainable, but only when we reject the hierarchical systems that dominate our world and build from the ground up.

Development of a Private Healthcare System

In many industrialized countries, healthcare is seen as a public good financed through taxes and made available to all. The costs are shared across society, which leads to more equitable outcomes and often lower expenses overall. Contrast this with the system in the United States, where healthcare is largely driven by private insurance markets, and approximately 20% of the population remains without proper coverage. The result? A system that costs double compared to other nations, yet ranks last in terms of quality and outcomes, with medical errors accounting for an estimated 500,000 to 700,000 deaths annually, a figure unchanged for generations.

Faced with such inefficiencies, many societies throughout history have turned toward cooperation and mutual aid. These efforts have often succeeded where governments have not. Instead of waiting for flawed policies or market-driven solutions to deliver healthcare, people can build systems rooted in human values—systems where care is given not for profit but for the wellbeing of all.

To rely on the private sector alone for healthcare is a misunderstanding of what is needed. Businesses exist primarily to generate profit within a framework of monetary exchange. Healthcare, however, should be viewed not as a commodity but as a shared responsibility. The use of money, particularly when governed by state-issued fiat currencies, often reflects deeper power dynamics. The value of these currencies is tied to military strength, rather than to any inherent human need. But beyond this monetary system lies the possibility of what we might call a "human economy"—an economy where exchanges are based on mutual care and obligation, not debt or profit. It is an economy where, in the words of Jesus, we "render unto Caesar what is Caesar’s," but we also nurture the human connections that truly sustain life.

What we must build is a healthcare system based on these human principles, not on the dispassionate logic of market efficiency. A system rooted in mutual care will address the very human needs that the current for-profit system overlooks. If we believe in the power of human learning and cooperation, then surely we can develop a system where care is provided, not as a transaction, but as a shared social duty.

Healthcare is something that can be built from the ground up, and it starts with community. Small groups of volunteers can accomplish what large, impersonal systems often cannot—meeting the needs of those who fall through the cracks. A remarkable example of this is found in *Share the Care,* a book by Cappy Capossela and Sheila Warnock. It tells the story of how friends and family came together to support their loved one, Susan, through her battle with cancer.

Susan’s story is one of resilience, but it is also one of community action. Despite having medical professionals, she found that her friends—ordinary people—were her greatest source of strength. They formed what they called "Susan's Funny Family," taking over her cooking, shopping, and appointments, all while surrounding her with love and companionship.

This is not an isolated case; it is a model for how we can reimagine healthcare. It is practical, it is personal, and it requires no complex system, only the willingness to help each other. Such a

cooperative approach bypasses the limitations of profit-driven healthcare systems, focusing instead on human needs and connections.

Many families today find themselves in similar situations, caring for loved ones with chronic illnesses, injuries, or other long-term needs. Often, it is one or two caregivers shouldering the burden, leading to burnout. But what if we collectively organized to share this responsibility, creating volunteer groups that could help alleviate the strain on individual caregivers?

This model of cooperative care might be the key to a more humane healthcare system, one that serves people rather than profits. It is based on a simple truth: we are all, at some point, going to need help. The question is whether we will have a system in place—rooted in the values of mutual care, trust, and cooperation—that will be there for us when we do.

The following pages outline some practical ideas for setting up volunteer groups and cooperative healthcare systems. Let us explore how we can build something new—an approach to healthcare that recognizes the intrinsic value of human life and the power of community.

Summary of the Organization of a Medical Mission

1. Find Volunteers
    a. Patients (Temporarily Able-Bodied People)
    b. Health Care Providers (MDs, DOs, NPs, Oms, MAs)
2. Find people in need of care because of sickness, injury, or disability
3. Get the names and contact numbers for their friends and relatives
4. Hold a Share the Care meeting with the patient and their friends and relatives
5. Listen to the wants, needs and abilities of the patient and the potential volunteers
6. Make the lists as suggested by Share the Care
7. Train each volunteer in the basic skills needed for care taking
8. Elect a captain and co-captain of the group for each week of service rotating those roles among the whole group
9. Suffer wrongs patiently
10. Do what you can do and not more than you can do
11. Help others make groups by your witness and example
12. Do what you think is the right thing, always
13. Prayers can be aloud or silent, God hears in either case.

Cooperative Clinic

1. Open for primary care
2. Monthly retainer fees
3. Other income is from donations
4. One full-time equivalent physician can take care of 1,000 patients a year
5. Clinic is controlled by the patients and their providers

Medical Volunteers – A Cell Church Type Organization

In the New Testament of the Bible, there are several references to Jesus Christ performing various healing miracles, which could be seen as a form of a medical mission. There are numerous accounts of Jesus healing people suffering from various illnesses and disabilities, such as leprosy (Matthew 8:1-4), blindness (John 9:1-7), paralysis (Mark 2:1-12), and fever (Matthew 8:14-15). Jesus is reported to have raised several people from the dead, including Lazarus (John 11:38-44) and the daughter of Jairus (Mark 5:35-42). Leprosy was considered a severe and incurable disease in ancient times, and Jesus was recorded to have cleansed people with leprosy, restoring them to health (Luke 17:11-19). Jesus healed several blind individuals, granting them sight (Matthew 9:27-31, Mark 10:46-52). In some instances, people were reported to be possessed by evil spirits, and Jesus cast out these demons, liberating the afflicted individuals (Mark 5:1-20, Luke 8:26-39). These healing miracles were seen as signs of Jesus' divine authority and compassion, demonstrating his power over sickness, death, and the forces of darkness. They also served as a means to reveal God's love and bring hope to those who were suffering.

From a theological perspective, the primary purpose of Jesus' mission was not a medical one but rather to bring salvation and reconciliation between all people and God through his life, death, and resurrection. However, the healing acts were significant aspects of his ministry and helped illustrate the compassionate nature of his mission. All of the people have been and still are engaged in the struggle to live and avoid suffering and accept death and hope for some form of resurrection beyond faith and within comprehension. A way to continue the Gospel example is to help each other when the burdens of sickness and injury are too great to tolerate and require friends and family to share the burdens compassionately. There have been many examples of such medical missions in our time like those written about Jesus and his disciples and the people for whom they cared and loved. Calling these acts miracles may be a shorter expression of the good result about which the means was not understood. It is clear from careful studies of biblical writings that the men and women of that Era were no less intelligent nor less informed than people before their time and afterward, including people in the current century.

While the last 5,000 years of human history has been dominated by power struggles and attempts to control the way we exchange goods and services only a little progress has been made in the relief of suffering and extending the normal human span of life. In fact, in our time and place, commerce and the money exchange have made it more difficult to help each other when we become sick or disabled. In the last sixty years several systems for caring for each other have shown promise to relieve suffering and to restore the kind of compassion and love the Gospel writers have called miracles. The examples are among volunteer organizations driven by people who have been aware of their own temporarily able-bodied condition and of the need to help the sick and injured people near and dear to them. Some of these people have been family and friends and others have been strangers who stimulate your compassion and the desire for love.

Over the last sixty years, several volunteer organizations in the United States have been dedicated to providing healthcare services to underserved and poor populations. Some of these organizations and their accomplishments include:

1. Volunteers in Medicine (VIM): Founded in the 1990s, VIM is a network of free clinics staffed by volunteer healthcare professionals. It aims to provide medical, dental, and behavioral health services to individuals without insurance or access to affordable healthcare. VIM clinics have been successful in improving access to primary care for the uninsured, managing chronic conditions, and reducing emergency room visits.
2. Remote Area Medical (RAM): RAM was established in 1985 and offers free medical, dental, and vision care to underserved populations, including those in rural areas. The organization operates mobile clinics and hosts large-scale events providing comprehensive healthcare services. RAM has made a significant impact in delivering care to remote communities with limited access to medical facilities.
3. National Association of Free and Charitable Clinics (NAFC): NAFC was formed in 2001 and represents a network of free and charitable clinics across the country. These clinics provide a range of medical services, including preventive care, chronic disease management, and specialty care, to individuals without insurance or adequate healthcare coverage.
4. Doctors Without Borders/Médecins Sans Frontières (MSF): While primarily known for its international missions, MSF also operates in the United States. It provides medical care to vulnerable populations, including undocumented immigrants and refugees. MSF has been involved in responding to natural disasters and public health emergencies within the U.S.
5. AmeriCares: AmeriCares is a disaster relief and humanitarian aid organization that also provides medical assistance to underserved communities in the U.S. The organization offers healthcare programs to improve access to medication and medical services for vulnerable populations.
6. Community Health Centers: Federally Qualified Health Centers (FQHCs) and other community-based health centers play a vital role in providing affordable healthcare to low-income and uninsured individuals. These centers receive federal funding and are scattered across the country.

These organizations, among many others, have made significant contributions to improving healthcare access and outcomes for vulnerable populations in the United States. Their efforts have helped bridge gaps in healthcare services, reduce health disparities, and enhance the overall health and well-being of underserved communities. However, the NAFC clinics report that they served about 2,000,000 people in 2022 and FQHCs served about 10,000,000 and all of the organizations listed above served less than 5% of the total population. This means that volunteerism in our human economy compared to the commercial economy is not ubiquitous enough to improve health care, relieve suffering, and mitigate the extraordinary, inflated cost. **These non-profit organizations are so entangled in the fiat money of the commercial economy that has captured medical care that the power of grass roots health care and education of each other cannot be released.**

Something else is needed. It is **Cell Church Type Organization** (small groups of people [10-14] who work together as volunteers for someone else's health benefit). The Cells must be enhanced by medical education at the most basic skill levels. They must reenact what Jesus and his disciples did in their medical mission, hopefully without being tortured and killed. There are

two examples of which we are aware of **Cells** of volunteers in the human economy which have proven effective for medical missions that unburden the participants, relieve suffering, and demonstrate that love will work for the helpers as well as the sick, injured, and dying. The first was a hospital volunteer group started by Jan and Marjorie de Hartog in Houston in 1960s and the second was Share the Care started by Cappy Capossela and Sheila Warnock in 1990s. Both couples wrote very popular books which are a joy to read**, The Hospital** by Jan de Hartog and **Share the Care** by Cappy Capossela and Sheila Warnick. I quoted letters from Susan and Cappy and Sheila at the beginning of this paper. Both books are still available.

Before telling you what these great people did you should know a bit more about what we are facing in health care and why what they said is so important.

It is popular to say that health care is a human right but that thought is derived from a basic need for humans to cooperate with each other to survive. Rights are built on foundations of material and labor, love and respect for each other, honesty, and truth in relationships. It is difficult to impose a right on any group of people by fiat or force but it is even harder to deny that right when it is created by people in their labor, their sharing of material goods, their teaching each other skills, and their cooperation in the welfare of family, friends, and neighbors. Whether people in the such a "Gathering" are rich or poor is of no consequence in the creation of their rights. What matters is that every human being in a "Cooperative Gathering" is cared for and everyone who can provide skills and resources participates. People call it Love. God is Love.

The economic and political systems in which rights can be established are mostly matters of opinion, but those systems in which universal rights established by the participants are denied or become exclusionary are faulty. Capitalism and Socialism have manifested such faults and need not have major influence on the creation of a health care system by a "Gathering" of people who love and care for each other. "Health care for all" is built on "Cooperative Gatherings" in each community everywhere. It should be enabled by honest trusteeship of required resources which need to be shared between the communities. Presently, governments, State and Federal, in the United States have not been good examples of cooperation despite the desires of many representatives to change laws and regulations to make trusteeship and cooperation vibrant.

How are we to begin the transformation of economics and medical education so that it fulfills our health care wants and needs? Taking measures of what we see and feel is the starting place. Of course, you cannot measure anything without the right view and right intention. When there are preconceived material barriers to the collection of evidence then the right intention cannot be reached. We cannot exchange values for services and materials if the work that makes those values is determined by fiat based on mere consumption of unrelated goods and services. If you start a system with a price for something, then the margin sought will be distorted by exchanges in the general marketplace. You will never know by nature what you desire. Your senses will deceive you and change your work, the advice, and the cooperation needed for the right intention.

The medical community must be free of ideas from the 19th century which are grounded in capitalism and socialism. They must find joy "in doing the right thing always" with other people

who share their wants and needs in health care. No “fiats,” No “best practices,” No “predetermined rates of exchange” are needed. The material is already there. The energy for the work is in the group that gathers, and the exchange will be fair regardless of what it is because it will have been measured and watched and shared without waste and with the right view and right intention.

Some very smart people (“scientists” – in past centuries called “natural philosophers”) are certain that what humans do and say will not matter and that most people will not last beyond the next few centuries. But, like patients who have been told their time is short and nothing can be done to reverse death, humans will persist without regret. T.S. Eliot said, “I have known…the evenings, mornings, afternoons. I have measured out my life with coffee spoons, I know the voices dying with a dying fall….” So, the time humans have is not bound by great ideas but crowned by hope and the notion that life is suffering. Humans are here to relieve that suffering for as long as necessary because they “…have seen the eternal Footman hold [their coats], and snicker….”

Right View, seeing health care as it really is, gives prudence to the Gathering so that the members actions are appropriate to real situations.

“*This clear-eyed objectivity, however, cannot be achieved and prudence cannot be perfected except by an attitude of "silent contemplation" of reality, during which the egocentric interests of man are at least temporarily silenced…. Prudence implies a transformation of the knowledge of truth into decisions corresponding to reality…. Everywhere people ask: ‘What can I actually do?’ The answer is as simple as it is disconcerting: we can, each of us, work to put our own inner house in order. The guidance we need for this work cannot be found in science or technology, the value of which utterly depends on the ends they serve; but it can still be found in the traditional wisdom of mankind.”* **E.F. Schumacher.**

The health care financing systems in the United States do not enable people and patients to choose what they want, when they want it, and from whom they get advice, care, and treatments. These systems do not follow nature in having multiple pathways for communication and protection. They were not born of the step-by-step building of a living system which takes millions of years, but out of convenience for the United States economy that was under the stress of depression in the 1930s followed by wars in the 1940s and after. Health care financing was built on the premise that adults had enough information and education to make intelligent decisions about the values of the products and services they buy. Further, the products and services were deemed to be affordable and readily available, but the measure of that was the profit of the enterprise and not the health outcomes of the patients. The consideration that these systems were about the preservation of life, the complex interconnections between people, their labor, and their dedication to each other was set aside in favor of monetary exchange for profit. The consequences have been a poor economy, poor health, and unnecessary loss of life. While other nations have given health problems more attention in the last five generations for reasons of the economy, they have done only slightly better in health outcomes. The main problem is about how to live and not about how to trade representations of goods and services for health care advice and treatment.

Regardless of the outcry about excessive costs and bad outcomes in health care from the most knowledgeable people in our society, a top-down solution to the problems has not worked. The solution, if there is to be one, must come from the bottom-up, from the patients, their interconnections with each other and the inclusion of knowledgeable caregivers in guild driven self-directed small communities. People must be nudged into organizations that raise their level of understanding of medicine and leave them empowered to act in their best interest and economy. Health care providers are a likely class of people in this kind of guild/community to have a positive impact. However, these providers will be a subset of physicians and other non-physician providers; those who deal with both health and disease, acute and functional disorders and have an ardent desire to teach medicine and health maintenance to people in a comprehensive and reproducible way. There are many willing physicians and nurses to help. They need only be invited by patients willing to care for them. We are all "Temporarily Able Bodied," even our care givers.

In healthcare, there is some risk that patients will be hurt rather than helped. That risk is greater if the patient receives invasive procedures or is hospitalized. The statistics are appalling and reporting them in the press is avoided as much as possible. However, physicians and medical researchers have reported the problems in detail. It was even reported in USA Today in October of 2011 and in 2018 by Martin Makary, M.D., M.P.H., professor of surgery at the Johns Hopkins University School of Medicine. In an earlier report called, "Death by Medicine," Gary Null, Ph.D., Carolyn Dean, M.D. N.D., Martin Feldman, M.D., Debora Rasio, M.D., and Dorothy Smith, Ph.D. had this to say about the American Medical System:

A definitive review and close reading of medical peer-review journals and Government health statistics shows that American medicine frequently causes more harm than good. The number of people having in-hospital adverse drug reactions (ADR) to prescribed Medicine is 2.2 million. Dr. Richard Besser, of the CDC, in 1995 said the number of unnecessary antibiotics prescribed annually for viral infections was 20 million. Dr. Besser, in 2003, now refers to tens of millions of unnecessary antibiotics. The number of unnecessary medical and surgical procedures performed annually is 7.5 million. The number of people exposed to unnecessary hospitalization annually is 8.9 million. The total number of iatrogenic[induced inadvertently caused by a physician or surgeon or by medical treatment or diagnostic procedures are 783,936. The 2001 heart disease annual death rate is 699,697; the annual cancer Death rate is 553,251. It is evident that the American system is the leading cause of death and injury in the United States.

John James, PhD, formerly a medical advisor with NASA, published an article in Journal of Patient Safety in September 2013 that said the preventable adverse events in hospitals contribute to the deaths of 440,000 Americans each year. His report was based on data published by the Office of the Inspector General of the Department of Health and Human Services and data published in peer-reviewed medical journals. He included errors of omission (failure to follow guidelines), errors not apparent in medical records, errors of communication, and diagnostic errors. This estimate places the annual death rate from suboptimal hospital care as the third leading cause of death behind heart disease (650,000) and cancer (550,000), and well ahead of cerebral-vascular disease (160,000).

Below are some findings of Dr. James from published studies:

* It takes 15 years for a new medical discovery to be used by half the clinicians. Balas and Boren (2000) studied the average rate of increase in use of 9 clinical procedures based on landmark studies and found that the average rate of increase in use was 3.2% per year, thus 15.6 years were required on average for 50% implementation.

* It took 25 years (1982-2007) for cardiologists to bring the prescribing of beta-blockers to full use in heart patients that needed them to live.

* Cardiologists hide medical errors. An article surveying the professionalism of doctors by specialty found that almost 2/3rds of cardiologists admitted that they had recently refused to report a serious medical error that they had direct personal knowledge of to any authority (Campbell, et al., 2007).

* Medical records are of inferior quality based on a study of records on hospitalized heart patients. The grade using a standard tool was 62%-failing in most systems (Dunlay et al. 2008)

* The medical records of 1000 hospitalized patients were reviewed for medical errors and patients were interviewed about medical errors. Three times more serious medical errors were known by patients compared to the number recorded by doctors in medical records (Weismann, et al. 2008).

* Medical specialists are not required by any law to study or demonstrate competency in their specialty after their initial medical training. In Texas, the law requires 24 hours per year of continuing medical education, but there is no requirement that physicians take that in their specialty. The Texas Medical Board does random checks on 1% of physicians in Texas each year to determine if they have done any CME. Five states have no requirement for CME.

* The American Board of Internal Medicine gave lifetime board certification in cardiovascular disease until 1990. Cardiologists certified before that year have been grandfathered, which means they do not have to do anything to maintain board certification. In 2005 more than half of all cardiologists enjoyed this status as board-certified for life and refused to participate in voluntary maintenance of certification.

* The US ranks 19th of 19 developed countries in deaths preventable by adequate healthcare in persons under 75 years of age. Approximately 330,000 deaths occur prematurely in the US simply because of failures of the healthcare industry. The death rate in France [the best-performing developed country] is approximately half of ours.

* The first-year infant mortality rate in the US ranks 42nd of all countries as reported by the United Nations in 2009. There is no developed country with a higher infant mortality rate than ours. If our infant mortality in the first year of life were as low as that of Japan, then 16,000 more American babies would live each year.

* The rate of maternal mortality (death associated with childbirth) in the U.S. ranks us 39th among all countries of the world (Lancet, 2010).

* Patient safety is not improving – based on a report in the 24 November 2010 New England Journal of Medicine, the number of medical errors in North Carolina hospitals did not decrease from 2002 to 2007.

* The US health care industry costs us about twice as much per person as any other major healthcare system in the world.

* The Commonwealth Fund ranks states according to the quality of healthcare available to children. Texas ranks 46th among the states and DC in healthcare quality (Mitka, 2008).

We know from the data that death from medical causes has been persistent for the last generation and from historical reports that such causes can be attributed to prior generations too. If you count the deaths in the last 30 years from only the medical records that have been revealed it is more the ten million deaths. That is more Americans lost than in all the wars we have every fought, more than all the pandemics we have experienced. It is a leading cause of death as the writings quoted above have reported.

To change the course of this trail of tears we must heed the gospel of Matthew, *"Jesus went through Galilee, teaching in their synagogues, preparing the good news of the Kingdom, and healing every disease and sickness among the people…. He called his twelve disciples to him and gave them authority to drive out evil spirits and to heal every disease and sickness."* This was a medical mission which has not changed and the miracles of that era have been gradually revealed especially in the last three hundred years. He said, *"you shall know the truth and the truth shall make you free."* This problem is not economics, but an unwillingness on the part of those who have learned how life is made and sustained to accept their mission. The part of those who suffer is to support the education and work involved in healing themselves and their families.

The message in the street is that we need universal insurance, top-down leadership, laws that force excellent work, and penalties that keep everyone in line. **The counter argument** is that we need sharing ministries that help every member of the "club" pay for the health care they need if they are morally upright and financially responsible. **The reality** is that medicine is a money machine which performs most of the time for about half the population and very well for the money handlers. These popular opinions are not a medical mission that will work.

We must do the work to save lives and relieve suffering despite greed, ignorance, lying, cheating, and lack of cooperation and faulty 19th century economic ideas. It is a slow walk, hand in hand, away from the marketplace where Jesus turned over the tables of the money changers. Dorothy Day would have done it. Peter Maurin told us how to do it. **"***I want a change, and a radical change. I want a change from an acquisitive society to a functional society, from a society of go-getters to a society of go-givers***."**

The energy, the means of exchange of values for goods and services, and the medical skills are all available within small communities in the United States. We tap into them every time there is a crisis. There is no reason we cannot cooperate in advance and turn education, health care, and exchange of values into trusted and practical relationships. We can be impertinent enough to not ask for a miracle to cure a blind man, but to discover what Christ knew about the medical

problem and what was in dirt and spittle that cured his patient. We must discover the basis of what we are doing and chase the money changers from the temple. Gather, learn, teach, do the work, make sure no one is suffering in any way.

We can become **Volunteers** within the practices of the care givers of each small group of people who want to express their love and show their support for learning and the relief of suffering. We have had a splendid example in the work of Jan and Margorie de Hartog in the 1960s.

About The de Hartog Medical Volunteers

In medical oaths taken by physicians and nurses and in the charter of most hospitals the organizers agree to accept everyone who needs medical or surgical care unconditionally. These types of care givers must have community support in all of the usual ways from government, private companies, individuals, and charities. However, volunteer labor is more important to how well the medical and surgical service providers perform than the usual monetary sources of support. Such labor includes Physicians of every specialty, Nurses of every type, Nurse's Aides, Orderlies, Housekeepers, Mechanics, Administrative Assistants, Cooks and Servers, Trades persons of all types, Teachers, and Fund Raisers.

In charity hospitals about 30% of the total budget of a medical system is dependent on volunteers because people do not yet have governments anywhere in the world that are inclusive of everyone and protective of every environment. This is true of clinics and private practices as well. This 21st century is still that of the Via Dolorosa (the route believed to have been taken by Jesus through Jerusalem to Calvary) and acts of charity are our main tools for the relief of suffering and restoration of joy for those who are in pain and need physical help. We have had an excellent example of how to build and operate a volunteer system for health care in Texas in the works of Marjorie and Jan de Hartog at Jeff Davis and Ben Taub County hospitals in Houston, Texas in the 1960s.

It was memorialized by Jan in his best-selling book, The Hospital, published in 1964 after Marjorie and he had served as volunteer Orderlies for two years at both facilities. Their witness led to the creation of a volunteer system managed by the Red Cross in which hundreds of people from every background were trained by Red Cross nurses to be Orderlies and Nurses' Aides, which are the very lowest but most necessary services needed in health care for the survival of sick and injured patients. I, Don McCormick, was one of the first 200 volunteers in 1964 trained by the Red Cross under Marjorie's leadership to serve at Ben Taub Hospital. Our experiences were described well by Jan in his book. He helped us understand "a disaster syndrome" and how to bring a hospital out of hell and into the bright light of day. It required people to give up their time and to see the jobs to be done with fresh eyes and not something they could ignore because another crisis came through the front door.

TBT, our lay religious order, in its projects with medical care providers and hospitals, has opportunities to be far in front of any "disaster syndrome" and to take medical care and human relationships to a new level of awareness and performance regardless of a practice or facility's past experience, expertise, or bureaucratic inconveniences. The spirit of this effort is shown in a quote from Jan de Hartog, *"[The rapture of mercy], like love…is…ecstasy, universal, and incommunicable, presenting itself to each individual in an utterly exclusive way. Compassion in action is as deeply emotional and all transforming as love; it takes over your life, pervades your thoughts, makes your other activities and preoccupations seem secondary to that one overpowering urge to help the helpless, to dispel darkness."*

In addition to de Hartog's book you can get an idea of why the volunteer system is necessary to overcome the "disaster syndrome" usually at the heart of the problem in every busy practice and hospital. A quote from the legend of Our Lady of Guadalupe is revealing in the same way that Quaker inspiration drove Marjorie and Jan to do hard and unusual work to solve real world problems. Juan Diego, upon whose cloak the Image of the Virgin appeared, was supposed to

have met the Virgin to let her know if the bishop was going the build the Basilica on the site she had selected, but instead Juan had attended his sick brother and when he did encounter her this is what happened**:**

"To avoid being delayed by the Virgin and ashamed of having failed to meet her on Monday as agreed, Juan Diego chose another route around Tepeyac Hill, yet the Virgin intercepted him and asked where he was going (fourth apparition); Juan Diego explained what had happened and the Virgin gently chided him for not having made recourse to her. In the words which have become the most famous phrase of the Guadalupe apparitions and are inscribed above the main entrance to the Basilica of Guadalupe, she asked '¿No estoy yo aquí que soy tu madre?' ('Am I not here, I who am your mother?')."

Marjorie and Jan could have said something similar to the people running the county hospital so badly in Houston in 1962**,** *"Are we not here, we who are your volunteers"* TBT members do not want to miss signs that have been as plain as day and they have a picture of Our Lady and a copy of Jan's book so that everyone will know where their heart is and where they find faith. Marjorie and Jan in the Society of Friends celebrated their faith in silence and felt a presence of God that made doing the most humble and difficult things possible even when they doubted that their effort changed one dreadful thing around them.

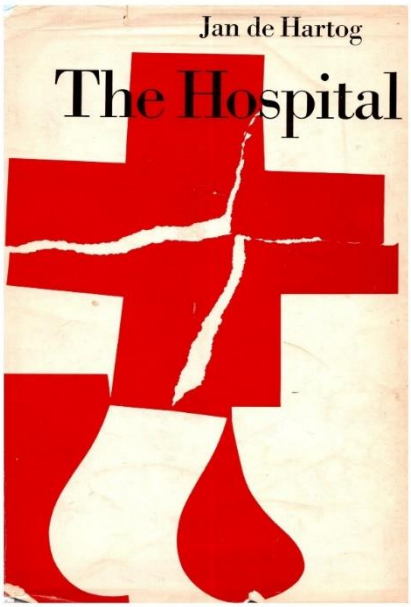
Here is a little about them to help you understand that ordinary people who persist often do extraordinary things which may not bear much fruit for generations. While Jan was out lecturing at the University of Houston on play writing, Marjorie was looking for community volunteer opportunities for both of them to participate in. She decided on Jefferson Davis County Hospital. Conditions there were bad at that time, and with the hospital being significantly underfunded, understaffed, and overcrowded, showed no sign of getting better. Jan decided to document the conditions there, resulting in the non-fiction memoir The Hospital (1964), which exposed the awful conditions of Houston's charity hospitals in the 1960s. The book received a national response, but also a local response in which, within a week of the book's release, nearly four hundred citizens volunteered at the hospital. It led to significant reforms of the city's indigent healthcare system through the creation of the Harris County Hospital District. It also led, however, to considerable hostility and many anonymous threats, which finally forced the de Hartogs to move back to Europe. [No good deed goes unpunished.]

The nature and way of volunteerism was changed by Marjorie and Jan and I was a young man awestruck by what they were doing. They caused certain people within Ben Taub Hospital to be their champions and help them bring the Red Cross to train and to manage the volunteers. Marjorie and Jan subverted the power elite that were still caught between the pretensions of Dixieland after the Civil War and the first Robber Barons and founders of Houston, an unlikely Sea Port and hot-as-hell mosquito farm. Money had, and still does have, a tight hold onto the people who hold it. Those people have not been the vast majority that ever lived in Houston. Bravo for the Dutchman and his English Wife. They let a little civilization creep in and we name our volunteers for them, "Marjorie and Jan de Hartog." We are unlike the City Council and The Commissioner's Court that named the replacement county hospital after Ben Taub to try to get him to pick up the bills and which hospital patients began to call "Uncle Taub's Cabin."

We will not create such dependencies on the status quo in our quest to make Charity Hospitals or health care worthy of a Quaker action taken in silence and in peace. This honorable movement started by the de Hartogs can be the vehicle that breaks the chain of dependence by which health

has been bound to the business of medicine and which chain has retarded the quality of health care and depressed and confused its providers. Volunteers can be trained, can do medical work, and can raise money. Patients can get care unconditionally and care givers can be supported by people with their eyes wide open and better financially than the current salaries and piece work systems.

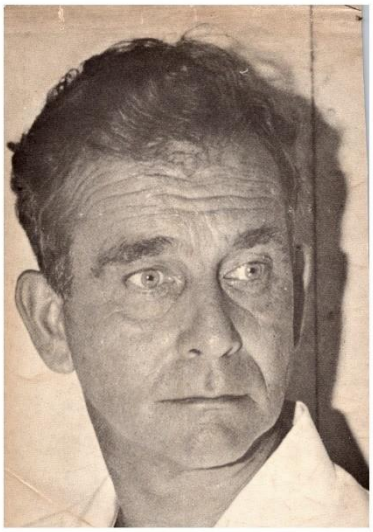
Be like what God is, love other people, learn medicine. be a volunteer. Join a local gathering, support and practice, honor what Jan and Majorie de Hartog did, let "**your other activities and preoccupations seem secondary to that one overpowering urge to help the helpless, to dispel darkness.**"



Jan de Hartog

Jan de Hartog was born in Haarlem, Holland, in 1914, and ran off to sea at an early age. In 1940, just after the Germans occupied Holland, his novel *Holland's Glory* was published, a rollicking story of the Dutch ocean-going tugboats on which he had served. Although it mentioned neither the war nor the Germans, it became a symbol of Dutch defiance and was banned by the Nazis, but not until 300,000 copies had been sold. The author escaped to England, by "the long trail": via Belgium, France and Spain, a journey of six months during which he was imprisoned five times, crashed with a plane and was wounded by rifle bullets as he crossed the Spanish border. The journey left no mark on him, he says, other than that it turned him into a vegetarian. ("After leading the life of a hunted rabbit for six months, I just went on recognizing my brother whether roasted, stewed, fricasséed or smothered with onions.") But in a sense "the long trail" which started in Amsterdam in April 1943, when a young man slipped out the back door of an Old Ladies' Home where he had been in hiding, led to a charity hospital in Houston, Texas, in September 1962, when a middle-aged volunteer orderly first entered the Emergency Room.

In the meantime, he sailed many miles and wrote many books and plays; best known are *The Fourposter*, *The Spiral Road*, *The Distant Shore* (movie title *The Key*) and *The Inspector* (movie title *Lisa*).



MEDICINE & HEALTH

"*Share The Care* is one of the best books ever written to help family caregivers. I was wowed by the first edition and this one is even better."
—Suzanne Mintz, president/cofounder, National Family Caregivers Association

"The guidelines and support offered in this book were invaluable to the Share The Care Circle organized to assist my sister Mimi [Fariña] during a long illness, and in her case, dying process . . . I cannot recommend it highly enough." —Joan Baez

You Don't Have to Do It Alone

Whether you're prepared for it or not, chances are you'll take on the role of caregiver when a family member or friend is affected by a **serious illness** or **injury,** or when you find **your elderly parent needs help.** As you'll soon discover, the range of tasks and responsibilities involved are overwhelming. *Share The Care* offers a sensible and loving solution: a unique group approach that can turn a circle of ordinary people into a powerful caregiving team. *Share The Care* shows you how to:

- **Create a caregiver "family" from friends, real family members, neighbors, coworkers, and acquaintances**
- **Hold a meeting to organize your group, and introduce members to the Share The Care systems that guarantee every job will be done and no one person will have to do too much**
- **Discover the hidden talents within the group, make the most of their resources, cope with group issues, and stay together in the face of adversity**

Included here are valuable guidelines, compassionate suggestions, and a simple-to-use workbook section that together offer support to free the patient from worry and the caregivers from burnout. *Share The Care* offers friends and family the best answer ever to the frequently asked question "What can I do?"

Share The Care was born when twelve people—including **Sheila Warnock** and the late **Cappy Capossela**—came together to help their terminally ill friend and stayed together caring for her for three and a half years. The authors documented the systems developed during that period for others to follow. Tragically, in 2002, Sheila spearheaded a group for Cappy when she was diagnosed with a brain tumor. Following Cappy's death, Sheila created a website and a nonprofit organization in Cappy's memory dedicated to bringing the Share The Care model to caregivers everywhere.

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Organizing Basic Health Care

The creation of a truly human-centered healthcare system, a “gathering” of volunteers to provide care, faces challenges beyond logistical or medical concerns. One of the greatest obstacles is not technological, but deeply rooted in the way we communicate and relate to one another. This challenge lies in how we engage people in healthcare systems that they actually want and need. It is not a problem of resources, but of trust, understanding, and personal connection. As Henry Ospitia described in his book *The Basics of Marketing*, building trust between two people is the bedrock of any meaningful change, especially in healthcare.

Ospitia's insight, rooted in practicality, echoes the wisdom of thinkers like E.F. Schumacher, who famously argued in *Small is Beautiful: Economics as if People Mattered*, that our modern systems have estranged us from reality. Schumacher warned us of our tendency to disregard anything that isn’t created by human hands, ignoring the deeper, more organic connections that shape our lives. In healthcare, this means that a system designed solely around efficiency, numbers, and profits is disconnected from the real human needs it is supposed to serve.

At the heart of Ospitia's method is the recognition that transformation in any aspect of life, including health care, begins with personal relationships and observed realities. He believed, like Ernesto Sirolli, that those who seek to help must first "shut up and listen." True solutions emerge from within communities themselves, from people who know their own needs, desires, and hopes for the future. As Sirolli advised, we must respect the passions and local knowledge of people, creating environments of trust where individuals can act based on their own understanding of what will improve their lives.

This human-centered approach contrasts sharply with the often impersonal, bureaucratic nature of modern healthcare systems. Ospitia’s success, enrolling over 30,000 individuals into Medicare Advantage plans through personal interviews, demonstrates the power of this intimate, people-first approach. In a world dominated by mass marketing and impersonal services, he showed that the key to engagement lies in building trust, one person at a time.

As Schumacher noted, the complexity of our problems often stems from approaching them with the wrong assumptions. In healthcare, the assumption has long been that efficiency and scale are the answers to improving outcomes. Yet, as Beau Lotto observed in *Deviate: The Science of Seeing Differently*, when we approach a problem with the wrong assumption, we can only go deeper into that flawed understanding. The solution, therefore, is not more of the same, but a fundamental shift toward seeing healthcare not as a commodity to be traded, but as a basic human need to be met through cooperation and mutual care.

Henry Ospitia’s grandmother, in her simple wisdom, taught him that any problem can be solved by breaking it down into its fundamental steps, and this too applies to healthcare. Building a system of care that works requires us to return to the basics: understanding what people truly need, building relationships of trust, and focusing on the personal connections that make healthcare effective.

This is not just a lesson for marketing, but a guide for life. Whether we are talking about healthcare, marriage, raising children, or any other endeavor, the principles of clear observation, personal engagement, and trust are key to meaningful improvement. Ospitia's success was built on this foundation—listening to people, meeting them where they are, and offering help based on their real, lived experiences.

As we consider how to organize basic healthcare, we must remember these lessons. True care cannot be imposed from above; it must be grown from within communities, based on mutual respect and understanding. The future of healthcare lies not in grand, top-down solutions but in the small, personal connections we make, one conversation at a time.

Let us honor Henry's legacy by continuing his work—not just in enrolling people into healthcare plans but in transforming the way we think about care itself. The future of healthcare will not be built by large institutions or distant governments. It will be built by individuals who take the time to understand one another, to listen, and to act with compassion and trust. This is how we can begin to push back against the cold, impersonal logic of commercial healthcare and return to a system that truly serves people.

TBT Summary of our Intentions

As members of The Order of Love Peace Truth Tolerance and Cooperation, DBA TBT- Tomorrow's Bread Today (TBT), we are committed to:

* Love, Peace, Truth, Tolerance, and Cooperation;
* Working and ministering within the local community in the service of others;
* Performance of Corporal and Spiritual works of mercy;
* Commitment to the construction and operation of facilities and organizations needed to serve the members of local communities.

Article Twelve of our Regulations

Health Care Facilities (Hospitals and Clinics)

* TBT does not let net earnings inure to the benefit of any private shareholder or individual.
* TBT has no activities that consist of carrying on propaganda or otherwise attempting to influence legislation.
* TBT does not participate or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office.
* TBT does not engage, other than as an insubstantial part of its activities, in activities which in themselves are not in furtherance of one or more exempt purposes.
* TBT will dedicate the organization's assets to charitable purposes upon dissolution.
* TBT will for the benefit of the people in the surrounding communities operate hospitals and clinics to help with the care and treatment of residents and members.
* TBT will not distribute its net earnings to any private shareholder or individual.
* TBT is to serve the public rather than the private interest of its members.
* TBT is religious, charitable, scientific, and educational.
* TBT promotes health and benefits to the community by providing facilities for both care and treatment of sicknesses and injuries.
* TBT also provides members and patients with power to have group health insurance which is inclusive of all residents of the communities they serve regardless of pre-existing conditions or financial means.

TBT will:

* Operate an emergency room in areas where it has a hospital open to all, regardless of ability to pay.
* Maintain a board of directors drawn from the community into its membership.
* Maintain an open medical staff policy.
* Provide hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare.
* Use surplus funds to improve facilities, equipment, and patient care; and
* Use surplus funds to advance medical training, education, and research.
* Elect members of the hospital medical or administrative staff or their

representatives to serve on the governing body of the hospital, which also is composed of members of the community.

* Does not allow members of the governing body who are also members or representatives of the medical or administrative staff to participate in the decision-making process where questions of inurement or private benefit to members of the medical or administrative staff arise. However, other areas that are within the expertise of the members of the medical staff, such as appropriate medical treatment and medical research or education, may be subject to their unrestricted control.
* Refrain from making rules that favor physicians on staff that favor admissions over an open staff that may admit infrequently.
* Encourage the building of a medical staff whose skills and abilities lead to better medical outcomes and a scientific approach to medical care and treatment.
* Determine that a particular patient is covered by health insurance, governmental program or otherwise has sufficient resources to pay for health care, and the hospital has the available space and can provide the appropriate medical services, the patient if needed will be admitted to the hospital in a nondiscriminatory manner.
* Use its surplus funds to improve the quality of patient care, facilities, and equipment, and to advance its medical training, education, and research programs to promote the health of the community.

What help is available now from the marketplace?

The underlying assumptions are:

1. People will form volunteer cells to help each other in time of medical need.
2. These cells are in or near the same geographical location.
3. The cells are not mostly comprised of disabled or sick people but are reflective of the composition of the age groups, genders, health conditions of the general population.
4. The vast majority of people have an average income for their community.
5. People want to belong for their benefit and that of their friends and relatives.
6. Current resources are there that enable the creation of cells and the gathering of at least 1,000 members in one year.

The participants in the services are:

1. Medical professionals (Doctors and Nurses) that will volunteer and will accept direct monthly payments for their services.
2. Medical Specialists that will accept direct monthly payments or assignments of any type of insurance for their services
3. Patient Advocates that will assist each member in getting services and resolving billings.
4. Ancillary medical services and supplies are either prepaid or at discounts of 50 to 90 percent.
5. Association Insurance issued to the group that covers at least 90 percent of the hospital and out of network medical expenses from 0 to 50,000 dollars per year per person.
6. Stop loss Insurance that covers an excess of 50,000 dollars to an unlimited amount
7. A Non-Profit 501c3 Patient Association in which each individual can be a member and through which group health insurance and charity help in times of need can be obtained.
8. A local non-profit organization is aligned with the medical professional volunteers who care for 1,000 patient members and determine their own wants and needs in their local group.
9. Linkage of each 1000 member local with the 501c3 sponsor for power in dealing with the commercial markets to assure best prices and services.
10. Currently Established prices for one person of any age to have the complete healthcare system:

1.	Direct Pay to Medical Professionals	$100
2.	Discounts or prepayments for Ancillary Services	$ 65
3.	Association Coverage 0-50,000	$100
4.	Stop Loss excess of 50,000 to unlimited	$ 65
5.	Patient Association Membership (Local $ 501c3)	$ 40
6.	Charity Support Fund	$ 38
7.	Administration and Patient Advocacy	$ 40
8.	Reserves	$138
9.	Total	$586

The prices above are the average for all age groups and should be compared to the market cost average for all age groups, which is about $1,000 per month.

Prices for younger age groups and for couples and families are less per person because some costs are fixed and not variable and younger people have a lower morbidity rate.

The out-of-pocket expenses in this cooperative plan now being sold could be as much a 10% which would raise the cost on average to another $43.50 per month. However that cost $586.is still far less than the total of $1,000 which is the average spend per person for insurance and out of pocket medical in the U.S.A. in 2024. It is a 45% saving.

This is the benefit description for that available plan for Patient Association Members:

Commonality of interest within the TBT AHP

Member employers, large or small, are either medical care providers, companies, or individuals that are volunteers as defined in the by-laws of TBT. Volunteers in TBT are self-employed members (2 or more people) to provide the labor and resources needed to achieve health education and care that is supportive of the direct care given by the professional providers. Corporate Suppliers of Services, Material, and Technology

Support Companies for TBT

1. **Innovations HR**

Offers Ovation Health group health plans for employers and subscription health plans for individuals. We have a proven model of lowering health care costs by combining the advantages of telemedicine, a robust pharmacy program, and a growing network of physicians. We do this by fixed rate direct contracting and expanding relationships with additional provider networks.

2. **Doc Wellbee**

Doc Wellbee Health & Wellness plan is administered by Affordable Family Health Services Company, a Licensed Discount Medical Plan Organization (DMPO) since 1991. Its mission is to help members save real money on health and dental care. Headquartered in Atlanta, GA., Affordable Family Health network includes Dental practitioners and other health care facilities nationwide, as well as many retail chains and online providers.

3. **Quest Diagnostics**

Quest Diagnostics is an American clinical laboratory. A Fortune 500 company, Quest operates in the United States, Puerto Rico, Mexico, and Brazil. Quest also maintains collaborative agreements with various hospitals and clinics across the globe.

4. **Teladoc (Empowering all people everywhere)**

Teladoc Health was founded on a simple, yet revolutionary idea: that everyone should have access to the best healthcare, anywhere in the world on their terms. Today, we're delivering on our mission by providing whole-person virtual care that includes primary care, mental health, chronic condition management and more.

5. Schulte law

Bret A. Schulte, J.D. graduated from Yale and Ohio State Moritz College of Law has been in practice for 22 years and specializes in real estate and health care law. His offices are in Houston, Texas.

6. TBT Association Health Plans

Why TBT is an Association Health Plan (AHP) under the Final Rule about AHPs by the DOL in 2018.

"… the rule contains an explicit safe harbor under which a substantial business purpose is considered to exist in cases where the group or association would be a viable entity even in the absence of sponsoring an employee benefit plan. The final rule also states that business purposes is not required to be a for-profit purpose. Thus, for example, a bona fide group or association could offer other services to its members, such as convening conferences or offering classes or educational materials on business issues of interest to the association members. Depending on facts and circumstances, a bona fide group or association might be tax-exempt under Code section 501(a) as an organization described in Code section 501(c), with a purpose unrelated to the sponsorship of the AHP, if it meets all the requirements for exempt status, including furthering an exempt purpose. A bona fide group or association could also act as a standard-setting organization that establishes business standards or practices."

Commonality of Interest within the TBT AHP

Member employers, large or small, are either medical care providers, companies, or individuals that are volunteers as defined in the by-laws of TBT. Volunteers provide the labor and resources needed to achieve health education and care that is supportive of the direct care given by the professional providers.

TBT Purchases a group policy from Alliance Re to cover medically necessary services at Medicare rates which are not covered by direct payment agreements with providers and are less that $50,000 in a year per individual above which is covered by the stop loss insurance.

7. Odyssey Reinsurance

OdysseyRe is a globally diversified underwriter of property and casualty reinsurance. Headquartered in Stanford, Connecticut, their operations include a global network of 14 branches and representative offices. A (Excellent A.M Best Rating) 2.8 Billion in written premiums.

*In **Complete Care PPC** patients and physicians cooperate with each other to relieve pain and suffering while not wasting time or resources.*

The Basic Membership in the AHP

TBT has gathered all of the ancillary resources available throughout the nation and made them economical and easily used by patients, their families, and their providers of care,

A. Laboratory tests from Quest Diagnostics at no copay, deductible, or coinsurance cost.
B. Prescription Drugs through Drexi Health at 20% to 80% off Average Wholesale Prices in the majority of Pharmacies in every State. Also, it can be prepaid from Magic Pill.
C. Dental, Vision, Hearing, Assistance through Doc Wellbee at 50% to 70% discount in every State.
D. Telemedicine from Teladoc 24 hours a day 365 days a year from Board Certified Physicians in every State with no copayment.
E. Legal defense from Schulte Law against balance billing claims by out of network hospitals and clinics.
F. Patient Advocacy from Ovation Health to find the right care at the right price for each patient.
G. Diagnostic Imaging in Texas through HMI with no co-pay.

The Underlying Insurance

Remove the fear of major medical expenses by buying stop loss insurance from A (Excellent) Insurers through TBT AHP Group, which has no pre-existing conditions excluded.

The Direct Payment of Physicians

Establish a Health Care Saving Account for each member so that routine primary care, imaging, and specialty care can be paid directly at the time of visit or on a monthly payment plan from saving in the patient's account accumulating for a future use determined by the member.

The Houston Club Membership Through TBT

Athletics, health club, dining, and meeting rooms at country clubs national and internationally have been contracted to serve TBT members that need those amenities. Exercise and social interactions between people promote and sustain good health and improve the outcomes of our health care mission. We have included an example of our total plan, its prices, and comparative costs on the following page. We do not have to speculate about what we are already doing.

The Houston Club Members enjoy a host of benefits both In Houston and out of town in 200 locations. The benefits include the following:

• **Productivity Spaces** that are useful work zones where you can quickly visit and be productive
• **Touch Down Rooms**: Close your next deal or work alone in these fully equipped private mini offices
• **Anytime Lounge**: Our Allen's Landing Is our upscale bar and grill with elegant seating and a wide selection of your favorite wines. whiskey and local craft beers. The perfect backdrop to your next social gathering
• **A variety of business and social networking opportunities** throughout the month.
• Beautifully appointed **Private Event** space and **Board Rooms** with no room rental fees
• **Social events** such as pop-up dinners hosted by well-known Chefs. wine dinners and tastings. annual holiday brunches and many more
• **Access to complimentary golf and dining locally and worldwide** through our network of Invited properties.
• **Complimentary Happy Hour Appetizers** from 5pm to 7pm

- **Access to National and International Clubs through:**

Houston Club XLife Membership, a collection of private clubs and premium benefits. With this Membership our Members have privileges to 13 local area clubs and 200 clubs throughout the Unites States and worldwide
Up to (12) rounds of golf per year (2 per month. per membership. play rate and cart fees may apply)
50% off A La Carte Dining at The Houston Club and dining access to all business clubs
• Full Dining and Member Excess to every City Club Nationwide
• invitations to Member-only events at clubs around town. wine tastings. networking forums. golf events and more

Take your membership wherever you go When you travel. enjoy the best of **Invited Network**
• Cart fee only ·golf with Tee times up to 30 days In advance and TaylorMade loaner clubs at Invited family country clubs
• Access to more than 700 hotels. resorts and entertainment venues. including tickets to theaters. concerts and sporting events Special packages and destination offers to The Masters, US Open Kentucky Derby, Super Bowl, Final Four, and more.

Xlife City **Dining Benefits** at Your Home Club
• Preferred Member Pricing, up to 50% off daily dining, at your home club
Xlife City **Dining and Entertainment Benefits** When Visiting Qty and Stadium Clubs
• Preferred Member pricing, up to 25% off dining at participating City and Stadium clubs (Excludes Stadium Club gamedays, California City Clubs and Alliance Clubs)
• **Full dining and Member event access** to every City Club nationwide
Xlife City **Dining Benefits When Visiting Golf & Country Clubs** Nationwide
• **Anytime dining access at Golf Clubs**

Xlife City **Golf Benefits When Visiting Participating** Golf & Country Clubs Nationwide
Xlife City Members may enjoy access to Tee Times. Play Rate plus a Cart Fee may apply when visiting the collections below•
• Access to over 200 Golf and Country Clubs in the Invited Network•
• Up to 12 rounds per year (2 per month, per membership; play rates and cart fees may apply)
• 30-day advance access for participating courses when traveling (properties outside of Home Club market)'
• 7-day advance access to participating local courses; Sunday noon to Friday noon (properties within Home Club market)
• Access to premium Callaway rental clubs at a preferred rate ($25 per set, subject to availability)
• Invitation to participate in Invited national tournaments

Golf Price Color Codes for each club

BLUE	YELLOW	GREEN	ORANGE
$75 + Cart	$50 + Cart	$25 +Cart	Cart

* Denotes City and Stadium Clubs with Dining Access and 25% Off Dining

+ Denotes City Clubs and Alliance Clubs with Dining Access Only Denotes Golf & Country Club with Dining Access Only

• Denotes Golf & Country Club with Preferred Play Rate + Cart Fee and Dining Access Only

$ Denotes Preferred Golf Rates at Owned and Alliance Golf Clubs and Dining Access Only

(A) Denotes Alliance Club

•xufe City dining and golf benefits are exclusively for City Club Members. Participation and availability varies by club. Clubs within the Blue collection offer Sunday Noon to Friday Noon access. Restrictions may apply within local or neighboring markets. See home club for details.

ALABAMA

Anniston
- Anniston Country Club (A)

Birmingham
- ★ City Club Birmingham

Mobile
- Rock Creek Golf Club (A)

ARKANSAS

Hot Springs
- Diamante Country Club (A)

ARIZONA

Phoenix/Scottsdale
- Anthem Golf and Country Club
- Gainey Ranch Golf Club
- Seville Golf and Country Club
- $ SunRidge Canyons Golf Club (A)
- + University Club of Phoenix (A)

Tucson
- ★ Arizona Sands Club - Stadium Club
- Oro Valley Country Club
- SaddleBrooke TWO - MountainView Golf Club (A) (Closed for Course Renovations)
- SaddleBrooke TWO - Preserve Golf Club (A)
- Skyline Country Club (A)

CALIFORNIA

Los Angeles
- Braemar Country Club
- + City Club Los Angeles
- Porter Valley Country Club

Orange County
- Aliso Viejo Country Club
- ! Coto de Caza Golf and Racquet Club

KENTUCKY

Mayfield
- MayfieldGraves Country Club (A)

LOUISIANA

New Orleans
- Chateau Golf and Country Club (A)
- + House of Blues – Foundation Room (A)

MAINE

Portland
- + Cumberland Club (A)

MARYLAND

Baltimore
- Eagle's Nest Country Club

MASSACHUSETTS

Boston
- + House of Blues – Foundation Room (A)
- Ipswich Country Club
- The Haven Country Club
- The Ridge Club

MICHIGAN

Detroit
- Oakhurst Country Club
- Oak Pointe Country Club
- Paint Creek Country Club (A)
- TPC Michigan
- $ The University Club of MSU (A) (Forest Akers Golf)

Grand Rapids

SOUTH CAROLINA

Aiken
- + Green Boundary Club (A)
- Woodside Country Club

Charleston
- $ Charleston National Golf Club (A)
- Dunes West Golf and River Club (A)
- Snee Farm Country Club (A)

Columbia
- ★ Capital City Club

Hilton Head
- Country Club of Hilton Head
- Golden Bear Golf Club
- Golf Club at Indigo Run
- $ Haig Point Country Club (A)
- Riverton Pointe Golf & Country Club (A)

Myrtle Beach
- Lockwood Folly Country Club (A)

SOUTH DAKOTA

Rapid City
- Arrowhead Country Club (A)

TENNESSEE

Bristol/Kingsport
- Club 1894 (A)
- Ridgefields Golf & Athletic Club (A)

Nashville
- Bluegrass Yacht and Country Club
- + Nashville City Club (A)
- Temple Hills Country Club

TEXAS

Amarillo

- Monarch Country Club
- ★ Tower Club

Gainesville
- Hawkstone Country Club

Jacksonville
- The Golf Club of North Hampton (A)
- Marsh Creek Country Club
- Queen's Harbour Yacht and Country Club

Orlando
- Alaqua Country Club (A)
- $ Celebration Golf Club (A)
- ★ Citrus Club
- $ Mystic Dunes Golf Club (A)
- Rio Pinar Country Club (A)

Sarasota
- The Meadows Country Club (A)

Tampa
- ! Ardea Country Club
- ★ Centre Club
- Countryside Country Club
- Hunter's Green Country Club
- Tampa Palms Golf and Country Club

GEORGIA

Augusta
- + The Pinnacle Club (A)

Atlanta
- Atlanta National Golf Club
- Bear's Best Golf Club
- Braelinn Golf Club
- Brookfield Country Club
- Brookstone Country Club
- ★ Buckhead Club
- Canongate 1 Golf Club
- ★ Commerce Club
- ! Country Club of the South
- Eagle Watch Golf Club
- Flat Creek Country Club
- + Governors Gun Club (A)
- Laurel Springs Golf Club
- ! The Manor Golf and Country Club
- Olde Atlanta Golf Club
- + The Peachtree Club (A)
- Sun City Peachtree Golf Club (A)
- ! White Columns Country Club
- White Oak Golf Club
- Whitewater Creek Country Club
- Windermere Golf Club

Las Vegas
- Bear's Best Golf Club
- Canyon Gate Country Club
- + House of Blues – Foundation Room (A)
- $ Reflection Bay Golf Club (A)
- + Stirling Club (A)

NEW HAMPSHIRE

Portsmouth
- + The One Hundred Club (A)

NEW JERSEY

Bedminster
- $ Fiddler's Elbow Country Club (A)

Princeton
- Cherry Valley Country Club

NEW YORK

New York City
- The Hamlet Golf and Country Club
- + The View of the World Terrace Club (A)
- Willow Creek Golf and Country Club
- Wind Watch Golf and Country Club

NORTH CAROLINA

Charlotte
- + Charlotte Motor Speedway Club (A)
- Firethorne Country Club
- TPC Piper Glen
- $ Verdict Ridge Golf & Country Club (A)

Greensboro
- Danville Golf Club (A)

Outer Banks
- Currituck Golf Club
- Nags Head Golf Links

Raleigh/Durham
- ! Brier Creek Country Club **(Dining available only to Members outside of Raleigh/Durham)**
- ★ Carolina Club
- ★ City Club Raleigh
- Devil's Ridge Golf Club
- ! The Hasentree Club **(Dining available only to Members outside of Raleigh/Durham)**
- Lochmere Golf Club
- Hillcrest Country Club (A)
- ★ Texas Tech Club - Stadium Club

San Antonio
- Fair Oaks Ranch Golf and Country Club

Temple
- Wildflower Country Club

Waco
- ★ Baylor Club - Stadium Club

UTAH

Salt Lake City
- ★ Ken Garff University Club at Rice-Eccles Stadium

VIRGINIA

Blacksburg
- ★ University Club of Virginia Tech

Charlottesville
- + Greencroft Club (A)

Norfolk
- Greenbrier Country Club
- ★ Town Point Club

Richmond
- Stonehenge Golf and Country Club

Williamsburg
- Ford's Colony Country Club

WASHINGTON

Seattle
- Canterwood Golf and Country Club
- ★ The Collective
- ★ Columbia Tower Club
- $ The Golf Club at Hawks Prairie (A)
- $ Golf Club at Newcastle (A)
- $ Harbour Pointe Golf Club (A)
- $ Trophy Lake Golf and Casting Club (A)
- $ Washington National (A)

WASHINGTON, D.C.

Washington, D.C.
- Belmont Country Club
- Chantilly National Golf and Country Club

+ House of Blues – Foundation Room (A)
! Old Ranch Country Club

Palm Springs Area
● Indian Wells Country Club
(includes weekend access, space available)
● Mission Hills Country Club –
Arnold Palmer Signature Course &
Pete Dye Challenge Course
(includes weekend access, space available)
$ Rams Hill Golf Club (A)

Riverside
● Canyon Crest Country Club (A)

Sacramento
● Granite Bay Golf Club

San Diego
● The Heights Country Club
● Shadowridge Golf Club
+ University Club Atop Symphony Towers

San Francisco/San Jose
● Berkeley Country Club (A)
+ Silicon Valley Capital Club
+ Amador Club (A)

Santa Rosa
● Santa Rosa Golf and Country Club

COLORADO

Aspen
● Aspen Glen Club

Colorado Springs
+ El Paso Club (A)

Denver
● Black Bear Golf Club
● Blackstone Country Club
● Lake Valley Golf Club (A)

Fort Collins
● Cheyenne Country Club (A)
● Fort Collins Country Club (A)

FLORIDA

Fort Lauderdale/Miami
● Boca Lago Country Club (A)
$ Eagle Trace Golf Club (A)
● Jupiter Country Club
(May – October Only)*
$ Macatawa Legends Golf Club (A)
$ Muskegon Country Club (A)
$ StoneWater Golf Club (A)
$ Sunnybrook Country Club (A)
$ Thousand Oaks Country Club (A)
● Watermark Country Club (A)

MINNESOTA

Minneapolis
● Medina Golf and Country Club

MISSISSIPPI

Biloxi
● The Oaks Golf Club (A)

Jackson
$ Patrick Farms Golf Club (A)
$ Whisper Lake Country Club (A)

MISSOURI

Cape Girardeau/Sikeston
● Cape Girardeau Country Club (A)
● Fox Haven Country Club (A)

Joplin
● Twin Hills Golf and Country Club (A)

Kansas City
● The National Golf Club of Kansas City
● The Deuce Golf Club

St. Louis
● Old Hickory Golf Club (A)
+ Missouri Athletic Club (A)

MONTANA

Bozeman
● Riverside Country Club (A)

Butte
● Butte Country Club (A)

Missoula
● The Ranch Club (A)

NEVADA

+ The Amarillo Club (A)

TX

Austin
+ Austin Club (A)
● The Hills Country Club - Flintrock Course
● The Hills Country Club - Yaupon
● The Hills Country Club - Live Oak
! Westlake Country Club
★ The University of Texas Club - Stadium Club

Corpus Christi
● River Hills Country Club (A)

Dallas/Fort Worth
● Brookhaven Country Club
! Canyon Creek Country Club
● Cedar Creek Country Club (A)
+ City Club Fort Worth (A)
! The Clubs of Prestonwood – Creek Course
! The Clubs of Prestonwood – Hills Course
+ Frisco Gun Club (A)
! Gleneagles Country Club
● Hackberry Creek Country Club
+ House of Blues – Foundation Room (A)
! Las Colinas Country Club
● Oakmont Country Club
+ Park City Club (A)
! Stonebriar Country Club
! Stonebridge Ranch Country Club - Dye
! Stonebridge Ranch Country Club - Ranch
★ The Constellation Club
! Timarron Country Club
★ Tower Club Dallas
● Trophy Club Country Club
● Walnut Creek Country Club

East Texas
+ Summit Club - Longview (A)

Houston
● April Sound Country Club
● Bay Oaks Country Club
● The Club at Falcon Point
● The Clubs of Kingwood
! Deerwood at Kingwood
+ Downtown Club at Houston Center
+ Downtown Club at the Met
● Hearthstone Country Club
+ House of Blues – Foundation Room (A)
★ The Houston Club
● Lake Windcrest Country Club
● Magnolia Creek
● Willow Creek Golf Club
! The Woodlands Country Club - Tournament, Player, Palmer, Trails

Lubbock

Columbus
● Saugahatchee Country Club (A)

HAWAII

Maui
$ Dunes at Maui Lani Golf Course (A)

Oahu
$ Hawaii Prince Golf Club (A)

IDAHO

Idaho Falls
● Idaho Falls Country Club (A)
● Juniper Hills Country Club (A)

ILLINOIS

Chicago
● Crystal Lake Country Club (A)
$ Geneva National Golf Club (A)
+ House of Blues – Foundation Room (A)
★ The Metropolitan
● Ravinia Green Country Club
● Rolling Green Country Club

Springfield
● Panther Creek Country Club (A)

INDIANA

Evansville
● The Pearl Club (A)

Indianapolis
● Hillcrest Country Club (A)
★ Skyline Club - Indy

South Bend
● Knollwood Country Club

IOWA

Des Moines
+ Des Moines Embassy Club (A)

KANSAS

Overland Park
$ River Landing Country Club (A)
+ University Club – Durham (A)

Wilmington
+ City Club Wilmington (A)

Winston-Salem
● Bermuda Run Country Club
$ High Point Country Club (A)

OHIO

Cincinnati/Dayton
$ Stillmeadow Country Club (A)
● Sugar Valley Country Club (A)
● Traditions Golf Club (Kentucky) (A)

Cleveland/Akron
+ Chagrin Valley Athletic Club (A)
$ Firestone Country Club*
$ Fox Meadow Country Club (A)
+ Hill n Dale Hunt Club (A)
+ House of Blues – Foundation Room (A)
+ Lakeside Yacht Club (A)
+ Mentor Harbor Yachting Club (A)
+ Pine Lake Trout Club (A)
● Quail Hollow Country Club
$ Red Tail Golf Club (A)
+ Shoreby Club (A)
$ Signature on Solon Country Club (A)
● Silver Lake Country Club
+ The Club at Hillbrook (A)

Columbus
● Heritage Golf Club

Toledo
+ The Toledo Club (A)

OKLAHOMA

McAlester
$ McAlester Country Club (A)

Oklahoma City
● The Greens Country Club (A)
● Oak Tree Country Club
● Shawnee Country Club (A)
● The Trails Golf Club (A)

Ponca City
● Ponca City Country Club (A)

Tulsa
● The Club at Indian Springs (A)
★ City Club of Washington
● Dominion Valley Country Club
$ National Golf Club (A)
● Norbeck Country Club
● Oak Creek Golf Club
● Piedmont Club
● Regency at Dominion Valley
● River Creek Club
★ Tower Club Tysons Corner

WISCONSIN

Milwaukee
+ University Club of Milwaukee – Downtown (A)

WYOMING

Cheyenne
● Cheyenne Country Club (A)

CANADA

Montreal, Quebec
$ Club de Golf Haute Plaines (A)
● Club de Golf Islesmere (A)
$ Rosèmere Golf Club (A)

Ottawa, Ontario
● Eagle Creek Golf Club (A)
$ Greyhawk Golf Club (A)
$ Kanata Golf and Country Club (A)

Toronto, Ontario
$ Bethesda Grange at Rolling Hills Golf club (A)
$ Blue Springs Golf Club (A)
$ Lake Joseph Resort and Golf Club (A)
$ Rocky Crest Resort and Golf Club (A)
$ Sherwood Inn (A)
● Caledon Woods Golf Club (A)
$ Cherry Downs Golf Club (A)
$ The Country Club (A)
$ Diamondback Golf Club (A)
$ Emerald Hills Golf Club (A)
● Forest City National Golf Club (A)
● Georgetown Golf Club (A)
$ Glen Abbey Golf Club (A)
$ Glencairn Golf Club (A)
● Glendale Golf and Country Club (A)
● Greenhills Golf Club (A)
$ Greystone Golf Club (A)
$ Heron Point Golf Links (A)
$ Hidden Lake Golf Club (A)
$ King Valley Golf Club (A)

● Nicklaus Golf Club at LionsGate

OREGON

Bend
✚ The Loft (A)

Medford
● Grants Pass Golf Club (A)

Portland
✚ University Club of Portland (A)

PENNSYLVANIA

Erie
● Country Club of Meadville (A)

Harrisburg
✚ The Hill Society (A)

Philadelphia
$ Applecross Country Club (A)
$ French Creek Golf Club (A)
● Hartefeld National
● Meadia Heights Golf Club (A)
● North Hills Country Club
★ Pyramid Club
$ Talamore Country Club (A)
✚ University and Whist Club (A)
● Woodstone Country Club (A)

Pittsburgh
● Diamond Run Golf Club
★ Rivers Club
$ Seven Oaks Golf Club (A)
● Treesdale Golf and Country Club
● Slippery Rock Golf Club (A)
$ King's Riding Golf Club (A)
$ National Pines Golf Club (A)
$ Rattlesnake Point Golf Club (A)
● Station Creek Golf Club (A)
$ Wyndance Golf Club (A)

CHINA

Beijing
+ Capital Club (A)

Hong Kong
$ Mission Hills Golf Club (A)

Zhejiang
+ West Lake Mansion (A)

FRANCE

Paris
● Paris International Golf Club (A)

GERMANY

Frankfurt
+ Frankfurt Airport Club (A)

MEXICO

Puerto Vallarta
● Club de Golf Marina Vallarta
● Club de Golf Vista Vallarta

SWEDEN

Stockholm
● Vidbynäs Golf Club (A)

SWITZERLAND

Lipperswil
● Golf Club Lipperswil (A)

Four ways to participate in the TBT Program
for Complete Care in a Patient Physician Cooperative (CompletecarePPC.com)

1. As a member of TBT in the category of Volunteer
2. Enrolling in the basic health care benefits of the cooperative at the current monthly retainer fees:
    a. Primary Care $0 Copay
    b. Lab $0 Copay
    c. Imaging $0 Copay
    d. Prescription Drugs $0 Copay
    e. Telemedicine $0 Copay
    f. Patient Advocacy $0 Copay
    g. Legal Defense against excessive medical and hospital charges $0 Copay
    h. Discounted Prices for Dental, Vision, Hearing (50% to 80% off)
3. Enrolling in the TBT Association Group Health Plans
    a. Group Coverage for medical and hospital expenses from 1-50,000 dollars
    b. Stop Loss Coverage for medical and hospital expenses from 50,001 to unlimited
4. Social, Business, Wellness and Sports plan through TBT's membership in The Houston Club and Invited Clubs which includes access to 200 Country Clubs throughout the World.

These plans through TBT membership as a volunteer can be separate or combined to fit the exact needs of the members. There are no corporate members of TBT but there are corporate sponsors that offer these benefits to their associates and contractors. There are administrative allowances for sponsors that offset the non-profit's administrative expenses.

The current prices for Membership on a monthly basis per individual are as follows:

1. Volunteer Member $25 per month per family
2. Basic Retainer Benefits: Adult $145 Child $82
3. Group Medical and Hospital Including TBT Membership and Basic Retainer Plan

	Platinum Plan	Gold Plan	Ovation HD Plan
Adult	$652.25	$586.25	$520.25
Child 0-17	$502.25	$466.25	$436.25

4. **Supplemental Health Plan to a Government or Employer plans that covers the 0-50,000**. Includes *Membership, Basic Retainer Benefits, Stop Loss in an excess of $50,000* and *The Houston Club with Xlife* (Invited's 200 Country Clubs.) Club Membership is for the family including children to age 23 and its cost is in the Adult price shown. The usual individual club membership outside of the TBT Group is from $255 to $375.

Adult	$380
Spouse	$205
Child	$142

- *volunteer membership in TBT prices is included already in the prices for the benefit plans 2-4.*

Postscript

The people who have read this book often asked about the step-by-step process for forming a cooperative of the kind we have described. While it's possible for any small group of people to self-organize for purposes of helping each other very few people have knowledge and experience in the practice of medicine, surgery, or nursing. Further, they are dependent on an exchange of money to trade for services even among themselves much less than the support of medical care providers.

This is what we have been able to do in the past:

1. Find key specialist physicians that will organize as a non-profit medical group for the purpose of developing primary care practices that serve a self-organized local patient cooperative.
2. The key specialists are:
    a. Cardiology
    b. Pulmonology
    c. Ophthalmology
    d. General Surgery
    e. Podiatry
    f. Urology
3. These specialists provide the development capital for the establishment of two primary care practices in which each practice grows a membership of 300 households in a specific geographical location that is as small as 1.5 miles in diameter to as much as 25 miles in rural areas.
4. The primary care provider works for the medical group.
5. The development cost is $300,000 for two PCP practices, which is $50,000 for each specialist for which TBT arranges the financing.
6. In addition the PCP, a nurse assistant and four cooperative enrollers/patient advocates are hired for each practice.
7. The patient enrollments come from the referrals made by specialists practices and from the contacts established in the community by the enrollers.
8. As the patient members are enrolled they are organized into health volunteers teams and trained in the basics skills of a nurses aide or orderly as in the examples from share the care and the De Hartog volunteers.
9. The organization is protected from catastrophic loss excess of 50,000 by Stop Loss Insurance from a national, A excellent reinsurer. The expenses that are less than $50,000 are paid by monthly retainers or by charity from the organization through donations from many sources.
10. The result is a local full benefit health organization that is better, less expensive, and inclusive of everyone that joins TBT as a volunteer member.
11. Local captures of the TBT organization can sponsor a program and to begin we require at least 20 households the want the programs. The local chapters are funded by the donations made to TBT from the local enrollments. Such funding is expected to be about $10 per month per enrolled member.