Paleo Solution - 373

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Robb: Hey, folks, welcome back to another edition of the Paleo Solution Podcast. Very excited for today's guest. I'm a huge fan of alternate -- And it really shouldn't necessarily be alternate approaches to medicine and health care but that expands everything from nutritional interventions, various other modalities but also I'm really interested in the kind of market-centric element.

And so today's guest is Dr. Brandon Alleman, MD PhD. He received his MD and PhD in translation biomedicine. He also holds bachelor's degrees in Mathematics and Physics. He is here to talk to us about this topic as well as a number of other inter-related topics and also to expose us to Antioch Med which is a new program that he's going to share some info with us. Doc, that was most clumsy introduction you've probably ever received and that I've likely ever done. Welcome to the show.

Brandon: No, that was perfect. That was perfect. Thank you for having me on.

Robb: Doc, that was a paltry introduction. I should probably -- I'm always hesitant to just read the bio straight off the bio page. But can you tell folks more about your background. It's interesting to me both you and, I guess, your colleague, Dr. Thompson, both of you have advanced Mathematics degrees, engineering backgrounds, Physics backgrounds but then went into medicine. And I've just got to say that people that I see doing the best work in this space, this ancestral health space, they tend to be folks that had either an engineering or an advanced Mathematics background and then they jump into the medical scene and they just look at things in a profoundly different way. Could you talk a little bit about that process? Because, I think, a lot of people who get that foundational training like you have, usually medicine isn't the first thing that they're thinking about. Like what brought you into this space?

Brandon: Yeah, that's a great question, one I get often when people look at my background. I can kind of give you the short version of how I wound up in medicine. It was a very circuitous route. I came out of high school knowing I was good at science, went to undergrad and kind of the most interesting courses to study for me were doing Math and Physics. They were some of the most challenging things on campus and something I really enjoyed doing.

The change for me really happened when I went to Africa for a month right before the summer after my junior college. Kind of went over there and did

some AIDS education within high schools there and came back and worked at a particle accelerator programming in C++ for eight hours a day. And there was just a big disconnect. I loved what I was doing, programming, loved the mental work it took but didn't see as much purpose in doing that day to day as potentially doing something science related with medicine to really be able to affect people's lives.

Made the switch at that point. So, finished my degrees before my junior year, took all my Biology, Chemistry, Organic Chemistry all in one year, my senior year in college, and then applied to medical school. During the application process, I really knew that I could do the basic science work, knew I could go into their graduate program and be successful but wanted to try my hand at clinical stuff as well. So, I wound up in the MD PhD program.

And then through that seven years, two years of medical school, PhD work and then medical school, finishing my rotations afterwards, just kind of went more and more towards clinical. So, wound up in family medicine, which is the really abnormal thing for somebody with an MD PhD to do but one that's been really good for me.

Robb: That's awesome. And it is so interesting. Do you feel like you've got a bit of a comparative advantage given you're steeping in Math and Physics, when you are just trying to deconstruct mechanistic processes and whatnot? It's so interesting to me. There are very smart people that take different routes into medicine but it seems like that engineering, Math, Physics just seem to be kind of a comparative advantage. Would you agree with that?

Brandon: Yeah. I think it helps mostly in just clarity of thought and taking in new information and then being able to synthesize it for my parents. So, everybody can read the news headlines and some new study comes out and they say, "Well, what about this?" And just a way to think about that critically, think about magnitude of effect, think about how impactful it's really going to be in someone's life. I feel like that helps me a lot in communicating that to my patients. And then I'm still interested in conducting clinical research in the future if that happens with my career. I think, yeah, it does approach how I affect or how I deliver patient care on a daily basis.

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Robb: Right, right. So now, you have clearly, something about the clinical interface has struck you. It sounds like that was a kind of a motivator when you did the work in Africa, like just having this direct interaction with people. Clearly, your clinical practice has influenced your thinking in kind of where you want to go with your career path. But what was it about the clinical application of medicine that

brought you into what you're doing with Antioch Med in this direct primary care medical practice? And maybe we should talk a little bit about what direct primary care medicine is, kind of unpacking all that.

Brandon: I'll explain kind of what I saw through my medical training and then how that led into my interest in direct primary care and what that is. So, more and more just going through med school, finishing residency, you see the frustrations that both physicians and patients have with our current medical system. Our current medical system is you have some sort of third party coverage. That could be a private insurance, that could be something through the state, that could be something federal. And you have to take that card and then take it to your doctor's office and they use that to pay for your care.

What that means is the doctor's office has to -- They only get paid when you're in front of them and they only get paid when they can see X amount of people in the day to cover their overhead. And then their overhead is very expensive because they have to deal with all these payers. They have to pay a billing department to deal with them. They have to pay a nurse to do all their prior authorizations. There's just a lot of bloat within the system that neither the physician nor the patient is very happy about.

When they call a physician office, they get a receptionist who then will talk to a nurse who then will talk to the doctor and then the doctor may not be able to get back to them that day. So, as I went through my training, I said there's got to be a better way to do this. And what we've kind of come across is this direct primary care model. And this is a model that basically delivers primary care which is 90% of what anybody's going to get for their health care, delivers that in a way that's directly to the patient.

So, our clinic is -- Well, there's a saying that once you've seen one direct primary clinic you've seen one direct primary care clinic. So, in a sense, is fairly typical and that how it works is people pay a membership fee. So, they become members of our clinic through paying a monthly fee. How I explain that to people is they are paying for my time. So, for the less than the cost of somebody's cell phone bill, they're going to get a doctor that is devoted to creating a care plan for me, who's going to be answering their text, their emails, their calls, there to answer their questions.

Along with that, we try to provide other benefits. And so we don't take any of those payments from third parties. We think people should have catastrophic insurance so that if they get in a car crash, if they have a major surgery, that's there to pay for that. But the day to day things I can do for their monthly fee plus inexpensive ancillary benefits. So, some of those include -- I hear on your podcast you talk about labs that people should be checking and talking about

these things. Well, labs through our office for basic thyroid test, basic lipid test, blood count, electrolyte counts, like if you test all of those at once, they're $15 from us. We have just agreement with a national carrier. You get your labs at a discounted cost through our office. Same thing with imaging tests. We can get CTs and MRI scans for anywhere from $300 to $400 instead of running it through your insurance and paying $2000 to $3000 for those types of things.

Robb: Keep going. Keep going. You're on a roll.

Brandon: All right. I was just saying. And then in office procedures, many things like pregnancy tests and urine tests and ECGs, they cost so little for me to buy. There's no point in charging them. It's included in the membership. And then if you need sutures I just charge you for the cost of suture kit that I buy. It's $10, and you've already paid for my time with your membership fee. So many of the things we do in health care that can be done at the clinic level with your primary care doctor. It's just bloat to kind of deliver them through a third party payer.

The analogy we use is the car analogy. Nobody pays for their windshield wipers or put gas in their car or to put tires in the car through their auto insurance. The auto insurance is there if they get in a wreck. Well, true health insurance would operate similarly to that and we can save people lots of money and deliver a lot better care through this model that's been developed.

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Robb: Doc, man, I'm thinking a million different things here. One of them is that when we look at the history of medicine in the United States relative to the rest of the world, there was a time not that long ago that virtually all care was effectively direct primary care. Perhaps it wasn't the -- It was still kind of fee per service but there was competition, you could price shop. And then around World War II we had a situation in which there was some wage freezes because they didn't want to pay people back home more than what the folks fighting the war were getting paid.

And so one of the workarounds on this was that employers, to get better workers, they had more kind of savory insurance programs. And so that was the workaround. I know you know all this stuff. But in trying to explain how our health care system has reached the point that it's at, we seem to have an enormously broken system in the United States and then we have some systems like the Canadian system, Northern European systems which have some very laudable characteristics that pricing and the cost tend to be controlled because they kind of capitates stuff, some central planners dictate what the pricing is going to be and there's a little bit of rationing and stuff like that.

But people usually don't appreciate that there is a way to dispense medicine without this third party payer system. And one of the analogies that I make is actually veterinary medicine. We have not seen exponential increases in veterinary medicine despite the same types of technological advances, pharmaceutical advances. Could you talk a little bit about that? I know this stuff gets so politically charged and complex and whatnot. But could you talk maybe a little bit about the moral hazard that occurs in that third party payer system?

Brandon: Sure. Yeah. And I will, from listening to previous podcasts of yours, I think we would come down politically in agreement but I'll try to stay away from those hot button issues.

Robb: I just want people -- I don't want to trigger people right out of the gate such that they just turn this off but I would like to throw out there that there may be some different ways of doing things. Just as a possibility.

Brandon: Yeah. And I will basically kind of stick to why I think our model simplifies things and can make both doctors and patients and payers happy. So, the first place to start is you gave a good history. We have, for whatever reason, and World War II is about the time it moved much into this third party model. When you have a third party, so when a patient is spending a third party's money, whether that be their employer's money, whether that be the government's money, whether that be their insurer's money, they just have a lot less incentive to care what happens to them.

So, if you have really good insurance and you go get labs done you don't care if they're $15 or what most people come in. So, if they've seen a doctor in the previous four months and have labs done, they are $350. If they don't see that cost, they don't have any incentive to price compare. Like you're talking about, the transparency is not there. What we're seeing more and more is that deductibles are rising and people are starting to care more and more so they realize that, hey, if I'm somebody with any chronic condition and I'm going to have to take a medicine and have my labs drawn on any regular basis I should care where I get this done and I should care about the service that I get when I get it done. I should care if my doctor calls me the next day with the lab results and explains them to me.

So, the option to have a place like ours, and there are lots of clinics like ours throughout the country, the option to do that, I think, is starting to catch on with people. And it's starting to catch on with the medical community too and that doctors are realizing that there's another way to practice medicine that doesn't make them see 20 to 30 patients a day, spend eight minutes with a patient, spend the majority of the time with their electronic medical record and go home

tired because they didn't really do what they were trained to do. They did most of their time billing and documenting.

The one thing I will touch on is we do try to, while we don't accept payments from any third party, we do try to help businesses out. For whatever reason we are still kind of stuck within the you-get-your-health-insurance-through-your-employer. We try to help local businesses out with that too. If a local business wants to work with us and pay the membership benefit on the patient's behalf, they will see savings because we will handle so much within our clinic that people aren't having to go get super expensive lab bills, aren't getting referred to specialists unnecessarily, aren't making a bunch of claims for every time they to go the doctor so that their premiums rise every year.

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And if they decide to give the option for a cheaper premium with a higher deductible in their plan, they can use the HSA to pay for all the ancillary things that happen in our office. So, it's a way for them to lower their cost and for their patients paying as well. So, we do somewhat try to work with businesses to reduce their cost, let them do what they do well with their business so they don't have to worry as much about health care costs affecting their business. So, that's something we started to do as well.

Robb: Interesting. And Doc, this question may take us out into the weeds a bit but have you noticed that the businesses that are more open to doing this process, are they mainly self insured captives?

Brandon: It runs the gamut. So, somebody even that buys an off the shelf plan from a major carrier with just a high deductible they will use our services. Somebody that is partially self insures, and actually I'm not an insurance specialist but the few that we run into, we explain that you can get creative where you can craft the plan around this. Again, this is outside my area of expertise but there is something creative you can do for people that want to self insure as well. So, it runs the gamut of business.

And some businesses will just say, "Hey, I only have five employees. I don't have enough employees to be required to offer health insurance but I think this is something I'm going to do for my employees," right off the top. Just, "Hey, you have doctor. This is a benefit that is affordable we can give to you," and it's going to help them retain the quality employees by keeping them there. So, we help businesses of all different kind of sizes and shapes.

Robb: That's fantastic. It's interesting. So, we have a somewhat similar process here at the, Specialty Health Clinic in Reno. When we've rolled out this wellness program

that we developed initially with the police and fire departments, the main folks that have bought into the process are these self insured captives. And again, I don't want this to get out into the weeds of insurance and I also am not an insurance expert, but just kind of throwing this out to people again to think about the big picture levers that get pulled that can make things either more or less effective.

But these self insured captives are sticking money into an insurance product as a means of wealth maintenance or wealth growth potentially and there's some tax benefits to it. But this is basically the pool of money that is then being used to insure and provide care for the employees or like members of a police or fire department or what have you and they really care about what's going on. Because if they burn through all that money then they're kind of out of luck.

I actually just had a reach out from one of the native American nations that is interested in getting more of this direct primary care process going because they basically self insure their community and one year ago, within a two-year time, they increased their diabetes related costs went up 30%. This was from $120 million of aggregate diabetes related costs and then that went up to $180 million for this group of people. That whole thing is kind of running into a brick wall at some point with these costs.

Maybe you could talk a little bit about that. Also, I've tried to use some analogies like Moore's Law, like our cell phones get cheaper and better over time. We know more about medicine than we've ever known, pathology, but yet things get more expensive. And people are oftentimes confused by that. I would argue that it's the lack of market signaling in this current environment that drives that. if we look at things like LASIK eye surgery and some other elective procedural type processes, typically the process has gotten better and cheaper over time. But we see kind of the inverse of that in general medicine. Could you talk a little bit about that?

Brandon: I think that goes back to our earlier comments about spending other people's money. When that's happening, you put layers of safety in place to make sure it's being spent appropriately. Those layers of safety cost money. Doctors spend their time doing prioritization and doing lots of non-patient centered things with their time. They then try to squeeze out profits where they can. Whenever the insurance says you can charge for lab, they're going to charge that, try to get the most out of it they can. They try to bill to the highest level.

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If I see this person, I can list all their chronic problems. They bill to the highest level. And neither the provider or patient really -- There's no agreement between

them. I think most doctors go into this wanting to just take care of patients, take care of patients well and improve their health. But when they get into it and if they're co-owner or they're practice or even if they're employed, they will have -- They'll be held to some kind of productivity standards and that drives just seeing more people billing to the highest level and then not kind of really knowing where the money goes after that.

And ours is just very simple. The monthly fee pays for my time and then I am able to have the time. So, what our clinic looks like, every new patient that comes to me, I spend at least an hour with getting their medical history, hearing what they've done in the past. And then you kind of touched on the diabetes cost. Like this is where I feel like we really are able to help businesses or other entities or even just individuals is that a doctor sitting down and not just saying, "Your blood sugars are bad, take more medicine."

But if a patient really wants to change and really wants to heal from diabetes, explaining to them the underlying concepts, and actually this can kind of tie in with some of the nutrition topics that are much more related to the normal fare on your podcast. A doctor taking the time to really dig in and explain that to them and explain how they can take care of themselves instead of increasing the cost of more and newer medicines that we can give them is really important.

Now, I am not an anti-medication person by any stretch of the imagination. I try to provide really evidence based care and for patients that want to keep their current lifestyle we need to give them things that mitigate the effects of that. That's probably what you're seeing or that person that reached out to you where they're saying their diabetes costs increase exponentially. If there's no behavior change, yes, you're just going to have to do kind of more and more things to manage the effects of the diabetes.

But if you have somebody that can understand the mechanisms, explain that to a patient in a way that they decide like, "Hey, this is something I can do and something I can change," then the cost savings are enormous. I'm not sure if I fully answered your question.

Robb: You did. Yeah, yeah, that's fantastic. So, you mentioned and HSA earlier, health savings account. I would definitely like to talk about that just a little bit. And again, this is where this stuff gets really complex and very emotional for people. But when I look at this system and the way the systems have run in the past we have so much inefficiency, this third party payer system with all of the moral hazard that's build into it where I don't really care what the insurance is paying and they try to short the doctor and so the doctors got in labs or what have you to increase their prices. And it's this cat and mouse game instead of having just some transparency.

I've oftentimes mentioned the Singapore model which is health savings account driven which these things are an opportunity for people to put pre taxed dollars into an account and they can spend it largely any way that they want on elective medical procedures, on drugs, prescriptions and whatnot. And then they typically have a catastrophic plan so that if they get hit by a bus, have a major illness or what have you, that can be addressed. And then the topic comes up for people who are poor and are not making much money.

And in the Singapore model, the government actually provides a stipend that goes into an account that is owned by that individual and if that individual then gets a job and they start moving up the economic ladder they may not continue to receive that specific stipend. But the money that they had in that account doesn't go away. And so there is not that negative incentive to get out of that. Could you talk a little bit about -- And I know I'm throwing like gazillion different things at you. We didn't really discuss what we're going to get into before--

Brandon: These are all good questions.

Robb: -- the show. But could you talk a little bit about that and kind of how -- Like this is much closer to going and buying a car or buying a tomato than what our current expectations are from medicine. Could you maybe talk a little bit about that and kind of the potentially laudable elements of this whether you're an employer trying to help your work force have better health or whether you are a single parent who is trying to just make it one day and a time and you need some basic medical coverage.

Brandon: Yeah. I think the most important thing of the things that you talked about is a patient having the skin in the game to care about what kind of care they're receiving. With people that are employed and having health savings account, they get to put that money in tax free.

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It's their money and they want to choose it to use it wisely. We've had a couple employers decide to even match some contributions to HSA and that's been just great. Like if they put $500 in an HSA account for the employee, well, it's going to take me a long time with how cheap our labs and imaging are just spending $500. So, that may take care of most people's stuff from our clinic for a year's worth of time.

At the same end, you'd say how do we apply this to different populations? I think that's one of the things that's great about our clinic. One of the ways we're different a little bit than other direct primary care clinics is we do in patient

medicine. So, I will round on my hospitalized patients and be there doctor and charge them a very minimal fee for that. And then also we do obstetrics. We try to really cover the gamut of basic things that we can do for our patients. So, we get to take care of people that are holding down multiple jobs, have a couple of kids, single mom, uninsured, all the way to like the owners of these companies we're working with. So, our model applies to a very broad range of people within the spectrum.

Now, the one situation where you kind of brought up, so it would be most for the low income people. Those would be the people that would likely qualify for Medicaid. Right now, if you hold the Medicaid card, any provider that accepts Medicaid you can go in and you're not going to have any, usually not have any expenses related to that. You can go to the urgent care or ERs and, again, not really have a ton of expenses related to that with the Medicaid.

Now, could a state government get creative and say, "Hey, we're going to pilot a health savings account for our Medicaid population." You fund $500 to $1000 or something, whatever, below the cost of what you would expect to pay for a Medicaid person, have them have their stake to say, "I have a stake in this money. I can use this either to go to the ER or to pay a membership card clinic and I will come stitch you up for $10 instead of the $900 it would need to go to the ER." I think that's something that a government could be creative in doing. Unless you've run across anybody wanting to do that, I would love to talk to them. But it's not something that's been tried.

Robb: I have none.

Brandon: With the Medicaid population. Some states are actually moving towards using direct primary care to save money on their state employees. I can send you a couple of articles related to that. That's been done in a couple of counties and states in the past. So, they are seeing the model be effective in reducing costs for governments as well. But that would be my only thoughts of how you could get creative for a governmental third party payer to save money by partnering with us.

Robb: I love that. And this is something that I again try to share with folks a little bit. Here's an idea. If we dig back into history a little bit, when the Clint administration did a welfare reform program, they largely kicked that back to the states. Instead of just having one federally implemented program, the states were basically tasked with, okay, how are you going to provide the infrastructure we need, the incentives and whatnot. And there was a period of time where the different states chugged away on this stuff and there were some great innovations. There were also some absolute train wrecks in which things were not well thought or vetted out. But we had 50 different reaction vessels instead

of one. And then at the federal level, they kind of looked around, saw what was working and pulled that back up to more of a federal level and then recommended that back to the states.

This is something that I'd been suggesting to folks, that if we had an opportunity like this, if we tried to decentralize things more, run more of our health care and so much of our lives, education, more the local or state level, then we have much more opportunity for innovation and a lot fewer layers of governmental kind of influence on this. And so you've got people who are potentially more accountable.

And sometimes it will get some push back and people will mention, "Well, what about the northern European countries?" Again, they have some laudable programs like in Denmark and Sweden but what I also mentioned to folks is that we have 12 or 13 cities in the United States that have a larger population that these whole countries, than the country of Denmark or Sweden. And so the economies of scale are quite different. And we just have a really remarkable tendency in the United States to want to centralize things instead of decentralize them and get people more at the local level kind of playing with this stuff. What are your thoughts around that?

Brandon: Yeah. The comment I would add when people talk a lot about the Nordic countries and their successes, they also have one, the population amount, but nowhere near the heterogeneity of the population that we have in the United States.

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Here in Wichita, we have people from all over the place that come to get care at our clinic. And so in those countries, you're dealing with a much more homogenous population which is one that can be a big difference that I don't think is talked about.

Robb: Well appreciated, yeah.

Brandon: When they look at that. So, I thought about like how does that kind of apply? I think what you're kind of saying reminds me a lot about one of my favorite writers, Nassim Taleb. I think you've talked about his work before. To the extent possible, when you get things to a smaller level they can, the amount of overhead cost is just going to be so much less. And so if you're going to get creative in the health care sector, the Medicaid versus Medicare, which is more federally run, that might be the place to get creative because each state can kind of choose what they want to try to do with their Medicaid budget. That would be a place where I think the most innovation could occur.

Robb: And again, people get really nervous about this. I literally had folks say, "You just want old people to die in the streets." I'm like no, I really, really don't. I've actually spent 20 years trying to help folks and trying to navigate all sides of this story but there is some real renaissance to kind of acknowledge or embrace some of this stuff. It's interesting, there are some fascinating things changing just in Nevada last year.

There was a bill passed in which police officers or law enforcement officers that work within the state, if they are known tobacco consumers, they have like a four-month period in which they can become non-tobacco consumers. Otherwise, the state will effectively cease paying any future healthcare related costs that could be implicated as secondary effects of tobacco consumption which could be basically anything.

What's interesting with that is, on the one hand most people, because people have mixed feelings about police officers in general. Some people really like them and they feel like they're a public servant so they should toe the line better. Other people just don't like cops and so they want them to have a kind of rough going. But the exponential cost that are occurring, there are these kind of capitating processes where on the one hand we have opportunities to find kind of market driven solutions in these stories and a line incentive so that they work well.

And on the other hand, if we don't address these, what I've observed is that at some point the government will get in and say, "Well, if you're a smoker, we're not going to pay for stuff anymore and you are going to be out of luck if you continue to be a smoker." It won't be long before -- If you are diabetic and you continue being diabetic and you don't follow the guidelines that the government put out which is also kind of a scary thing because if people listen to this podcast you're kind of aware that our standard dietary model really isn't helping people that much.

But at some point they're going to say, "Well, if you've been diabetic for two years and you haven't reversed this type II diabetes then we're just not going to pay for your stuff." And so old people are going to die in the streets. These cost overruns have to be addressed one way or the other. And we're either going to do that in a more decentralized dexterous process, maybe with HSAs and this direct primary care which provides opportunity for health coaching and building relationships or we're going to have this very centralized government driven process in which they just decide you're too expensive to insure, too expensive to deal with, and that's kind of the way it's going to go. I mean, do you kind of see the story playing out like that?

Brandon: So, what I see in the government's place, honestly what I see, and the reason I think premiums are increasing and increasing, is because instead of allowing somebody to go to the market and say this is who I am, this is what I want for insurance, Blue Cross or any major carrier, what would you write me an insurance policy for? That is no longer legal.

So, what the government instead is every plan that's offered on the individual market has to meet certain guidelines. It has to cover these things that we have deemed to be routine, preventative care, has to cover all of those like within the insurance, no careabouts for even though I can do fecal occult blood testing once a year for $8 and screen somebody for colonoscopy or screen somebody for colon cancer. If they want the colonoscopy they can spend more. That would be their choice.

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But they're basically standardized. There's only one type of insurance project we can or one type of insurance plan that we can sell and everybody has to fit within this model of you take sick people and well people and put them in this model. The well people say, "That's way too expensive. I'm not doing that." That's where I see the process of things becoming centralized. They said this is the only insurance project that can be sold in the individual market. Everybody has to buy this and it's just super expensive when there are lots better options for like joining a clinic like ours and having a truly catastrophic plan would save people tons of money.

It's interesting. We see some responses to this just kind of whether the people that come to our clinic -- So, there's a big push to be part of cost sharing ministries. Some are fixed based, some aren't. But we see a lot of people that they write a $500 check for their family each month. They send it to somebody else. They're sharing the cost. But all of the routine stuff, they are responsible for. So, they are insuring, I mean, functionally insuring or cost sharing their health for $500 a month for a family getting all their care through us for very inexpensively for their primary stuff.

If they need a big surgery, that's there to back them up for those big things but they're saving thousands of dollars sometimes each month on insuring their families through the combination of these new products that are cost sharing ministries pairing it with DPC. So, I think we're seeing at least people getting more creative with how they go about paying for their health care as a response to this centralization and standardization of what's available.

Robb: Right.

Brandon: That was a little bit of a rambling answer.

Robb: No, no. It's fantastic. And I know for the two people who are still listening to us because we're talking a bunch of insurance and stuff like that, if one of those people happens to live in Europe or Australian, New Zealand, Canada, they're probably like, "Wow, the US is just screwed." Because they have these pretty well functioning comparatively state instituted programs. And again, there's some very laudable characteristics to that. But even these programs, because of changes in demographics, some of the northern European socialized medical systems, they were able to really provide some great service because they had a much larger productive population than an older consuming population. And consuming being medical needs.

And these demographics are changing everywhere. You look at the National Health Service and the UK, like the demographic bulge is going to really going to flip here in the next five to ten years and they're kind of easing up into that and they're seeing some things get tighter and tighter. And even in these established scenarios they are going to have to figure out how to manage all this stuff. And it's kind of butting up against also this tendency for what the US had done has exporting a dietary guideline and kind of philosophy that seems to make people sicker and sicker at an ever increasing rate, kind of running up against an aging population and then no real solid signaling, price signaling that will feedback and say, "Well, apples should be cheaper than Twinkies and being healthier should have some sort of a built in incentive financially and sociologically."

And those things will have to pop up at some point. It will be very interesting how all this develops in the future. But, Doc, I want to be respectful of your time. Can you tell folks where to find you and find Antioch med on the interwebs?

Brandon: Yeah. Our website is antiochmed.com. We have a Twitter account that, honestly, my business partner runs more of the social stuff than I do. I had to get a Facebook account in order to be a part of our Facebook page. But you can find us on Facebook. I think it's facebook/antiochmedclinic. And then we're at AntiochMed on Twitter. So, welcome to look us up there and we're happy to talk to other doctors that are interested in this, happy to talk to other people that have ideas about what our model could be useful for in business or all the areas that we discussed. So, we talked to a lot of people around the country about this stuff.

Robb: Fantastic. Well, Doc, so appreciative of what you're doing, very excited to see how you guys progress over time. Maybe six months down the road, can we bring you back on and just kind of discuss how things have developed since our first chat?

Brandon: Yeah. That would be great. I'd be happy to do that.

Robb: Fantastic. Doc, again, thank you for coming on the show and looking forward to meeting you in real life at some point.

Brandon: Yeah, that would be good.

Robb: Okay. Talk to you soon.

Brandon: Thanks.

[0:40:11] End of Audio