

Fixing America's Health Care System

A Progressive Plan to Cover Everyone and Restrain Costs

by David B. Kendall

The problems with America's patchwork health care system are fast reaching a critical mass. Soaring costs, rising faster than inflation, are eroding workers' coverage and paychecks. Sixteen percent of Americans have no coverage at all—a problem that has become worse in the last five years. And medical studies reveal an alarming extent of poor-quality care that affects everyone.

A slew of perverse incentives and outdated practices undermine the promise of modern medicine. Insurance companies pay doctors and hospitals the same fees regardless of clinical success or failure. The government subsidizes coverage for highly paid business executives more generously than for rank-and-file workers. Courts rule on malpractice lawsuits without giving doctors guidance about how to avoid medical mistakes. Doctors use paper records that cannot be automatically checked for mistakes, duplication, and missing care. Patients receive treatments for avoidable ailments without anyone showing them how to take better care of themselves in the first place. Scientists regularly produce important new knowledge, but fellow scientists fail to incorporate it into research that delivers cures, and it often goes unused by doctors for years.

These problems are serious but not unsolvable. What is missing today is the political

imagination and courage to move to a new vision of universal health care—one in which government takes action in the public's interest, without seizing control of the system. Such a vision would reject the false choices offered in the stultified left-right debate between those who seek a government takeover of health care and those whose veneration of free markets would leave individuals to fend for themselves. Instead, it would equip Americans with the tools they need to build the world's best health care system from the ground up.

President George W. Bush has pinned his hopes on health savings accounts (HSAs): tax-free accounts for ordinary medical expenses like physical checkups and preventive care. They must be accompanied by high-deductible insurance policies for major medical emergencies. They are meant to restrain spending by having consumers themselves pay for the full cost of health care services out of

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“One person with a belief is a social power equal to ninety-nine who have only interests.”

—John Stuart Mill

The Progressive Policy Institute

The Progressive Policy Institute is a catalyst for political change and renewal. Its mission is to modernize progressive politics and governance for the 21st century. Moving beyond the left-right debates of the last century, PPI is a prolific source of the Third Way thinking that is reshaping politics both in the United States and around the world.

The PPI invents new ways to advance enduring progressive principles: equal opportunity, mutual responsibility, civic enterprise, public sector reform, national strength, and collective security. Its “progressive market strategy” embraces economic innovation, fiscal discipline, and open markets, while also equipping working families with new tools for success. Its signature policy blueprints include national service, community policing, and a social compact that requires and rewards work; new public schools based on accountability, choice, and customization; a networked government that uses information technology to break down bureaucratic barriers; pollution trading markets and other steps toward a clean energy economy; a citizen-centered approach to universal health care; and a progressive internationalism that commits America’s strength to the defense of liberal democracy.

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their accounts. But HSAs are not the panacea for rising health care costs that conservatives claim. Although they would stop some patients from running to the doctor unnecessarily at someone else’s expense, they would still require insurance companies to pay the bulk of health care costs, since most health care spending is for emergencies and other high-cost care, not ordinary expenses.¹ These accounts are also unfair to patients with chronic illnesses who have higher everyday expenses that will quickly exhaust their savings accounts.

Health care is not merely an individual responsibility. Like education, health care is critical for our personal and collective prosperity. It cannot guarantee good health, but it can prevent setbacks from diseases and accidents.

All Americans should have an equal opportunity to receive high-quality care.

The United States should have a health care system that covers everyone; uses choice, competition, and performance standards to discipline costs; shares the responsibility for paying for health insurance between individuals and society; and rewards doctors and hospitals for the quality, not quantity, of the care they provide. This system needs to be as up-to-date in Information Age technologies as financial services, manufacturing, and other major industries. It needs the support of a legal system that provides reasonable compensation to injured patients based on clear legal and medical standards, which can help doctors prevent injuries. Finally, it needs to be continually renewed with the promise of

cures for those who suffer from disease and injury. Specifically, we propose six steps toward high-quality, affordable health care for all:

- 1) Universalize the health care choices members of Congress enjoy;
- 2) Require shared responsibility for the cost of coverage;
- 3) Pay doctors and hospitals according to their performance;
- 4) Deploy information technology for better care and lower costs;
- 5) Create health courts for fair and reliable justice in malpractice cases;² and
- 6) Create a National Cure Center to speed medical breakthroughs.

What Is Wrong With Health Care in America?

Having a good job with health care benefits is part of the American dream but that dream is threatened by the glaring shortcomings of America's patchwork health care system. The problems fall into three main areas: burgeoning costs and declining quality of coverage among those who have it; preventable death, disability, and bankruptcy among the uninsured; and unsafe and low-quality care that affects everyone.

Burgeoning Costs and Declining Coverage

Too many U.S. workers feel their health care benefits slipping away. Medical coverage is again at the center of labor disputes, as employers are cutting back or reducing benefits. Here are the trends:

- ❑ **Rapidly rising premiums.** After a lull in medical inflation during the early and mid-1990s, health care costs began to rise again in the late 1990s and have rapidly increased since 2000.
- ❑ **Health care costs outstripping wages.** Health care premiums have been increasing faster than wages since 1998. For the past four years, the average premium hike has been at least triple the country's wage growth.³
- ❑ **Less coverage.** From 2000 to 2004, the number of people without health insurance rose by 6 million, according to the U.S. Census Bureau.⁴ This precipitous increase has wiped out all the progress made in the mid- and late 1990s, when the rates of people without insurance fell for the first time since the Census began collecting data on health insurance in 1987.
- ❑ **Shrinking benefits.** Deductibles have increased by nearly 20 percent each year since 2000. Employees in small business now typically face a deductible of \$600.⁵

Rising costs are clearly disruptive—especially when they greatly exceed wage growth. But some portion of the rapid cost growth accurately reflects the growing value of modern medicine. Costly new technologies may drive up premiums, but they also yield longer, healthier lives.

Meanwhile, an aging population and the impending retirement of the baby boom generation will drive up health care spending and put ever-greater financing demands on younger workers. The great public policy challenge of our time is to ensure that everyone has access to a basic level of health care services that continually improves yet remains affordable as demographics drive up demand and technology drives up costs.

Death, Chronic Illness, and Bankruptcy Among the Uninsured

A coroner's report will never list lack of insurance as a cause of death, but people in fact die when they do not have access to appropriate care. Paramedics and emergency room doctors can treat a heart attack victim, but they do not provide the drugs and follow-up care needed to prevent further heart problems. The costs of our nation's chronic failure to cover the uninsured are high and mounting:

- ❑ **Preventable deaths.** According to the Institute of Medicine, 18,000 uninsured Americans die prematurely each year because they lack access to the non-emergency care that those with insurance typically receive.⁶ That is roughly equal to the number of Americans who are murdered each year.
- ❑ **Chronic illness.** Uninsured people with chronic illnesses lack access to regular care and suffer poorer health than those with insurance.⁷ They are three times more likely not to receive needed care,⁸ and under-insured people with chronic illnesses are twice as likely to be in fair or poor health and to be disabled.⁹ Additionally, increased copayments and deductibles for drugs in employment-based health plans have caused people with chronic conditions to cut back on their medications. For example, when patients with diabetes see their insurance copayments double, they cut back on their medications by 23 percent, which is likely to lead to complications such as amputations and heart disease after a few years.¹⁰
- ❑ **Bankruptcy.** Medical bills, along with credit card debt, are the most common reasons for personal bankruptcies in the United States.¹¹ Medical bills contribute to about one-fourth of personal bankruptcies.¹²

Although research does not show how often being uninsured causes bankruptcy, it does show that the lack of health insurance frequently worsens individual financial problems.

- ❑ **Economic losses.** The loss of productivity when workers are sick, the extra costs of medical care for uninsured Americans, and related costs total between \$65 billion and \$130 billion annually, according to economic researchers assembled by the Institutes of Medicine. The net economic gain from covering the uninsured would be between \$31 billion and \$61 billion per year.

Unsafe and Low-Quality Care Affects Everyone

Our health care economy is plagued by unsafe, low-quality care and chronic waste. For example, prescriptions are not routinely checked for dangerous interactions or whether patients even picked them up at the pharmacy. Medical mistakes are hushed to avoid lawsuits instead of being discussed openly to prevent future errors. New medical knowledge is not automatically or consistently incorporated into the process of how doctors make treatment decisions. And health care delivery is hardly a model of efficiency: Medical records are often kept in thick paper files and archived in distant warehouses, while nurses and doctors track down patients by phone instead of email to deliver test results and schedule follow-up care.

No one wants to see doctors and hospitals in a bad light since everyone depends on them at some time; the very act of healing often relies on trust in a medical professional. So, these inefficiencies often appear to patients as inconveniences rather than indicators of poor quality. Despite countless hours searching for the right care, waiting to see the doctor, or learn test results, and wondering how much it will all cost, most people rate their own care as

satisfactory or higher. Such confidence reflects the health care system's general effectiveness and the need for patients to believe in their care when they feel vulnerable. To be sure, many doctors and other health care professionals have impressive medical expertise, life-saving insight, considerable technological capacity, and vast amounts of compassion. Despite the best intentions, the quality of care suffers and waste proliferates in many ways.

- ❑ **Unsafe care.** Polls show that one-fourth of the public has experienced a medical error, and between 48,000 and 98,000 patients die each year due to medical errors in hospitals alone.¹³
- ❑ **Substandard care.** Research shows that, on average, patients receive the right care only one-half of the time.¹⁴ Much of the deficit is omitted care as opposed to mistaken care. For example, surgeons performing hip replacements often fail to order antibiotics to prevent infections, which are especially threatening to older patients.
- ❑ **Variation in medical practice.** Health care researcher Jack Wennberg has documented wide variation in the use of medical services that have no effect on the medical outcome for patients.¹⁵ In fact, more intense use of medical care can produce poorer health when patients are overmedicated with conflicting prescriptions written by multiple physicians who do not coordinate their care.
- ❑ **Duplicative testing.** At least 13 percent of x-rays, blood work, and other diagnostic tests are duplicated because one doctor cannot readily call up the tests of another doctor.¹⁶ The annual cost of that duplication is \$15 billion.¹⁷
- ❑ **Unnecessary emergency room use.** Uninsured patients are not alone in receiving

care inappropriately through the emergency room. Hospitals spend about \$30 billion on patients (with and without insurance) who are admitted unnecessarily because emergency room doctors lack vital information about patients' health care problems and existing treatments.¹⁸

Six Steps To Comprehensive Reform

The system clearly needs sweeping reform. The political challenge, however, is to make comprehensive reforms without threatening existing health care for most people. The following six proposals for reform would give everyone an equal opportunity to be healthy without forcing anyone give up what they already have.

1. Universalize the Health Care Choices Members of Congress Enjoy

Millions of workers, especially those in small businesses, have no choice in their health care coverage because their employer picks a provider for them. This lack of control makes them less satisfied with their health care plan, suppresses competition between health plans, and gives health plans the wrong impression that employers, not employees, are their customers. In contrast, members of Congress and federal workers have a wide array of excellent private health plans to choose from within the Federal Employee Health Benefits program (FEHB). This system provides essential health care benefits, such as prescription drugs and mental health services, and gives federal workers a choice of 11 to 20 health plans, depending upon where they live.

The federal government should work with the states to universalize the FEHB approach. In

such a partnership, Washington's primary role should be to help people pay for coverage who do not have insurance, and the states should ensure that everyone has access to choices of coverage through either FEHB or a comparable menu of options that may be better suited to the way health insurance works in a given state. (Insurance laws and practices vary widely from state to state.) Sens. Richard Durbin (D-Ill.) and Blanche Lincoln (D-Ark.) and Reps. Jim Cooper (D-Tenn.) and Ron Kind (D-Wis.) have introduced legislation similar to PPI's proposal.¹⁹

In order for a health plan to be listed on a menu of options for workers, it should meet benefit standards similar to the FEHB. The same kinds of services should be covered, and individuals should be able to choose their own levels of deductibles and copayments as they can with FEHB. To ensure that any mandated benefits are cost effective, Congress should require that any legislation for mandatory benefits be subject to a cost-benefit analysis similar to current congressional budgetary reviews.²⁰

To make coverage affordable for moderate and middle-income uninsured workers and their families, Congress should enact a tax credit to offset at least one-half of the cost of the coverage. Congress should also enact a smaller tax credit for employees who are struggling to keep the health care coverage they have, but who are already receiving a partial tax break for their coverage. Health care benefits, unlike wages, are tax free. But this tax break perversely provides larger subsidies to workers in higher tax brackets. Tax credits would correct much of the inequity without creating big, disruptive public programs.

Public programs, such as Medicaid and the State Children's Health Insurance Programs (SCHIP), should continue to play a key role for low-income Americans and their gaps should be filled. For example, Medicaid leaves out many childless adults living in or near poverty because it was originally designed as part of the welfare system for women with children. The program

should be expanded to ensure that the children of moderate-income parents (about twice the poverty level) have coverage.

At the same time, Medicaid and SCHIP should be meshed seamlessly with job-based coverage to end the separate and unequal treatment of patients in these programs. States should allow people who qualify for public programs to enroll at work or school, rather than forcing them to enroll through the welfare office. States should also allow eligible families to use the money from Medicaid and SCHIP to purchase or supplement coverage at work. And Medicaid and SCHIP should be among the options available through the state-based FEHB-style menu of health plan choices. By eliminating the isolation of public programs, they would be less likely to dictate artificially low prices for health care services, a notorious practice that often limits access to care for patients in public programs.

This proposal asks employers to play a new, supporting role, rather than mandating that they assume the burden of America's health insurance crisis. Employers that do not provide coverage should offer the state-approved menu of choices, and use their payroll deduction systems to allow workers to take immediate advantage of new federal tax credits for health insurance. Employers who already provide coverage could use the menu to expand choices for their workers. For unemployed, temporary, and part-time workers, states should make their FEHB-style menus available through the unemployment insurance system, job training centers, and public websites. The administrative costs to states and employers for creating and administering a menu of choices would be offset with federal tax subsidies.

Workplace enrollment is convenient and effective. Studies show that making enrollment as automatic as possible can produce much higher participation in job-based benefit plans.²¹ With automatic payments, employees do not regularly confront the question of whether

health care coverage is worth it when compared to other purchases that may hold more immediate appeal.

The net cost of making coverage affordable for all Americans is roughly \$70 billion annually. However, such a steep price tag should not deter incremental progress, which could be achieved for roughly \$20 billion.²² This initial investment could be financed with savings generated by deploying information technology to reduce duplicative and unnecessary health care services (see step four), and other revenue sources such as taxes on insurance premiums or pollution. Future expansions would be contingent on the success of other cost restraint measures, such as the pay-for-performance programs described below in step three.

2. Require Shared Responsibility for the Cost of Coverage

The uninsured impose a cost on everyone when they need care. Although hospital emergency rooms are rightfully open to everyone, regardless of the ability to pay, they are under increasing threat of closure due to an influx of non-paying patients. In effect, the insured pay for the cost of maintaining this safety net. Only by covering everyone can we end this inefficient and inhumane system of cost shifting.

Universal coverage should be a shared responsibility, not some new government entitlement. Government should pay for those who cannot afford to buy their own health insurance. But people who can afford coverage should be required to pay. Specifically, individuals who can get insurance through the workplace should be required either to take that coverage or pay a tax penalty (such as the loss of a personal tax exemption, which was \$3,100 in 2004). The tax penalty would then go to an uninsured health care fund to finance safety net providers, much as people without auto insurance are required to pay into uninsured motorists' funds in several states.

This requirement should be phased in according to income, starting with upper-income individuals (who make up about one-fourth of the uninsured), as Sen. Bill Frist (R-Tenn.) has proposed.²³ As tax credits and public programs make coverage affordable, the requirement should extend to all income levels. For example, as former Sen. John Edwards (D-N.C.) proposed during his campaign for the Democratic presidential nomination, parents should be required to obtain coverage for their children as part of a new bargain that makes coverage affordable through tax credits and public programs.

Employers should not be required to pay for their employees' coverage because the costs of such a mandate would fall most heavily on low-income workers in lower take-home wages. Nonetheless, surveys show that most small business owners who currently do not provide coverage would like to do so and would be willing to pay for a portion of health care benefits.²⁴ If Washington paid more than one-half of the tab for covering the uninsured, PPI's approach would enable those employers to kick in their own money for their workers' benefits.

3. Pay Doctors and Hospitals According to Their Performance

The old adage that you get what you pay for is often not true in health care. The income of doctors and hospitals generally depends on the volume of procedures they provide, rather than how well they perform those procedures. Nor are they rewarded if they drive costs down. Good, efficient care is obviously more valuable to patients than bad care, but it is all the same to providers' bottom line; they generally get the same payment either way. Doctors who try to deliver high-quality, cost-effective care are not rewarded by the reimbursement system.

Health plans basically pay medical providers for specific procedures, not for attending to the overall health of patients. This is akin to buying the parts of a computer without any guarantee

that they will work together. And many studies show that the various parts of the U.S. health care system do not work well together. A comprehensive national study by RAND shows that patients receive the right care only about one-half of the time.²⁵

Additionally, health care costs are out of control because there is little competition to reduce them.²⁶ Employers traditionally have shielded workers from the cost of services, so the price of those services did not much matter to patients. Today, employers are shifting costs to employees, but they are not giving them the tools they need to be effective health care consumers. For example, patients cannot engage in comparison shopping for lower-cost care because health plans and providers do not tell them the price of their care ahead of time.

Fortunately, some innovative employers, health plans, and providers are working together to change the reimbursement system. For instance, seven health plans in California are collaborating with providers and medical experts to set standards by which health plans reward high performance.²⁷ Insurers receive a bonus if their patients with diabetes have their condition under control. In contrast, paying by procedure rewards providers when diabetes is out of control and patients need amputations, eye surgery, or heart surgery. Nationally, approximately 35 health plans covering about 30 million people have pay-for-performance programs.²⁸

The federal government should leverage pay-for-performance and similar market trends in the following ways:

- ❑ ***Expand regional purchasing coalitions.*** Larger employers have formed coalitions like California's Pacific Business Group on Health to improve their negotiating leverage with health plans and providers. In Washington, King County County Executive Ron Sims has launched an alliance that will coordinate systemwide quality improvement and cost restraint efforts.²⁹

Many such coalitions lack the resources and market clout to be effective, however, and most areas of the country do not have one. The federal government should expand purchasing coalitions and increase the effectiveness of their activities by offering performance-based grants that reward groups of employers that improve quality and lower costs by collaborating with providers and patients and sharing successful methods. Coalitions could use these grants to purchase and deploy new technology for reducing costs and improving quality.

For example, a company called Symmetry Health Data Systems has developed episode treatment groups (ETGs), a system for comparing costs. These ETGs bundle together all the bills from doctors, hospitals, and related services in ways that patients experience health care problems and services—for example, normal pregnancy without Caesarian section, minor depression, or surgery for back pain.³⁰ Using ETGs, health plans can identify and reward providers who have the lowest costs for specific problems by steering patients to them. Health plans could also develop a patient-friendly version of ETGs so that patients themselves could make a cost-conscious choice about their health care for a given medical problem.

- ❑ ***Give patients (and providers) information on performance.*** When a patient makes a choice about a health care treatment, provider, or plan, she should have information about how it will affect her health in addition to her budget.³¹ The government should develop standards for reporting performance and use a carrot-and-stick approach to ensure that providers make this information available to patients. Today, many workers, including federal employees, have performance information about competing health plans (such as the use of preventive

services like cancer screening).³² Performance information about hospitals is becoming more widely available thanks to Medicare and regional employer coalitions.³³ Public performance information about doctors remains sparse, but many health plans provide feedback privately to doctors about their performance.³⁴

- ***Use the same performance incentives in federal programs and private health plans.*** Medicare has been conducting a pay-for-performance demonstration program that rewards hospitals for high-quality care that has shown early signs of success.³⁵ This program would be expanded throughout Medicare under legislation proposed by Sens. Max Baucus (D-Mont.) and Charles Grassley (R-Iowa), the leaders of the Senate Committee on Finance, which has jurisdiction over Medicare.³⁶ But to keep up with private-sector innovation, Medicare's administrators will need more flexibility to operate regionally in conjunction with employer coalitions. Due to Medicare's large size, any attempts to simultaneously change health care across the country are clumsy. As PPI has proposed, Medicare needs to be administered regionally by medical directors who can work in partnership with local employer health care coalitions and implement other initiatives in pursuit of national goals for quality improvement.³⁷ In addition, state Medicaid programs that have already taken the lead in quality improvement, especially for patients with chronic illnesses, should leverage their considerable investment by encouraging similar efforts in the private sector.³⁸

4. Deploy Information Technology for Better Care and Lower Costs

Making an appointment with your doctor, getting lab results, and renewing prescriptions

should be as easy as checking your bank balance online. But the health care industry lags behind most other sectors of the economy in the use of information technology. This slow adoption of information technology (IT) is dangerous and inefficient. Lifesaving records about medical history, prescriptions, and allergies are locked away in filing cabinets and isolated computer systems. The Food and Drug Administration cannot easily monitor the safety of drugs after they are approved for marketing. Doctors order duplicative tests because they do not have quick access to previous results. They cannot track the outcomes and costs of procedures as patients move from provider to provider. Experts estimate that nationally deploying IT in health care could save the industry \$78 to \$81 billion per year—about 5 percent of the country's total health care spending.³⁹ The federal government needs to mount a massive effort to bring health care into the Information Age.

The debate in Washington, shaped by political leaders such as Sen. Hillary Clinton (D-N.Y.) and former House Speaker Newt Gingrich (R-Ga.), has focused on how to move to electronic health records. Bipartisan groups in Congress have introduced legislation on this issue, and the administration's health IT czar, David Brailer, is developing proposals for promoting and sharing medical records electronically.⁴⁰

Despite the bipartisan interest in electronic health records, however, the debate about the government's role has focused too narrowly on setting data standards. Data standards are important to prevent confusion in the system, so that, for example, a doctor who records patients' weight in kilograms can understand the records of another doctor who uses pounds. Yet, data standards already exist for most critical health care data like diagnoses, prescriptions, allergies, vaccinations, and lab test results. These data are available in standard electronic form today, but the Bush administration is pushing for new data

standards instead of first putting existing standardized data to good use.

The federal government should spur the creation of a national network for exchanging standardized health information electronically. Its basic goal should be to build trust among patients by giving them control of who has access to their records through the network. It should also give clear benefits as part of a virtual medical home that includes their health records, online appointment scheduling, email access to doctors and nurses, electronic transmission of prescriptions and referrals, online support groups, self-care information (also known as therapy information), and customized delivery of medical information based on their health care problems and interests. Patients should be able to sign up for access to the network through their doctors' offices. For doctors, providing health network sign-up forms would be no different from providing information about patients' privacy rights under federal law, as they do now.

All parties affected by the use of health records should govern the network, including representatives of patients, doctors, and hospitals. The nonprofit organization Patient Safety Institute currently provides a professional system within which health care providers can share information and could serve as a way to create a national network.⁴¹ The federal government should encourage providers to use such a system. A modest federal investment would let hospitals, large medical groups, and individual doctors (through state medical societies) join a network. In return, the network would produce savings many times over the initial investment, both from decreased hospitalizations that occur when doctors lack patient data and from eliminating duplicative lab and radiology tests.⁴² This network would account for the savings, which could then be reinvested toward covering the uninsured. The network should also be used to eliminate some of the costs associated with using multiple systems for claims processing; verifying patients'

eligibility for insurance benefits; tracking diseases; drug and device safety problems; and provider performance.

5. Create Health Courts for Fair and Reliable Justice in Malpractice Cases

The nation's system of medical justice suffers from two fundamental defects: It does not give most injured patients access to justice, and it does not send clear signals about standards of care that would help health care providers avoid medical mistakes in the first place.

Only 2 percent of patients injured by negligent hospital care file malpractice claims.⁴³ Elderly and low-income patients, in particular, are even less likely to sue. About one-third of malpractice claims produce a payment through a settlement or a trial. Approximately 1 percent of patients injured by malpractice receive any compensation.

Injured patients usually do not know if they are victims of bad care or simply bad luck, and filing a malpractice claim can be an emotional, time-consuming ordeal. It entails confronting one's doctor and spending countless hours in acrimonious legal proceedings. Only people with serious injuries and the potential for large awards are likely to find a lawyer to take their case because the legal costs involved are so high. Even for those with a serious injury (disability lasting six months or more), the malpractice system compensates only one in 14 people.

To fix these problems, Congress should create a national network of specialized health courts that would replace America's broken medical justice system. As explained in a recent PPI report, health courts would make it easier and less costly for patients to seek compensation.⁴⁴ States would establish them as specialized, administrative courts similar to the system that handles workers' compensation claims. Sens. Mike Enzi (R-Wyo.) and Max Baucus (D-Mont.) have introduced

legislation to encourage states to create health courts as pilot projects.⁴⁵

Under workers' compensation systems, workers injured on the job simply submit a claim form through their employer to an administrative law judge or board. If the judge or board determines that the injury occurred on the job, a worker receives compensation according to a schedule of benefits that takes into account the severity of the injury, the degree of disability, and the worker's age and pay.

A health court system would be similar to the workers' compensation system in two ways. First, there would be a schedule of benefits to compensate patients for medical injuries. Second, a health court system would be designed to provide quick, consistently fair damage awards. In a health court system, an injured patient would submit a simple claim form, available through her health care provider, to a local health court review board. These boards would investigate claims and determine if they are clear, uncontested cases of malpractice. In such cases, they would simply order the injured patient's health care provider to pay damages according to a schedule of benefits.

After a health court review board has ruled whether or not a case is cut-and-dry, appeals of that decision, along with cases that are not clear cut, would go to trial before a health court judge. In a health court trial, as in a civil trial, lawyers would represent both parties. But unlike malpractice cases in civil trials, health courts would render decisions that would help shape clear legal standards for medical practice. In addition, the health court judges, not the plaintiffs or defendants, would hire expert witnesses to settle questions about medical standards. When health court judges find incidents of malpractice, they would determine awards using the same schedule of benefits applied by the review board.

By setting legal standards for medical practice, health courts would give doctors and hospitals something they do not have today: clear legal expectations from the courts. They would

have new incentives to invest in patient safety measures like computer systems that can detect prescription errors and prevent injuries.

Health courts would be less expensive than the current system. Today, more than 50 percent of court awards go to legal costs and lawyer fees, nearly twice the overhead of a typical workers' compensation system. Over time, medical malpractice premiums should fall as compensation for injured patients becomes more predictable and the new system helps clarify standards of practice and reduce injuries. Initially, however, premiums would be about the same as they are now. Malpractice insurers would no longer pay any of the sizable awards that make headlines in the current system, but they would more frequently pay limited compensation awards for injuries that receive nothing today.

Health courts can break the deadlock in Congress over malpractice reform. President Bush and most Republicans blame "junk lawsuits" for driving up doctors' insurance fees. To fix this problem, they have proposed caps on non-economic damages awarded by juries. Democrats, meanwhile, focus blame for rapidly rising premiums on the malpractice insurance industry and argue that large malpractice awards finance access to justice by allowing trial lawyers to recoup the costs of cases they take without an upfront cost to injured patients. Health courts would give patients access to care *and* access to justice. They would enable all injured patients to seek reasonable compensation without high legal costs and would give doctors clear signals about standards of care that could help them avoid medical malpractice. Instead of debating whether to place award caps on a broken system of medical justice, Congress should adopt health courts as a Third Way.

6. Create a National Cure Center to Speed Medical Breakthroughs

Most of the health care reforms outlined here would ensure that everyone has an equal

opportunity to benefit from scientific advances in the practice of medicine. But ultimately, it is the scientific advances that count the most. The nation's medical research community, which receives most of its public funding through the National Institutes of Health (NIH), has produced great gains in reducing the burden of disease and injury through the curiosity and brilliance of individual researchers. That progress has often come through sheer serendipity, however; the NIH has not been as successful with mission-driven research that can accelerate the delivery of cures for specific diseases or types of injuries by planning research that can lead to cures by design. The NIH needs a clear focus on translating the scientific advances made at the laboratory bench to new therapeutics for use at the patient's bedside. Most bench scientists work within highly specialized knowledge areas, and most do not have the opportunity to synthesize new knowledge across disciplines to close the knowledge gaps that obstruct the development and delivery of cures. As a result, individual scientists often do not see the most likely pathways to cures or consider the opportunities for the clinical use of their own work, even when they pursue research dollars or review the proposals of their peers.

As Sen. Joe Lieberman (D-Conn.) has proposed, Congress should require NIH to organize a National Cure Center within the Office of the NIH Director.⁴⁶ The Center would focus on "cure gaming."⁴⁷ Like military war gaming, which integrates the capabilities of all branches of the armed forces, cure gaming would

include leaders from dozens of government agencies with health and medical-related technology portfolios, the health research leadership at academic institutions and industry groups, and representatives of patient organizations. Cure gaming would start with assessing the size, nature, and potential vulnerabilities of specific health threats from diseases and injuries. Cure game participants would create maps for solving the toughest cure-related problems by drawing on diverse fields of expertise and by using the science of risk analysis and decisionmaking to increase the chances for success. With these maps in hand, the NIH director and Center director would develop "cure-mission plans," with various tasks to be undertaken, as appropriate, with traditional NIH funding mechanisms, expanded public-private partnerships, and any other new financing mechanisms deemed necessary to achieve each cure plan's stated goals and milestones. Diseases like Alzheimer's and diabetes may be ideal for cure gaming. The NIH director and Center director would be publicly accountable for achieving specific cure-mission goals and milestones and would report plans and progress to Congress.

Conclusion

The six steps outlined here aim to create a distinctively American approach to providing universal health care that is decentralized, not top-down; that rests on the principle of mutual responsibility, not entitlement; and that puts patients—not providers, insurance companies, or bureaucrats—first.

Endnotes

- ¹ For example, 10 percent of the population each year has expenses that exceed \$3,000, which accounts for 60 percent of health care spending. "MSAs and the Number of Individuals Affected," Employee Benefits Research Institute, 1994.
- ² Udell, Nancy, and David B. Kendall, "Health Courts: Fair and Reliable Justice for Injured Patients," Progressive Policy Institute, February 17, 2005, <http://www.ppionline.org>.
- ³ "Employer Health Benefits 2005 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust, 2005, <http://www.kff.org/insurance/7315/index.cfm>.
- ⁴ DeNavas-Walt, Carmen, *et al.*, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," U.S. Census Bureau, August 2005, <http://www.census.gov/prod/2005pubs/p60-229.pdf>.
- ⁵ Gabel, Jon, *et al.*, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continue to Erode," *Health Affairs*, September/October 2005, <http://www.healthaffairs.org>.
- ⁶ "Care Without Coverage: Too Little, Too Late," Institute of Medicine, 2002, <http://books.nap.edu/books/0309083435/html/index.html>.
- ⁷ *Ibid.*
- ⁸ *Ibid.*
- ⁹ Reed, Marie C., and Ha T. Tu, "Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America," Center for Study Health System Change, February 2002, <http://www.hschange.org/CONTENT/411/>.
- ¹⁰ Goldman, Dana, *et al.*, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *Journal of the American Medical Association*, May 19, 2004, <http://jama.ama-assn.org/cgi/content/abstract/291/19/2344>.
- ¹¹ Domowitz, Ian H., and Robert Sartain, "Determinants of the Consumer Bankruptcy Decision," Northwestern University, January 1997, <http://ssrn.com/abstract=70>.
- ¹² Himmelstein, David U., *et al.*, "Illness And Injury As Contributors To Bankruptcy," *Health Affairs*, February 2, 2005, <http://www.healthaffairs.org>.
- ¹³ Kohn, Linda, *et al.*, eds., "To Err is Human: Building a Safer Health Care System," Institute of Medicine, 2000, <http://www.nap.edu/openbook/0309068371/html/>.
- ¹⁴ McGlynn, Elizabeth A., *et al.*, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, June 26, 2003, <http://www.nejm.org>.
- ¹⁵ Wennberg, John, *et al.*, "The Quality of Medical Care in the United States: A Report on the Medicare Program," The Center for the Evaluative Clinical Sciences Dartmouth Medical School, American Hospital Association, 1999, <http://www.dartmouthatlas.org/atlaslinks/99atlas.php>.
- ¹⁶ Tierney, William, *et al.*, "Computerized Display of Past Results: Effect on Outpatient Testing," *Annals of Internal Medicine*, October 1987.
- ¹⁷ "Information Technology: Benefits Realized for Selected Health Care Functions," U.S. General Accounting Office, October 2003, <http://www.gao.gov/new.items/d04224.pdf>.
- ¹⁸ "Economic Value of a Community Clinical Information Sharing Network," Patient Safety Institute, March 2004, <http://www.ptsafety.org/resources/>.
- ¹⁹ The Durbin-Lincoln/Kind-Cooper bill would allow small business in every state to participate in Federal Employee Health Benefits (FEHB), but it does not allow states to establish their own alternative. "Small Employers Health Benefits Program Act of 2005," 109th Congress, 1st sess., S. 637 and H.R. 1955.
- ²⁰ For a discussion of a specific mandate for mental health care, see Levine, Art, "Parity-Plus: A Third Way to Fix America's Mental Health System," Progressive Policy Institute, June 2005, <http://www.ppionline.org>.
- ²¹ Madrian, Brigitte and Dennis Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," Working Paper 7682, National Bureau of Economic Research, May 2000, <http://papers.nber.org/papers/W7682>.
- ²² For spending options, see Lemieux, Jeff, "Senator Kerry's Health Proposal—Prospects for Bipartisanship?," *Centrists.Org*, August 25, 2004, http://centrists.org/pages/2004/08/18_lemieux_health.html?0.64632808377883#low.
- ²³ Frist, Sen. Bill, "Transforming Health Care: A Patient-Centered, Consumer-Driven and Provider-Friendly Vision," speech before National Press Club, July 12, 2004, http://frist.senate.gov/index.cfm?FuseAction=Speeches.Detail&Speech_id=97.
- ²⁴ "The 2000 Small Employer Health Benefits Survey," Employee Benefits Research Institute, 2000, <http://www.ebri.org/sehbs/sehbsqst.pdf>; see also: "Employers Study," National Association of Health Underwriters, March 9, 2001, http://nahu.org/news/releases/small_business_survey/survey_full_report.pdf.
- ²⁵ McGlynn, Elizabeth A., *op. cit.*
- ²⁶ Porter, Michael E. and Elizabeth Olmstead Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*,

June 2004, http://harvardbusinessonline.hbsp.harvard.edu/b01/en/common/item_detail.jhtml?id=R0406D.

²⁷ Integrated Healthcare Association, <http://www.iha.org>.

²⁸ Endsley, Scott, *et al.*, "Getting Rewards for Your Results: Pay-for-Performance Programs," American Academy of Family Physicians, March 2004, <http://www.aafp.org/fpm/20040300/45gett.html>.

²⁹ Puget Sound Health Alliance, <http://www.metrokc.gov/exec/hatf/> www.govlink.org/psha.

³⁰ "Episode Treatment Groups," Symmetry Health Data Systems, Inc., http://www.symmetry-health.com/ETGTut_Desc1.htm.

³¹ Herzlinger, Regina, "Protection of the Health Care Consumer: The Truth Agency," Progressive Policy Institute, March 1, 1999, <http://www.ppionline.org>.

³² National Committee for Quality Assurance, <http://www.ncqa.org>.

³³ The Leapfrog Group, <http://www.leapfroggroup.org>; "Hospital Quality Initiative," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, <http://www.cms.hhs.gov/quality/hospital/default.asp>.

³⁴ One of the few public ratings of physicians is for the treatment of specific diseases like diabetes in the Bridges to Excellence project, <http://www.bridgestoexcellence.org/bte/physician/diabetesassess.htm>.

³⁵ "The Premier Hospital Quality Incentive Demonstration: Rewarding Superior Quality Care," Centers for Medicare and Medicaid Services, U.S. Dept. of Health and Human Services, February 18, 2004, <http://www.cms.hhs.gov/quality/hospital/PremierFactSheet.pdf>.

³⁶ "Medicare Value Purchasing Act," 109th Congress, 1st sess., S1356.

³⁷ Kendall, David B., *et al.*, "Healthy Aging v. Chronic Illness: Preparing Medicare for the New Health Care Challenge," Progressive Policy Institute, February 14, 2003, <http://www.ppionline.org>.

³⁸ "Fighting Medical Inflation by Reducing Poor Quality Care," Democratic Leadership Council, May 2, 2004, <http://www.dlc.org>.

³⁹ Walker, Jan, *et al.*, "The Value of Health Care Information Exchange and Interoperability," *Health Affairs*, January 19, 2005, <http://www.healthaffairs.org>; Hillestad, Richard, *et al.*, "Can Electronic Medical Record Systems Transform Health Care: Potential Health Benefits, Savings, and Costs," *Health Affairs*, September/October 2005, <http://www.healthaffairs.org>.

⁴⁰ Murphy, Rep. Tim and Rep. Patrick Kennedy, "21st Century Health Information Act of 2005," 109th Congress, 1st sess., H.R. 2234; Frist, Sen. William and Sen. Hillary Clinton, "Health Technology to Enhance Quality Act of 2005," 109th Congress, 1st sess., S. 1262; Enzi, Sen. Mike and Sen. Edward Kennedy, "Wired for Health Care Quality Act," 109th Congress, 1st sess., S. 1418.

⁴¹ Patient Safety Institute, <http://www.ptsafety.org>.

⁴² Middleton, Blackford, "The Value of Healthcare Information Exchange and Interoperability Center for IT Leadership," National Health Information Infrastructure 2004 Conference, U.S. Department of Human Services, July, 2004, <http://www.hsrnet.net/nhii/materials.htm>; "Economic Value of a Community Clinical Information Sharing Network," Patient Safety Institute, March 2004, <http://www.ptsafety.org/resources>.

⁴³ "Bovbjerg, Randall R., and Brian Raymond, "Issue Brief: Patient Safety, Just Compensation, and Medical Liability Reform," Kaiser Permanente Institute for Health, Summer 2003, http://www.kpihp.org/publications/abstracts/patient_safety.html.

⁴⁴ Udell, Nancy and David B. Kendall, *op. cit.*

⁴⁵ "Fair and Reliable Medical Justice Act," 109th Congress, 1st sess., S. 1337; Thornberry, Rep. Mac, "Medical Liability Procedural Reform Act of 2005," 109th Congress, 1st sess., H.R. 1546.

⁴⁶ Lieberman, Sen. Joe, "Issues and Legislation: Health and Social Policy," U.S. Congress, June 30, 2005, <http://lieberman.senate.gov/issues/health.html>.

⁴⁷ S. Robert Levine, M.D., conceptualized "cure gaming" in a private memo. Levine, S. Robert, personal correspondence to author, November 3, 2003.

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