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Moving United States Health Care Forward

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University of Connecticut

Honors Program

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Abstract

Moving United States Health Care Forward

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University of Connecticut
2011

Substantive Health Care reform poses one of the greatest current challenges to the American political system. The Patient Protection and Affordable Care Act of 2010 marks the most recent attempt at approaching this daunting task. Charged with expanding coverage while controlling costs, it pursues a sundry number of legislative solutions to achieve these seemingly incompatible goals. Despite the strides the Patient Protection and Affordable Care Act has made, lingering educational, pharmaceutical, and legal concerns stand to derail progress made on fixing the health care system. If these goals are to be successful, a number of additional measures are needed to supplement recent reforms. The policy recommendations in this paper look to ameliorate these areas of concern, and further strengthen United States health care. Without the implementation of these policy initiatives, we cannot expect to see a successful expansion of coverage nor a reduction in the growth of health care related costs. The human infrastructure, technological innovation, and cost efficiency such recommendations provide for are the premise on which a higher achieving system must be built.

1. Background

United States health care reform has been the subject of ongoing, intense political debate since the Progressive Era of President Theodore Roosevelt roughly a century ago. As health care costs have ballooned within the past few years, the industry once again finds itself in the forefront of politician's minds. To give some perspective on where the industry stands today, the Bureau of Labor Statistics reports that the health care industry accounts for roughly one-sixth of the entire U.S. economy, outsizing any other industry (1). Moreover, as shown in Figure 1, spending on health care currently totals about $2.5 trillion, or 17.6% of the U.S. Gross Domestic Product, up from 13.8% in 2000 and 5.2% in 1960 (1). Left unimpeded by political reform, health care costs stand to continue to increase at a pace that well exceeds inflation. Seeing as how this rise in Health Care expenditures burdens the broader economy, despite serving as a driver of local and sectoral economic growth, the need for reform is clear.

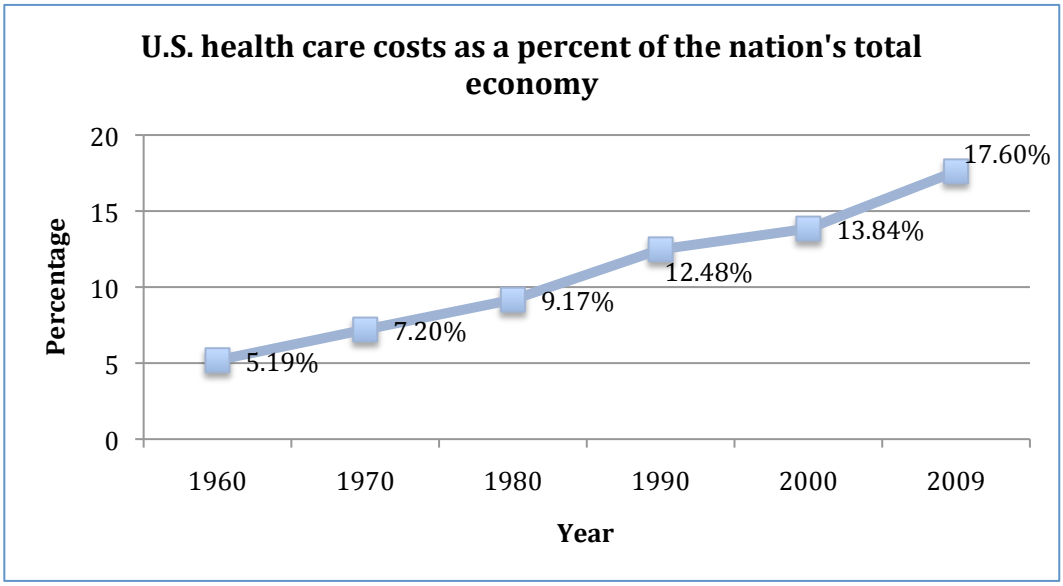

Figure 1. The Growth in U.S. Health Care costs as a percentage of U.S. Gross Domestic Product. Data used in this figure was compiled from the United States Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census (1).

Rising health care costs deteriorate Americans' paychecks and decrease American industry's competitiveness. This erosion of the American employee's take home wages is largely a product of how the vast majority of Americans receive part or all of their health insurance coverage through their employer. According to the Bureau of Labor Statistics' "Employer Costs for Employee Compensation" (ECEC) survey data, summarized in Figure 2, workers' inflation-adjusted average total compensation per hour increased by 5.88 percent from March 2001 to March 2010 (from $28.06 per hour to $29.71 per hour in 2010 dollars). Despite this growth in compensation over this period, workers on average experienced a 3.4 percent decrease in take home wages and salary over this period that can be attributed in part to a greater portion of their compensation going towards their health benefits (2, 3).

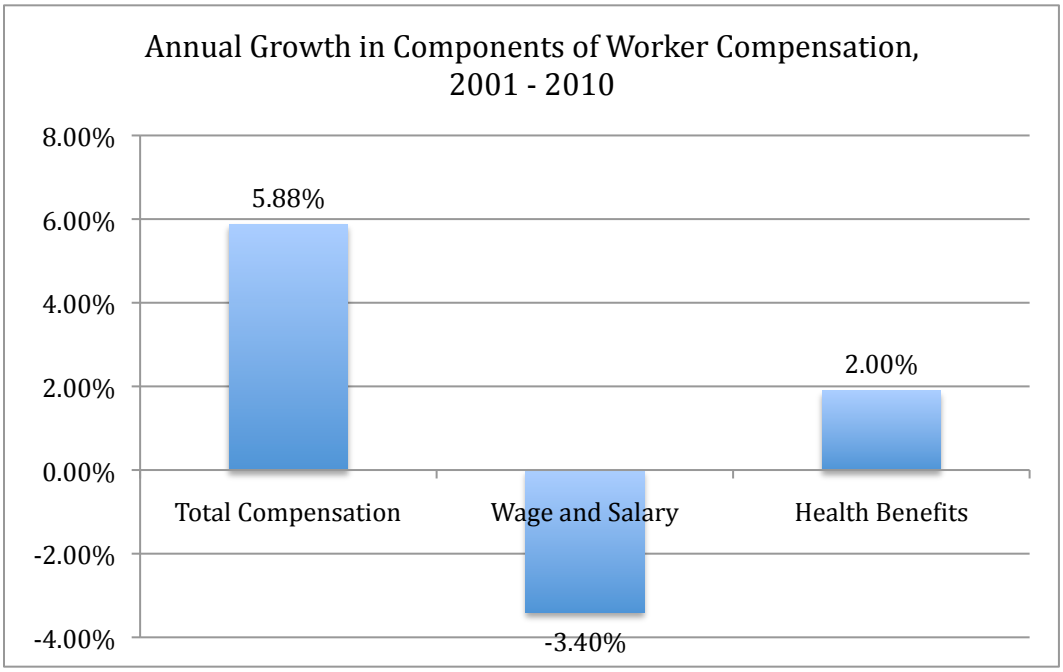

Figure 2. Annual Growth in Components of Worker Compensation. Author calculations are based upon Bureau of Labor Statistics data and adjusted for using the Consumer Price Index (2, 3).

If the growth rates in both workers' average total compensation and in employer-sponsored health insurance premiums remain at their current rates, this share will increase to 15.0 percent by 2019 and will continue to increase thereafter (4). While the steadily increasing share of workers' total compensation taken up by health insurance premiums illustrates the need for reform, the burden it places upon employers does as well.

Health care costs for some firms can have a crippling effect upon their profitability. With double-digit increases in health care spending, some employers are dissuaded from hiring new full-time, benefit-eligible employees, curtailing the investment in human capital that firms need to make in order to grow. In particular, companies with a large pool of unionized retirees are especially hurt by rising costs as they are forced to pass on this burden to consumers through higher prices. A marked example of this is how the price tag for a General Motors vehicle consists of more health care than steel costs (5). With countries like Japan providing the bulk of its citizens' health insurance, there is an obvious competitive advantage on the part of foreign firms. Thus, from the perspective of both the employee and employer, there is a palpable need for health insurance reform to slow this growth in costs, increasing U.S. firms' competitiveness and allowing workers to enjoy higher take-home wages.

In addition to the impact health care related problems have on the American economy, the vast number of uninsured Americans is a glaring issue in need of addressing by the government. According to the Census Bureau, 50.7 million

Americans lack basic health insurance (6). While it may seem as if this has no consequence for the rest of the general population, the truth of the matter is that insured Americans essentially pay to cover the cost of the uninsured. Hospitals, particularly in inner cities and rural areas, are known to charge patients with insurance higher amounts, in order to cover their losses incurred by uninsured patients who cannot pay their bills. This in turn raises insurance costs and feeds into the aforementioned problems associated with these higher costs.

Beyond the simple economics behind the provision of health care through the insurance market, there is an inherent moral issue at hand in not allowing 50.7 million Americans to have access to the medical care they need to enjoy a respectable quality of life (6). The concept of medical care as a fundamental right is not novel to the current health care debate. In his State of the Union Address in 1944, President Roosevelt proposed an "economic bill of rights" that included the right to adequate medical care. In his opinion, the first bill of rights "proved inadequate to assure us equality in the pursuit of happiness" (7). A year later, President Truman would assert in a message to Congress on November 19, 1945 that "The health of American children, like their education, should be recognized as a definite public responsibility" (8). On this basis he proposed a controversial national health insurance plan that came to Congress in the form of a Social Security expansion bill popularly known as the W-M-D bill (8). The American Medical Association was successful in defeating the bill by capitalizing on public fears of Communism and labeling it as a plan for "socialized medicine", but nevertheless

President Truman was successful in the end at publicizing the issue of Health Care.

The Patient Protection and Affordable Care Act (H.R. 3590), in redressing these problems, has come to represent a fundamental shift in paradigm for United States Health Care. Its mandate that all Americans obtain some form of health insurance by 2014 has achieved the elusive goal of extending coverage to all Americans. With this achievement, debate over health care policy has been reframed around the question of what policy groundwork is needed in order to extend care without having to compromise its quality. As millions more Americans enter the insurance market, unimpeded by any denials of coverage on the part of insurers, legislative measures to expand and educate the health care workforce, enhance care, and control costs are needed to prepare for this change.

2. Workforce Expansion and Education

a. Legislation

The Patient Protection and Affordable Care Act (PPACA) itself contains a number of key provisions that aim to ameliorate problems related to the massive influx of newly insured Americans and to make the U.S. health care system stronger in the long term. As outlined in Title V Health Care Workforce of PPACA, a variety of solutions have been proposed to increase the U.S. health care workforce and build the human infrastructure to provide adequate care for all Americans. To assess the progress in this area, Title V mandates the creation of a National Healthcare Workforce Commission to review the current healthcare workforce supply and distribution. As outlined in Section 5101, high priorities for the commission include:

(i) Integrated health care workforce planning that identifies health care professional skills needed and maximizes the skill sets of health care professionals across disciplines.
(ii) An analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace.
(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national workforce goals.
(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.
(II) Oral health care workforce capacity at all levels.
(III) Mental and behavioral health care workforce capacity at all levels.
(IV) Allied health and public health care workforce capacity at all levels.
(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.
(VI) The geographic distribution of health care providers as compared to the identified health care workforce needs of States and regions.

In addition to outlining in section 5102 the need for Federal grant money to be allocated to reach these goals, the PPACA provides the financial incentives needed to encourage members of the workforce to obtain the training needed to fulfill these goals. Of special interest is the education loan and grant programs of the Public Health Service Act (42 U.S.C. 294n et seq.). Sections 5203 and 5204 of H.R. 3590 amend Part E of title VII of the Public Health Service Act by adding to the end of it provisions that establish the following new loan repayment programs:

SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.
ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.
ESTABLISHMENT.—The Secretary shall establish the Public Health Workforce Loan Repayment Program (referred to in this section as the 'Program') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

Section 5606, however, recognizes that while the aforementioned programs address the need to expand the health care workforce, they employ too broad of an approach to the problem. There are significant disparities in the provision of health

care throughout the nation with rural and urban areas tending to be particularly underserved. Therefore section 5606 appropriates money so that states may award grants to health care providers who treat a high percentage of medically underserved populations or other special populations. Specifically, Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended so as to assist "eligible entities in recruiting students most likely to practice medicine in underserved rural communities, providing rural-focused training and experience, and increasing the number of recent allopathic and osteopathic medical school graduates who practice in under-served rural communities."

b. Improving Lower Science Education

The PPACA makes tremendous strides in improving Higher Education in order to correct for shortages in the health care workforce. It is in my opinion, though, that Lower Education Science Programs must be improved in order for the aforementioned reforms to be successful. Higher education reform simply addresses a problem at too late of a stage in a student's academic career. It is overly ambitious to believe that implementing student loan programs or increasing advising for students on track for a career in the health care field will translate into a marked expansion of that workforce. Students need a strong high school science curriculum in order to feel confident enough to pursue a college course load that would adequately prepare them for advanced education in a health-related profession. A student matriculating into an undergraduate institution from a high school with a weak science curriculum will much more likely be steered away from the sciences

by one of the first or second year general science courses that are reputed to "weed out" prospective medical, nursing, or pharmaceutical students. Had that same student received a more solid science education throughout high school that developed their analytical scientific skill set, there would be a far greater likelihood that they would successfully pursue a career in medicine.

It is no secret that our nation's lower science education programs are failing to meet expectations. In an often-cited study of students in grades 4, 8, and 12 throughout the U.S. conducted by the Nation's Report Card, a congressionally authorized project of the National Center for Education Statistics (NCES) within the Institute of Education Sciences of the U.S. Department of Education, this was painfully obvious (11). In this study, the 2009 National Assessment of Educational Progress (NAEP), only 21 percent of twelfth-graders performed at or above the *Proficient* level. Equally glaring of a statistic is how a paltry 60 percent of twelfth-graders performed at or above the *Basic* level (11). The *Basic* and *Proficient* achievement levels describing students' performance on both multiple-choice and constructed-response questions are determined by the NCES Governing Board based on recommendations from policymakers, educators, and members of the general public (11). This is an unacceptable reality if America is to remain competitive in the future. A higher quality lower education science program is not only an investment in the health care industry, but the broader economy as well. By investing in science education, we are cultivating more world-class engineers, inventors and researchers as well as doctors, nurses, physician assistants, and

pharmacists.

Beyond the simple investments in lower education such as new textbooks, lab equipment in schools, and teacher hires to improve student to teacher ratios, we need to look at how we educate students in the sciences. The current paradigm of science education is to distinguish each year of high school into discrete subjects reminiscent of a layer cake with life sciences being taught freshman year followed by biology, chemistry, and lastly physics. A more integrative approach is far more ideal for a couple of reasons. First, it allows educators to introduce topics and then revisit and build on the concept later in a student's academic career. Covering key curricular material repeatedly ensures that students attain a much greater lifelong understanding of science that will translate into future educational endeavors. Otherwise the student needs only to retain the information for the length of time that they may be tested on it. Secondly, utilizing this integrative approach to science education, students have a greater opportunity to develop a strong analytical scientific background and critical thinking. Drawing inferences across scientific disciplines is essential in conducting and applying research to real life problems. By acquiring this proficiency early on, students are honing the skills to make them better scientists later in life.

Creating a more integrative science curriculum is not novel. It first garnered national attention twenty years ago when the National Science Teachers Association published their Scope, Sequence, and Coordination Initiative (12). Its implementation has severely lagged behind its debate. Connecting the importance of

lower science education reform to the development and welfare of the U.S. Health Care workforce is the best way for policymakers to bring about real educational reform. In addition to pursuing a more integrative curriculum, high achieving students should have the ability to engage in a more rigorous educational environment. The most effective way of affording these students this experience is to establish magnet science academies such as the Greater Hartford Academy of Math and Sciences to supplement their basic curriculum. Many educators would argue against this approach, as stated by Dr. Bonnie Brunkhorst, former President of the National Science Teachers Association, "Mixing does not require that our brightest students become average achievers. Mixing provides opportunities for interaction, leadership, and success in science for all students at the level that matches their capabilities" (13). However, by offering higher achieving students additional opportunities to challenge themselves, they can be much more effectively driven to excel further. Not only does a magnet program offer intellectual stimulation through a more rigorous curriculum, but it also allows students to interact with a larger pool of students from whom they can expand their learning through collaborative academic efforts.

3. Primary Care & Preventative Medicine

a. Legislation

Another key component of the PPACA is its attempts to steer the practice of medicine back towards primary care in an effort to bolster preventative medicine. Over the past few decades there has been a shift towards specialized care in the

medical field, diminishing the role of primary care. However, in considering the common chronic illnesses that affect Americans such as heart disease, type 2 diabetes, cancer, and high blood pressure, preventative measures directed by a primary physician are crucial to a patient's health and well being. Recognizing the ability of primary care to increase the general health and welfare of Americans, Section 5508 of the Patient Protection and Affordable Care Act increases teaching capacity for primary care by amending Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) by adding:

"SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.
"(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

Furthermore, Section 5508 establishes a Primary Care Extension Program through amending the Public Health Service Act (42 U.S.C. 280g et seq.) that essentially enumerates the desire to promote the practice of preventative medicine through primary care providers.

The Primary Care Extension Program shall provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practice and to improve community health by working with community-based health connectors
(referred to in this section as 'Health Extension Agents').

b. Utilizing Education to Promote Primary Care

The United States medical education system has already begun to address the critical health care need for more primary care provision. Of special note is Quinnipiac University's decision to establish its own medical school with an

emphasis on primary care and global health. We can anticipate further medical school openings and restructuring devoted towards the promotion of primary care.

4. Prescription Drug Cost Control

a. Legislation

The PPACA recognizes that rising prescription drug costs are one of the leading causes of runaway health care costs. The Act attempts to address this concern for the long-term health of Medicare by amending Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to establish an 'Independent Medicare Advisory Board'. This body is charged with the task of recommending ways to reduce the per capita rate of growth in Medicare spending to Congress.

As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n).

Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a). As Medicare pays roughly 30 percent of the nation's retail drug bills, a recommendation to remove a high bid from the calculation of the national average monthly bid amount can have an enormous impact (21).

b. Sustained Pharmaceutical Innovation

Beyond the need to control the increase in prescription drug costs in order to avoid the bankruptcy of Medicare and Medicaid, there are other pertinent pharmaceutical concerns looming over the U.S. health care industry. Americans' spending on prescriptions per capita is higher than any other nation. This has been pointed to as a source of waste and mismanagement in our health care industry, while at the same time it has also fueled the pharmaceutical industry's research engine. This trend is likely to reverse as patents on a number of "megamedicines" whose annual sales have neared $50 billion expire in the next few years (10). This year, 2011, has been referred to as the "patent cliff" as a number of medicines that are integral to drug companies' profitabilities will have their patents expire (10). For example, Pfizer Inc. is set to lose control of Lipitor and Xalatan, two of its best selling drugs. Lipitor alone accounts for more than $12.4 billion of Pfizer's current annual revenue, yet it must legally allow Ranbaxy Laboratories Ltd. of India to sell generic versions of the drug in the United States starting November 30, 2011 (9). This year GlaxoSmithKline Plc. will also lose the patent to Advair this year, which alone accounts for 18% of its sales (9).

Most pharmaceutical companies lack new blockbuster drugs to compensate for the loss in revenue from patent expirations, and so it is expected that research and development budgets will be slashed across the industry. Seventy-five percent of prescriptions in the United States are already now low-price, low-profit generic drugs, so this new wave of key patent expirations is truly a crippling blow to the

industry (10). Of course, in the short term, this is beneficial to consumers as it stems the pattern of rising Medicare costs. However, if firms fail to produce new drugs to meet the public's need, the long-term social costs are quite substantial. The primary concern is that a reduction in research and development spending amongst pharmaceutical companies will evolve into a vicious cycle in which such reductions prevent future drug discovery and feedback into greater budget cuts. Dr. Francis S. Collins, director of the National Institutes of Health (NIH), realizes that "We seem to have a systemic problem here," and has thus proposed a billion-dollar drug development center at the National Institute of Health (10). Pharmaceutical innovation has long been a hallmark of our current health care system's success. Moving forward, it is critical that the government is equipped to pair with the private sector in order to ensure that this endures.

It is in the public's best interest for our pharmaceutical sector to remain capable of meeting the need for new treatment options. For example, the number of multi-drug resistant bacterial strains is a serious problem that would greatly benefit from the coupling of basic research and pharmaceutical innovation. This can only be accomplished by giving credence to Dr. Collin's proposal, which includes appropriating National Institute of Health funds for targeted drug development endeavors involving both academia and the private sector. Currently the agency supports clinical and translational research that transforms discoveries from untargeted research into medical practice. The National Institute of Health has had success in this capacity, notably the development of a vaccine for cervical cancer, underscoring their effectiveness in drug discovery. If they were to make a concerted

effort to collaborate with the private sector, I am confident this partnership would allow for continued pharmaceutical innovation.

Tightening budgets throughout the public sector including the NIH due to the weak U.S. economy further complicates this situation. This makes the question of whether to divert funding away from basic research, which does essentially provide the framework for all drug discoveries, towards strictly translational research more difficult. Nevertheless, additional resources to enhance small business development would certainly be an ideal solution. A business accelerator would allow smaller NIH funded labs to continue to conduct basic research and maintain control of their proprietary information while providing the business and scientific wherewithal to effectively turn it into a commercially viable product that serves a public good.

5. Tort Reform

The issue of Medical Malpractice Tort Reform must be seriously addressed if we are to curb the dramatic growth in medical expenditures. Large legal settlements due to malpractice lawsuits inflate the cost of basic medical expenses as doctors raise prices to cover their insurance costs. Furthermore, the fear of facing a financially crippling malpractice suit has led most doctors to practice "defensive medicine". From a cost perspective this has the negative effect of leading doctors to order what is in many cases an unnecessary number of tests prior to surgery. According to a 2003 study conducted by the U.S. Department of Health and Human Services, defensive medical practices account for somewhere between 5 and 9% of total U.S. health care expenditures (14). Medically speaking, defensive medical

practices can even reduce the quality of care a patient may receive as doctors may steer patients away from riskier procedures that may be exactly what the patient needs.

Section 10607 of the Patient Protection and Affordable Care Act amends the Public Health Service Act (42 U.S.C. 280g et seq.) to establish state demonstration programs to evaluate alternatives to current medical tort litigation. However, it contains no binding legislation to actually bring about meaningful change. To some, this lack of binding reform is welcome, as they perceive tort reform as a red herring in the health care debate. They often cite how medical malpractice payments comprise only two percent of total health care spending according to both the United States Department of Health and Human Services and the Congressional Budget Office (17, 18). Furthermore, in considering the annual number of paid medical malpractice claims according to the National Practitioner Data Bank (NPDB) and Physician Insurers Association of America (PIAA), we see only a modest increase in claims over time.

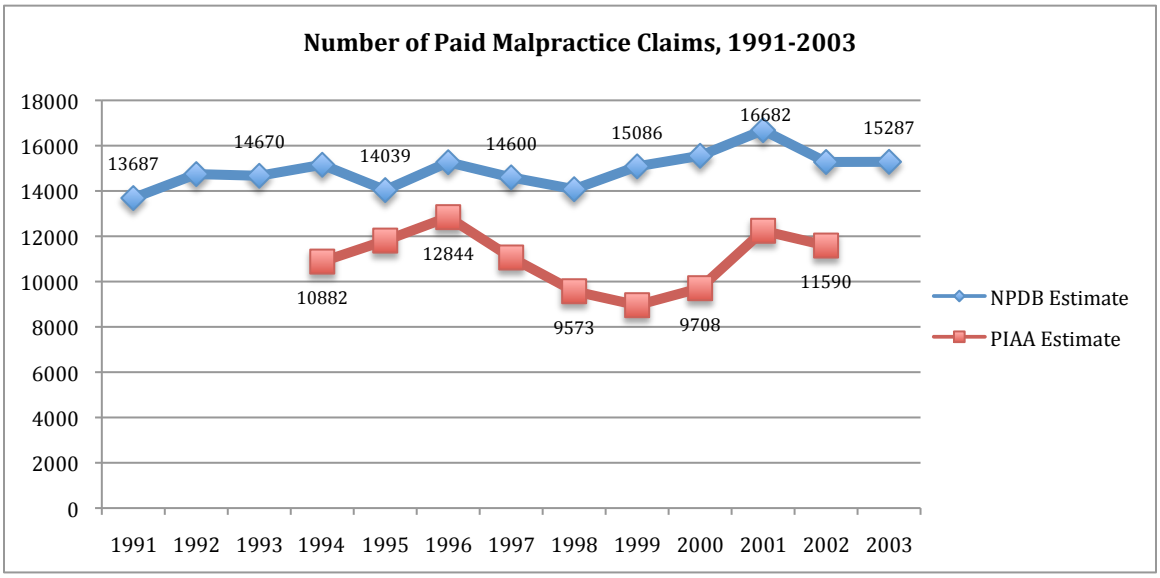

Figure 3. Growth in number of paid medical malpractice claims. This figure was adapted from the Kaiser Family report on "Medical Malpractice Law in the United States" Author calculations use data from the National Practitioner Data Bank (NPDB) and the Physicians Insurers Association of America (PIAA) (19).

Figure 3 shows the number of medical malpractice claims each year from 1991 to 2003 according to the NPDB data and from 1994-2002 according to the PIAA data. In considering just the start and end points in order to show a long-term trend, the NPDB data indicates a 12% increase while the PIAA data shows a 7% increase (19).

In using this data to substantiate claims that medical malpractice lawsuits are not a growing concern for the health of the industry, a number of important points are being overlooked. The first is the dramatic rise in the average defense cost per claim.

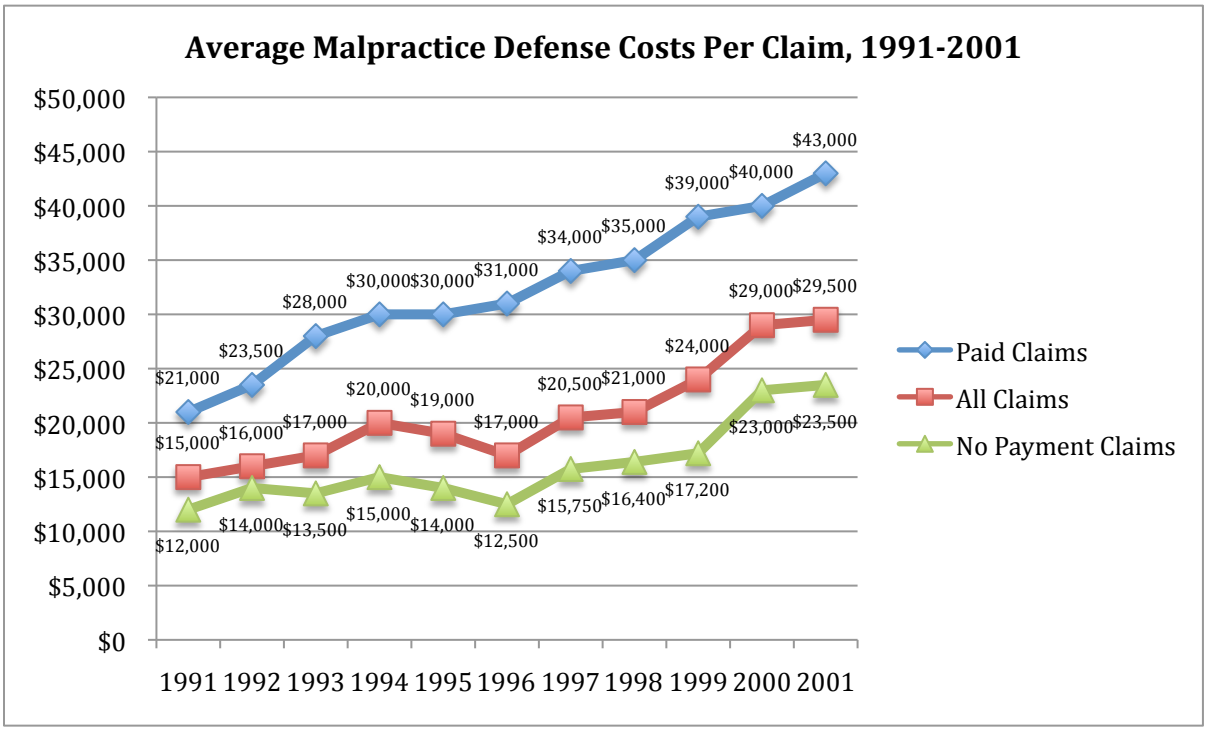

Figure 4. Growth in average malpractice defense costs per claim. This figure was adapted from the Kaiser Family report on "Medical Malpractice Law in the United States" Author calculations use data from the National Practitioner Data Bank (NPDB) and the Physicians Insurers Association of America (PIAA) and adjusted for inflation using the Bureau of Labor Statistics Consumer Price Index (19).

Figure 4 illustrates that within a ten-year period of time, the average cost of all claims has doubled. This far outpaces the rate of inflation over the course of that period. Therefore, while the number of claims has not risen substantially, the costs of each claim have, which does not bode well for the medical malpractice insurance industry. Of special note in considering the rising cost of claims is how the cost of "no payment claims" has nearly doubled from 1991 to 2001, rising from $12,000 to $23,500 (19).

Beyond this, the cost of payments in medical malpractice suits varies significantly, meaning that national averages often hide the severe toll medical malpractice lawsuits take on local or state level healthcare systems. To illustrate this

disparity, the NPDB reports that payments ranged as low as $121,313 for the state of Michigan to a high of $483,319 for the state of Connecticut (19). In states where payments are high, the resulting increase in insurance premiums will prompt some physicians to reduce high-risk services or in other more extreme circumstances to move or even close practices. This translates into a deficiency of care in these areas. One of the fundamental tenets of the Patient Protection and Affordable Care Act is to allow all Americans easy access to high quality, affordable care. This cannot be achieved if the high cost of medical malpractice insurance in one part of the country forces doctors in that area to reduce their offering of certain services deemed to be high risk in terms of potential litigation, such as mammograms, newborn deliveries, and spinal surgeries.

The U.S. General Accounting Office asserts that "Cycles in the medical malpractice market tend to be more extreme than in other insurance markets because of the longer period of time required to resolve medical malpractice claims, and factors such as changes in investment income and reduced competition can exacerbate the fluctuations." (20) At the same time, the medical malpractice market has a marked influence upon the broader health care industry. It would be my recommendation that legislation be passed to cap the amount of money awarded for "pain and suffering", which often bloats settlement figures, while allowing for unlimited "actual" damages for injuries. Such a solution would allow one to medically become whole again, while acknowledging their pain and suffering within reason. Data shows that such a cap can help stabilize the medical malpractice

market. "For example, from 2001 through 2002 average premium rates rose approximately 10 percent in the four states with noneconomic damage caps of $250,000 but approximately 29 percent in states with more limited tort reforms." (20) Without tort reform distortions in the health care workforce will persist and most likely become more pronounced into the future. While health care reform is a top down effort, it must be often analyzed from a grass roots level. Allowing for Americans to not have access to certain procedures due problems in the medical malpractice market represents not only a failure in the efforts of the ongoing reform effort, but also a violation of their right to health care.

6. Conclusion

In many ways, health care reform can be aptly described as throwing spaghetti at a wall to see what sticks. It is impossible to say with absolute certainty what specific reforms will turn around our deeply troubled health care industry. Nevertheless, this is an onerous task that must be undertaken for our nation's health as a whole. It is more than fair to say that health care is perhaps the greatest threat to America's future success. Not only does the private sector depend on the success of health care reform, but the public sector does as well. In addressing issues such as the ever-expanding federal budget, the role health care costs play in rising entitlement spending is integral to any serious debate. The positive aspect to this situation is that we are truly faced with a long-term health care problem. Therefore, we are afforded the ability to treat it as thus. In the Patient Protection and

Affordable Care Act, the ability to review the progress of specific reforms and fine-tune them down the road has been provided for. Of course, assessing the progress of various reforms presents a whole host of other challenges. Each reform will inherently take a different amount of time to have an effect. For example, while the impact of the individual mandate for health insurance will be discretely felt in 2014 as it comes into place, legislation supporting primary care and preventative medicine will have a much more long-term effect. Nevertheless, challenges involving the assessment of reform falls in line with how the Act acknowledges that it is not meant to be a comprehensive final solution to the problems with the U.S. health care system, but rather the first step of many. The solutions this paper enumerates, partnership with the pharmaceutical industry, lower science education reform, and tort reform, simply represent three of many potential next steps to come in moving U.S. Health Care forward.

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