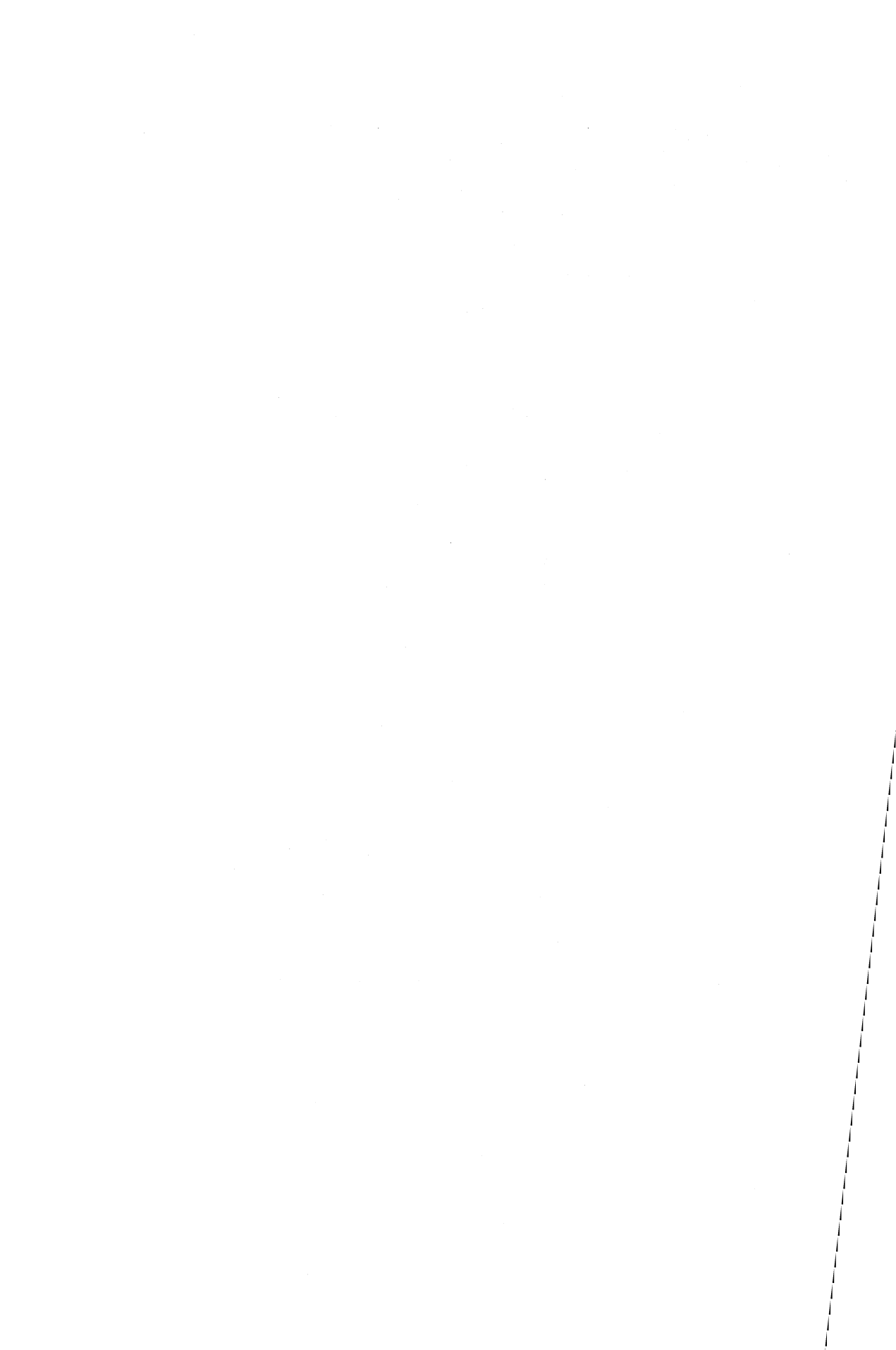


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# NO FAULT, NO WORRIES ... COMBINING A NO-FAULT MEDICAL MALPRACTICE ACT WITH A NATIONAL SINGLE- PAYER HEALTH INSURANCE PLAN

Jeremy Coylewright\*

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## I. INTRODUCTION

The United States faces an escalating health care crisis characterized by uncontrolled and inequitable health care expenditures, a growing body of over forty-three million uninsured citizens, and a system of medical malpractice liability that drives up insurance costs, frustrates providers, and provides little relief to injured patients. While diverse interest groups champion the cause of universal health care, others press for immediate tort reform. Ultimately, reform in each of these areas is needed to improve the health of the nation. A broad plan, coupling a universal system of national single-payer health insurance<sup>1</sup> with a no-fault system of medical malpractice compensation, may provide the necessary bridge to bring the champions of universal health care and tort reform together in the interests of establishing the best possible system of health care in the world.

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<sup>1</sup> For a simple background primer for single-payer and other health care finance models, see, e.g., PRASHANT TAMASKAR & JOSH RISING, AM. MED. STUDENT ASS'N, THEORETICAL MODELS FOR DELIVERING UNIVERSAL HEALTH CARE: AN ANALYSIS OF IMPORTANT CONCEPTS 2 (2003), available at <http://www.amsa.org/pdf/model.pdf> (“[A] single payer health-care system is one in which the medical costs of the citizens of a nation are financed by one source, usually the federal government.”). While discussion of the myriad of single-payer health insurance models will not be covered here, the model proposed in this piece and advocated for by this author is consistent with that of the 2003 Physicians’ Working Group for Single-Payer National Health Insurance. *Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance*, 290 J. AM. MED. ASS’N 798, 803 (2003) [hereinafter *Physicians’ Working Group*].

This Article takes the position that a dual health care policy approach coupling universal health care and tort reform is necessary to effectively repair the American health care system. Part II of this paper begins with a description of the health care crisis in the United States, both in terms of the devastating effects of inadequate health care coverage and the failure of the medical malpractice liability system. Part III describes the optimal health care goals for two of the health system's most important players: patients and providers. Part IV discusses several of the proposed options for both medical malpractice liability reform and the establishment of universal access to health care. Part V proposes that effective health care reform can be achieved by combining a no-fault medical malpractice compensation act with a national single-payer health insurance plan. Part VI concludes by suggesting the next steps that must be taken to implement this dual policy approach and stresses the importance of bridging the gap between patients and providers in their advocacy for the best possible system of health care in the United States.

## II. THE U.S. HEALTH CARE CRISIS: INADEQUATE HEALTH COVERAGE AND THE FAILURE OF THE MEDICAL MALPRACTICE LIABILITY SYSTEM

The U.S. health care crisis reflects itself on two fronts: A) in the inadequate health care coverage it provides despite some of the highest health care expenditures in the world and B) in the failure of the American legal system to adequately address the health care needs of injured patients through the medical malpractice liability system.

### *A. Inadequate Health Care Coverage*

The vast number of Americans without health insurance threatens not only those individuals without access to quality health care but also impacts the economic security and public health of the nation as a whole. More than forty-three million Americans are without health insurance today, which is nearly one in six persons.<sup>2</sup> Yet the United States spends more on health care than any other industrialized nation in the world, spending 15.3% of its gross domestic product ("GDP") on health-related expenditures, or on average, an expenditure of \$6,102 per citizen.<sup>3</sup> With so many uninsured citizens in a nation offering the

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<sup>2</sup> INST. OF MED., *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS 1* (2004), available at [http://www.iom.edu/Object.File/Master/17/732/Uninsured6-English\\_FINAL.pdf](http://www.iom.edu/Object.File/Master/17/732/Uninsured6-English_FINAL.pdf) [hereinafter INST. OF MED., PRINCIPLES AND RECOMMENDATIONS]. Forty-three million uninsured represents the total population of twenty-six states combined. *Id.* See also KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 1 (2006) [hereinafter KAISER, THE UNINSURED] ("Over 45 million Americans under age 65 lacked health insurance coverage in 2004 . . .").

<sup>3</sup> Compare the United Kingdom, which spends 8.1% of its GDP on health care expenses

highest levels of medical technology and expertise in the world these expenditures are not distributed equally amongst citizens. While some Americans undoubtedly receive the highest standard of health care in the world, others live in relative health poverty, without effective health care access.

Health insurance remains simply unattainable for many families in the United States, regardless of their employment status.<sup>4</sup> Many citizens without health insurance work for employers that do not offer health coverage.<sup>5</sup> For those employers that do offer coverage, it may still be unaffordable for working families.<sup>6</sup> Non-employment related health insurance is even less affordable and may explain why most Americans, specifically sixty-four percent, receive their health insurance through an employer.<sup>7</sup>

As a result, America has a high population of uninsured persons, and this

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(\$2,317 per capita), Canada, which spends 9.9% (\$3,165 per capita), France, at 10.5% (\$3,159 per capita), Germany, at 10.6% (\$3,043 per capita), Mexico, at 6.5% (\$662 per capita), and Sweden, at 9.1% (\$2,825 per capita). ORG. FOR ECON. COOPERATION & DEV., TOTAL EXPENDITURE ON HEALTH: % GROSS DOMESTIC PRODUCT (2006) *available at* <http://www.oecd.org/dataoecd/20/51/37622205.xls>. See also ORG. FOR ECON. COOPERATION & DEV., TOTAL EXPENDITURE ON HEALTH: PER CAPITA US\$ PURCHASING POWER PARITY (2006) *available at* <http://www.oecd.org/dataoecd/20/51/37622205.xls> (click on relevant tab in the Excel spreadsheet). Note that despite the huge expense, the United States fares poorly in the health quality indicators of infant mortality and life expectancy. See ORG. FOR ECON. COOPERATION & DEV., LIFE EXPECTANCY AT BIRTH (2006), *available at* <http://www.oecd.org/dataoecd/20/51/37622205.xls> (click on relevant tab in the Excel spreadsheet); ORG. FOR ECON. COOPERATION & DEV., INFANT MORTALITY DEATHS PER 1000 LIVE BIRTHS (2006), *available at* <http://www.oecd.org/dataoecd/20/51/37622205.xls> (click on relevant tab in the Excel spreadsheet). It has been argued that the United States would save over 2,000 additional babies a year if our infant mortality rate matched that of Cuba. Nicholas D. Kristof, Op-Ed., *Health Care? Ask Cuba*, N.Y. TIMES, Jan. 12, 2005, at A21 (arguing that universal health care coupled with the public health focus in the Cuban national health care system likely results in better infant mortality rates).

<sup>4</sup> KAISER, THE UNINSURED, *supra* note 2, at 4 (stating that approximately seventy percent of uninsured individuals are either full-time workers or dependants). INST. OF MED., UNINSURANCE FACTS & FIGURES: HEALTH INSURANCE IS OUT OF FINANCIAL REACH FOR MOST OF THE UNINSURED 1 (2004), *available at* <http://www.iom.edu/Object.File/Master/17/744/0.pdf> [hereinafter INST. OF MED., HEALTH INSURANCE OUT OF REACH] (“Unaffordability is the top reason uninsured adults give for being without coverage.”). An additional harm that may result from workers being unable to obtain health insurance is a lack of social cohesion; Americans working hard and failing to obtain the basic necessities of American life, like health care coverage, will increasingly become disillusioned with the American dream (i.e. meritocracy). The racial inequities in health care resources also contribute to a lack of social cohesion with Hispanic citizens being three times more likely to be uninsured compared with white citizens and black citizens who are twice as likely to be uninsured. See CHRIS L. PETERSON, CONG. RESEARCH SERV., HEALTH INSURANCE COVERAGE: CHARACTERISTICS OF THE INSURED AND UNINSURED POPULATIONS IN 2001, at CRS-3 (2003).

<sup>5</sup> INST. OF MED., HEALTH INSURANCE OUT OF REACH, *supra* note 4, at 1 (stating lower wage firms, small businesses, and seasonal employers may be ill-equipped or unable to afford the administrative costs associated with employee health plans).

<sup>6</sup> *Id.*

<sup>7</sup> PETERSON, *supra* note 4, at 1.

translates to a high population of those who “are sicker and die sooner.”<sup>8</sup> Over eighteen thousand unnecessary deaths occur each year due to the lack of health coverage.<sup>9</sup> Individuals without health insurance often defer necessary preventative care and primary health care treatment until it is too late.<sup>10</sup> This forces uninsured individuals into the emergency room with less treatable forms of cancer, uncontrolled asthma, diabetes, mental illness, and heart disease.<sup>11</sup> Forty-three percent of uninsured individuals defer necessary medical treatment when they have a medical problem, compared to ten percent of insured individuals.<sup>12</sup> Likely due to this (and other socioeconomic factors) the uninsured consistently exhibit worse clinical health outcomes compared to the insured when it comes to diabetes, heart and kidney disease, infectious disease, and mental illness.<sup>13</sup>

Lacking health insurance jeopardizes not only the individual but also their extended family and community. In addition to increased disease exposure opportunities from untreated illness, out-of-pocket costs can devastate the financial security of the individual and their entire family.<sup>14</sup> The medical billing and collection process, in addition to living with a family member with an untreated or poorly treated illness, emotionally strains families as well.

While the extended family bears increased health and financial risks, the public health of the community also suffers. Emergency rooms are often overburdened with people seeking acute primary care services in the emergent care setting. Many of these patients suffer from end stage manifestations of otherwise treatable chronic medical, infectious, or mental disease.<sup>15</sup> Local public health agencies may also have to divert local funds from emergency preparedness and the control of communicable disease to address the problems of the uninsured.

The risk posed by individuals lacking health insurance also impacts the economic security of the whole nation. While uninsured persons pay approximately thirty-five percent of their medical expenses through out-of-pocket payments, the government must account for the remainder of the cost.<sup>16</sup> Workers’

<sup>8</sup> INST. OF MED., UNINSURANCE FACTS & FIGURES: THE UNINSURED ARE SICKER AND DIE SOONER 1 (2004), available at <http://www.iom.edu/Object.File/Master/17/748/0.pdf>.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *See id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> INST. OF MED., UNINSURANCE FACTS & FIGURES: HEALTH INSURANCE: NOW YOU’VE GOT IT, NOW YOU DON’T 2 (2004), available at <http://www.iom.edu/Object.File/Master/17/742/0.pdf> [hereinafter INST. OF MED., NOW YOU’VE GOT IT, NOW YOU DON’T].

<sup>15</sup> *See* INST. OF MED., UNINSURANCE FACTS & FIGURES: UNINSURANCE COSTS THE COUNTRY MORE THAN YOU THINK 1-2 (2004), available at <http://www.iom.edu/Object.File/Master/17/746/0.pdf> (discussing particular vulnerability to outbreaks of measles and influenza).

<sup>16</sup> *Id.* at 1.

compensation benefits and public charity makes up some of this deficit, but tax dollars and public funds are still used to reimburse hospitals and other health care providers for uncompensated health care expenses related to the uninsured to the tune of over thirty-five billion dollars a year.<sup>17</sup>

The lack of health care insurance also impacts the United States labor economy. While eighteen-thousand individuals are estimated to die unnecessarily every year due to the lack of health insurance,<sup>18</sup> millions more suffer from chronic disease or lack the necessary primary care and preventative health services that would keep them in the American workplace as productive workers and taxpayers for a longer duration.<sup>19</sup>

### *B. The Failure of the American Medical Malpractice Liability System*

Even when Americans are able to access the health care system, the best medical outcomes do not always result. Mistakes happen, and when they do, patients may be handed the card of one of America's most famous health care advocates, the medical malpractice attorney. In most cases, injured patients do not file claims, but in a fraction of cases, they sue; and in a fraction of those cases, they win.<sup>20</sup> Plaintiff's attorneys declare victory, while physician's scowl, and insurance companies raise liability insurance premiums.<sup>21</sup> Patients who sue are then left either with the jackpot . . . or without a pot (as the saying goes).

The debate over reform of the medical malpractice system in the United States rages on, as it has repeatedly over the last forty years.<sup>22</sup> While the true nature of the medical malpractice crisis is in question,<sup>23</sup> it is clear that providers

<sup>17</sup> *Id.*

<sup>18</sup> INST. OF MED., UNINSURANCE FACTS & FIGURES: IT IS NOW TIME TO EXTEND COVERAGE TO ALL 1 (2004), available at <http://www.iom.edu/Object.File/Master/17/736/0.pdf>. See also INST. OF MED., NOW YOU'VE GOT IT, NOW YOU DON'T, *supra* note 14, at 1.

<sup>19</sup> "The [IOM] analysis suggests that, over one year, the diminished health and shorter life spans of Americans under age 65 who lack health insurance translates into between \$65 billion and \$130 billion. These are likely underestimates, given that they don't take into account additional positive effects on health and longevity after age 65 if individuals had always had coverage." INST. OF MED., NOW YOU'VE GOT IT, NOW YOU DON'T, *supra* note 14, at 2.

<sup>20</sup> See *infra* text accompanying notes 24-26.

<sup>21</sup> See *infra* text accompanying note 42 (testimony of Lawrence Smarr).

<sup>22</sup> Some have argued that the current frustration over the U.S. medical malpractice system is a repetition of a similar cycle of frustrations that took place in the early 1970s and the mid-1980s. BRIAN P. ROSMAN, COUNCIL ON HEALTH CARE ECON. & POL'Y, MEDICAL MALPRACTICE IN CRISIS: HEALTH CARE POLICY OPTIONS 1 (2003), available at <http://sihp.brandeis.edu/council/pubs/Malpractice/CouncilMalpracticeBackgroundpaper.pdf>.

<sup>23</sup> There is considerable debate over the nature of the medical malpractice crisis and whether or not medical malpractice jury awards have increased the costs of managing large malpractice insurance claims for insurance companies. See, e.g., Bernard Black et al., *False Diagnosis*, N.Y. TIMES, Mar. 10, 2005, at A27; Geoff Boehm, *Debunking Medical Malpractice Myths: Unraveling the False Premises Behind "Tort Reform,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 357, 358-366 (2005). Cf. AM. MED. ASS'N, MEDICAL LIABILITY REFORM—NOW! 3



are frustrated and that patients remain in the middle of a battlefield between trial lawyers and insurance companies, providers, and politicians. While the twin goals of the medical malpractice system, 1) compensation to redress harms and 2) deterrence of negligent conduct, fail to be fully realized, the current medical malpractice system remains stagnant in terms of improving health care delivery in the United States.

If the primary goal of the American medical malpractice liability system is to make injured patients whole by compensating them for the injuries they sustain, the system is clearly failing. A recent Harvard study showed that very few patients injured by the negligent actions of health care providers actually filed suit against those providers (one in eight or 12.5%).<sup>24</sup> Further, only a fraction of these claimants actually recover any form of economic compensation for their injuries (one in sixteen, or 6.25%).<sup>25</sup> Thus, many patients sustaining medical injury face the legacy of such injuries without any form of redress or compensation.

Additionally, those claimants who secure judgments at the trial level typically have to wait years after their initial filing to secure an award.<sup>26</sup> Economic necessities drive many negligently injured patients into early settlement, a situation that may not be discouraged by the lawyers representing them on a contingency fee basis.<sup>27</sup> Such arrangements typically skim an immediate thirty to forty percent of the award for attorney's fees and court costs, and after settling all past and present medical bills and personal debt due to lost wages, may leave little in the form of actual (allegedly-to-make-whole) compensation.

The undeniable wish for most injured patient-plaintiffs (and their attorneys) who stick it out through the entire litigation process is that they will be the ones to cash in on millions of dollars in punitive and other non-economic damages. Yet, even for these victorious plaintiffs, a monetary award is unlikely to address the full extent of emotional hardships that result from dealing with the prolonged litigation process, a lifetime of medical injury, the unfulfilled

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(2006), available at <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlmow.pdf> [hereinafter AM. MED. ASS'N, MEDICAL LIABILITY REFORM].

<sup>24</sup> Jeffery O'Connell & James F. Neale, *HMO's, Cost Containment, and Early Offers: New Malpractice Threats and Proposed Reforms*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 294, 294 n.52 (1998) (citing to a Harvard 1990 medical malpractice report to the State of New York).

<sup>25</sup> *Id.*

<sup>26</sup> One study showed, in the year of 2000, that the average time for resolution of a medical malpractice litigation claim was forty-five months or over three-and-a-half years. RANDALL R. BOVBERG & BRIAN RAYMOND, KAISER PERMANENTE INST. FOR HEALTH POL'Y, PATIENT SAFETY, JUST COMPENSATION AND MEDICAL LIABILITY REFORM 8 (2003), available at [http://www.kpihp.org/publications/docs/patient\\_safety.pdf](http://www.kpihp.org/publications/docs/patient_safety.pdf).

<sup>27</sup> Motivations may exist for the plaintiff's lawyer to encourage early settlement rather than pursuing a trial, regardless of the patient's best interests, if the lawyer stands to make a quick and efficient contingency fee. Alternatively, injured patients facing growing medical bills, lost wages, and uncertain chances in the courtroom may accept a lower settlement than they may be entitled, depending on the extent of their injuries.

desire for apology, and arguably, the hope for institutional change.<sup>28</sup>

If the secondary goal of the American medical malpractice liability system is to deter physicians from negligent conduct, the system falls short here as well. Instead of fostering the conversations necessary to elicit institutional change, the conversations of the medical establishment focus on the allegedly greedy lawyers and their allegedly frivolous, money-seeking claims filed on behalf of their clients. Physicians characterize the tort system as a corrupt one that allocates resources unfairly to lottery winners and cruelly punishes “competent, hardworking practitioners.”<sup>29</sup> Studies showing that successful claims depend more on the extent of injury rather than the actual negligence of the provider<sup>30</sup> only enforce such provider claims and stimulate concern with over-deterrence and the practice of defensive medicine.<sup>31</sup> Providers remain left with the notion that the only institution that needs change is one of legal rather than medical origin.

Characterizing the legal system as the problem prevents the necessary focus on the medical institutions that allow serious and medically negligent injuries to occur. And clearly, negligent and preventable death does occur; the Institute of Medicine (“IOM”) has reported that up to 98,000 deaths a year occur from medical error.<sup>32</sup> The national costs associated with such medical errors are estimated to be in the billions.<sup>33</sup> Despite this stunning volume of unnecessary patient death and injury, the medical establishment seems more vocal about the necessity of medical malpractice liability reform than the issue of patient safety.<sup>34</sup>

Addressing the institutional deficiencies that lead to preventable medical injury requires open conversation and analysis of the patient-provider interac-

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<sup>28</sup> In addition, the desire to become the jackpot verdict winner drives an increased and unnecessary padding of medical treatment and lost employment opportunity, and allegations of fraudulent and unnecessary claims. See, e.g., Jeffrey O’Connell, *A Proposed Remedy for Mississippi’s Malpractice Miseries*, 22 MISS. C. L. REV. 1, 3 (2002).

<sup>29</sup> David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 283 (2004).

<sup>30</sup> O’Connell & Neale, *supra* note 24, at 295 (citing Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996)).

<sup>31</sup> Defensive medicine may consist of either ordering additional unnecessary tests unjustified by medical indications (“positive defensiveness”) or denying treatment to persons who present complicated medical issues and are deemed high risk (“negative defensiveness”). BOVBERG & RAYMOND, *supra* note 26, at 11.

<sup>32</sup> INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 1* (Linda T. Kohn et al. eds., 2000) (discussing commonly cited medical errors including surgical mistakes and medication errors) [hereinafter INST. OF MED., *TO ERR IS HUMAN*]. This represents more deaths per year than are attributable to motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516). *Id.*

<sup>33</sup> *Id.* at 1-2 (estimating the associated cost attributed to such error as between seventeen to twenty-nine billion dollars).

<sup>34</sup> Boehm, *supra* note 23, at 357.

tions that lead to such medical errors.<sup>35</sup> However, the current system of malpractice liability offers little encouragement for such open analysis and creates incentives for provider silence in the face of patient injury and provider negligence.<sup>36</sup> While ethical obligations and even regulatory duties<sup>37</sup> call for the disclosure of medical negligence that results in patient injury, physicians are still likely to fear such disclosure as a pathway to a lurking malpractice suit. Apologies remain unlikely in this setting, especially as the finger-pointing process of medical malpractice litigation begins.<sup>38</sup> Discussion of medical error that does not result in tangible patient injury may even be stifled, as this evidence could be used in future malpractice litigation against providers. Physicians may also be fearful of open discussion with their peers who may be called to testify against them as expert witnesses at trial.<sup>39</sup>

In the environment of fear and silence that is stimulated by health care providers seeking to avoid personal liability in malpractice suits, deterrence of medical error takes a back seat to deterrence of litigation.<sup>40</sup> The tension that exists between the deterrence of medical error and the current system of medical malpractice liability signals the weakness of the current framework for our health care system. Greater efforts are needed to ensure deterrence of errors, and less time and energy needs to be spent on avoiding litigation.

The ultimate goal of the medical malpractice system should be to improve overall health care delivery. Again, however, realization of this overarching goal falls short. While stimulating the practice of defensive medicine and providers' fear of litigation, and failing to provide adequate redress for patients sustaining preventable medical injuries, the current system of medical malpractice litigation may also be limiting the scope of both health care delivery and

<sup>35</sup> INST. OF MED., TO ERR IS HUMAN, *supra* note 32, *passim*.

<sup>36</sup> *Id.* at 3.

<sup>37</sup> In response to the "To Err is Human" report, *supra* note 32, the Joint Commission implemented new regulations requiring reporting of medical negligence and unanticipated outcomes. *E.g.*, Lee Taft, *Apology and Medical Mistake: Opportunity or Foil?*, 14 ANNALS HEALTH L. 55, 56 (2005) (citing JCAHO Hospital Accreditation Standard RI.2.90. 2004).

<sup>38</sup> Note that physicians may be explicitly counseled against admissions of mistake, acknowledgement of error, or the granting of any apology that could be construed as an admission of liability for medical injury. Taft, *supra* note 37, at 58 (describing how physicians seeking to express an apology to patients who suffer injury due to medical error are confronted with a moral dilemma when they are counseled not to make such statements).

<sup>39</sup> Note that providers may also feel professional pressure from their peers to maintain an unhealthy perfectionism that does not facilitate the admission of mistake. It may be argued that slogans such as "Best of the Best" and others exemplify this seemingly unhealthy attitude among physicians. *See, e.g.*, Thank You to the Johns Hopkins Family for Once Again Making Us #1, [http://www.hopkinsmedicine.org/usnews/best\\_poster.pdf](http://www.hopkinsmedicine.org/usnews/best_poster.pdf).

<sup>40</sup> *E.g.*, Boehm, *supra* note 23, at 357. The American Medical Association, for example, tends to focus its malpractice lobbying energies on limiting liability for physicians rather than seeking ways to reduce medical errors. *See id.* *See also* AM. MED. ASS'N, MEDICAL LIABILITY REFORM, *supra* note 23 (highlighting the focus on tort reform by physicians).

citizens' access to care.<sup>41</sup>

The medical liability insurance industry argues that as malpractice claims increase and as jury awards and settlement figures continue to rise, they will be forced to continue raising malpractice insurance premiums or leave the market altogether.<sup>42</sup> In response to increasing insurance premiums, many providers have limited the scope of their practices by eliminating high risk procedures (such as obstetric services), moving to less litigious areas of the country, or abandoning the practice of medicine altogether.<sup>43</sup> Hospitals have also responded by limiting the number of high risk providers or reducing health coverage volume in high risk settings (such as emergency rooms).<sup>44</sup> Thus, any increase in malpractice premiums tends to reduce the variety of care options, limit the volume of available care, and raise overall health care costs.<sup>45</sup>

### III. THE OPTIMAL AMERICAN HEALTH CARE SYSTEM: OVERLAPPING HEALTH INTERESTS BETWEEN PATIENTS AND PROVIDERS

In understanding the current failures of the American health care delivery and malpractice liability systems, it is important to ascertain the interests of the significant players in these systems. While the political rhetoric pits health care consumers and their interests against those of physicians and other providers, patients and providers actually have an overlapping vision of the optimal state of health care delivery.

It is undeniable that every citizen wants access to high quality health care when faced with medical disease or injury. Equally clear is the notion that individuals suffering from such maladies do not want to face bankruptcy or extreme financial hardship to secure access to adequate medical care. While demanding affordable treatment costs, American consumers also demand the efficient use of tax dollars in health care. Health care consumers also typically

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<sup>41</sup> OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 3-10 (2003), available at <http://aspe.hhs.gov/daltcp/reports/medliab.pdf> [hereinafter ADDRESSING THE NEW HEALTH CARE CRISIS].

<sup>42</sup> See *Patient Access Crisis: The Role of Medical Litigation: Hearing Before the S. Judiciary Comm.*, 108th Cong. (2003) (statement of Lawrence Smarr, President, Physician Insurers Association of America) (describing the losses of the medical liability insurance industry between 1999 and 2001 and stating that in order to operate on a break-even basis insurance rate increases for providers are to be expected); see also ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 41.

<sup>43</sup> ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 41, at 3-6.

<sup>44</sup> Threats of potential liability and rising malpractice premiums even affect medical students' career paths; students may avoid high risk specialties or avoid residencies in areas of the country perceived as litigious. AM. MED. ASS'N, MEDICAL LIABILITY REFORM, *supra* note 23, at 4.

<sup>45</sup> ADDRESSING THE NEW HEALTH CARE CRISIS, *supra* note 41, at 3-11.

demand increased access to services, simplified billing processes, and the retained ability to choose their own physicians. In sum, citizens want to maintain the best possible standard of care, including access to the best providers and the most innovative technology, all at an affordable cost.<sup>46</sup>

When patients suffer medical injury, these goals do not radically change.<sup>47</sup>

Yet injured patients and their families are often driven toward litigation in order to obtain the resources necessary to deal with their injuries and get on with their lives.<sup>48</sup> In addition, they desire accountability for their injuries.<sup>49</sup> Individual and institutional apology, institutional change, or at times, individual civil and criminal accountability are all possible ways a plaintiff might seek redress and accountability for his or her injury. Such plaintiffs, however, rarely *want* to go to the courtroom at any point in this process.<sup>50</sup>

Physicians and other health care providers share these desires. They too seek the best possible standard of care<sup>51</sup> and access to the most innovative medical technology. Similar to patients being free to choose their physicians and treatment plans, so too do physicians desire the ability to freely practice medicine within the highest possible standards. Additionally, providers desire economic reliability: not the inconsistency that results from rapidly changing malpractice premiums, health care reimbursement rates, and other financial burdens that interfere with the practice of medicine.<sup>52</sup> While some seek to maintain the ability of physicians to act as regular businessmen and women offering an important and unique commodity,<sup>53</sup> many seek to maintain the high academic standard that surrounds them during medical training, working as a

<sup>46</sup> See, e.g., HENRY J. KAISER FAMILY FOUND., HEALTH CARE PRIORITIES—MOST IMPORTANT HEALTH CARE PROBLEM—HEALTH POLL REPORT—FEBRUARY 2004 (2004), available at <http://kaisernetwork.org> (search “Health Poll Search” for “Search by Topics,” with Topic, “Health Care Priorities,” Subtopic, “Most Important Health Care Problem,” View Date “Feb 05, 2004.”).

<sup>47</sup> Patients suffering from medically related injuries still want the best possible standard of living, access to the best providers, and the most innovative technology.

<sup>48</sup> E.g., BOVBERG & RAYMOND, *supra* note 26, at 13.

<sup>49</sup> *Id.* at 12.

<sup>50</sup> See, e.g., AMERICA’S HEALTH INSURANCE PLANS, PATIENTS’ RIGHTS—POST ELECTION HEALTH CARE PRIORITIES SURVEY—NOVEMBER 2004, available at <http://kaisernetwork.org> (search “Health Poll Search” for “Search by Topics,” with Topic, “Patient’s Rights,” Subtopic, “Patient’s Rights,” View Date “Nov 03, 2004”) (providing poll data showing reluctance of patients to sue providers in cases of conflict; seventy-one percent favored administrative resolution as compared to eighteen percent preferring litigation process).

<sup>51</sup> Physicians, too, seek the best possible standard of living.

<sup>52</sup> Cf. THE HENRY J. KAISER FAMILY FOUND., NATIONAL SURVEY OF PHYSICIANS PART III: DOCTORS’ OPINIONS ABOUT THEIR PROFESSION 4 (2002), available at <http://www.kff.org/kaiserpolls/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13966> (discussing provider dissatisfaction with increased paperwork and administrative responsibilities unrelated to patient care and frustration over inconsistent projected income levels).

<sup>53</sup> See, e.g., Merrill Matthews, *Medicine as a Business*, 71 THE MOUNT SINAI J. OF MED. 225, 226 (2004) (arguing that the medical profession and American health system would best be served under a pure business model).

health care team to improve and maintain a high quality of health for their patients.<sup>54</sup> And while physicians and other providers may be reluctant to admit that they make mistakes, they will admit them, with the wish that they are judged as humans rather than “malevolent tortfeasors:” humans entitled to make mistakes and not pay unjustly for them.<sup>55</sup> Like consumers, physicians maintain a strong desire to avoid the courtroom, and at the same time seek to maintain high professional standards. They also strive for individual and institutional accountability and improvement and are generally willing to provide adequate redress for patients who are genuinely injured by medical error.<sup>56</sup>

Despite the apparent overlap of patient and provider interests, however, mainstream policy proposals fail to link or establish the mutual coexistence of their desires. Rather, two distinct spheres of health care reform have developed: (1) a movement for tort reform undertaken largely by provider and insurance interests and (2) a grassroots movement for universal health coverage. Part IV will discuss these two distinct spheres of health care reform activity and will lay groundwork for the idea that dual and simultaneous reform is required for the success of either reform movement. Part V will follow with a discussion of the advantages of such a dual policy approach.

#### IV. DISCUSSING THE ALTERNATIVES: UNIVERSAL HEALTH CARE AND MEDICAL MALPRACTICE LIABILITY REFORM IN THE AMERICAN HEALTH CARE SYSTEM

##### A. *Tort Reform: From Alternative Dispute Resolution<sup>57</sup> to Arm-Wrestling?*

Despite the apparent overlap in the interests of patients and providers, reform proposals for the American health care system fail to adequately take both parties' wishes into consideration. Instead most reform efforts focus on either the medical malpractice liability system or expanding coverage for those without health insurance. In either case, the dynamic political rhetoric is one of finger-pointing, either toward allegedly greedy trial lawyers and runaway juries driving up health care costs, insurance companies allegedly concerned more

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<sup>54</sup> See, e.g., Herbert M. Swick, *Academic Medicine Must Deal with the Clash of Business and Professional Values*, 73 ACAD. MED. 751, 755 (1998) (“The leaders of academic medicine must preserve the primacy of the academic enterprise and professional values even as we confront a ‘profit-driven, geographically dispersed corporate system with capitalistic values.’”).

<sup>55</sup> Taft, *supra* note 37, at 58 (discussing the “intolerable dilemma” that physicians face in wanting to offer patients acknowledgment and apologies for medical errors and a health care system that does not allow such acknowledgment.)

<sup>56</sup> *Id.*; Albert W. Wu, *Medical Error: The Second Victim*, 320 BRIT. MED. J. 726, 726 (2000).

<sup>57</sup> Alternative dispute resolution (“ADR”) models include dispute settlement through structured negotiation, arbitration, mediation, and summary jury trial, amongst others. For a background primer on alternative dispute resolution, see generally LEONARD L. RISKIN & JAMES E. WESTBROOK, *DISPUTE RESOLUTION AND LAWYERS* (2d ed. 1997).

with fiscal health than health care, or toward physicians and medical institutions allegedly trampling patient rights and failing miserably to provide an affordable and comprehensive system of health care for all.

As previously discussed, most medical liability reform seeks to deter litigation rather than improve compensation for injured patients or improve the quality of care.<sup>58</sup> Major proposals for medical malpractice liability reform include 1) placing caps on non-economic damages that successful patient-plaintiffs may be awarded, 2) limiting the statute of limitations and lawyer's fees for the filing of malpractice suits, and 3) creating mechanisms for judicial review and the post-verdict reduction of jury awards.<sup>59</sup> Several of these measures have been implemented in various states.<sup>60</sup> Other reform proposals seek to remove malpractice disputes from the trial setting altogether, utilizing alternative forms of dispute resolution, such as 4) arbitration or mediation<sup>61</sup> and 5) medical review courts.<sup>62</sup>

An additional reform proposal is 6) exclusive enterprise liability, whereby hospitals and other medical institutions undertake the full extent of liability for the providers practicing within their walls.<sup>63</sup> While lessening liability insurance pressures on individual providers, deep-pocketed medical institutions, such as hospitals, would still be subject to large awards. Thus, the risk pool created at the hospital, rather than individual physician, level, still remains in jeopardy.<sup>64</sup> Institutional "conspiracies of silence"<sup>65</sup> may also be produced under such a scheme.<sup>66</sup>

Another option is 7) early-offer tort reform.<sup>67</sup> Under this system, civil de-

<sup>58</sup> See *supra* text and references accompanying notes 29-40 (discussing factors that lead to attempts at deterring litigation rather than medical error).

<sup>59</sup> E.g., BOVBJERG & RAYMOND, *supra* note 26, at 25. Judges may be granted the ability to reduce the jury's award with the collateral offset rule, whereby the award is decreased by the amount compensated through other means (such as existing disability and health insurance plans purchased by plaintiffs prior to sustaining their injury). See *id.* This and other measures are typically based on the design of California's Medical Injury Compensation Reform Act of 1975 ("MICRA"). See ROSMAN, *supra* note 22, at 3-4.

<sup>60</sup> BOVBJERG & RAYMOND, *supra* note 26, at 25 ("One tabulation lists fourteen states that have enacted caps on the recovery of non-economic damages in medical malpractice actions . . .").

<sup>61</sup> The use of summary jury trials presents another possibility. These abbreviated trials are designed by the parties to test specific issues by an agreed upon mock jury. *Id.* at 16.

<sup>62</sup> Medical review courts are set up to exclusively hear claims of medical malpractice. *Id.* at 18. Medically technical expertise in the judiciary could thus be concentrated at either the state or national level. *Id.* Medical review panels have also been set up in a limited number of states to screen claims before they reach the courtroom. See also Studdert et al., *supra* note 29, at 287 (discussing reform efforts that limit access to the courts).

<sup>63</sup> BOVBJERG & RAYMOND, *supra* note 26, at 16.

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

defendants have the opportunity to compensate injured plaintiffs within a prescribed number of days after an injury is sustained for the value of their medical expenses, lost wages, and reasonable attorney's fees.<sup>68</sup> While plaintiffs would be able to recover the full amount of claimed economic losses in a relatively short amount of time, they would be required to surrender any tort remedy and access to punitive damage awards.<sup>69</sup> Claimants who reject such an award would then face increased evidentiary burdens at the trial level (a clear and convincing standard instead of a preponderance of the evidence standard) for more egregious conduct (willful or wanton misconduct rather than mere negligence).<sup>70</sup> If defendants fail to make an early offer, standard medical malpractice litigation could ensue with the evidentiary burdens and award limits unchanged.<sup>71</sup>

Early-option schemes would likely speed up the compensation process for injured patients and place a cap on contingency fee arrangements.<sup>72</sup> Ideally, only the most egregious claims would be brought to trial,<sup>73</sup> while a greater number of injured patients would turn to the early-offer system to obtain redress for the injuries they have sustained. Critics of early-offer tort reform characterize providers as reluctant to admit liability at any point, for fear of stigmatization and an increased potential for liability at the trial level in subsequent cases.<sup>74</sup> Critics also charge that settlement is already an option for patients and providers.<sup>75</sup>

Yet another alternative for tort reform concerns is 8) no-fault compensation schemes. While a radical departure from traditional malpractice tort law, no-fault compensation schemes likely provide the most effective and comprehensive compensatory mechanism for injured patients.<sup>76</sup> Under such a system, providers are held strictly liable for damages caused by preventable medical injury, eliminating any burden of proof on plaintiffs to establish provider negligence in court.<sup>77</sup> Injured patients would be compensated according to a predetermined schedule of payments based on type and extent of injury.<sup>78</sup>

The Workers' Compensation system in the United States presents a model

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<sup>68</sup> See, e.g., O'Connell & Neale, *supra* note 24, at 310.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 311.

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> Cf. BOVBJERG & RAYMOND, *supra* note 26, at 17 (stating that a potential weakness of the early-offer system is that providers might "game" the system by making offers only to badly injured people").

<sup>74</sup> *Id.*

<sup>75</sup> See *id.*

<sup>76</sup> David Studdert & Troyen Brennan, *No Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 J. AM. MED. ASS'N 217-223 (2001).

<sup>77</sup> BOVBJERG & RAYMOND, *supra* note 26, at 20.

<sup>78</sup> *Id.*



for this type of liability reform.<sup>79</sup> Employees injured in the workplace are typically entitled up to two-thirds of their present wages for a set number of years.<sup>80</sup>

Medical costs for injured workers are covered indefinitely and more recently are covered on a periodic payment basis.<sup>81</sup> Applying this model to the medical malpractice setting, in exchange for quick claim determination and broad access to compensation, patients could easily recover lost wages and costs associated with medical expenses, all in the absence of legal counsel and outside of the courtroom.

As discussed above, the current system of medical malpractice liability fails in both adequately compensating injured patients and effectively deterring negligent providers. In separating the goals of patient compensation from provider deterrence, a no-fault compensation system would serve to effectively compensate the majority of patients sustaining injuries due to medical error,<sup>82</sup> while at the same time creating (and allowing) the incentives for providers and institutions to work in a cooperative and open manner to reduce preventable medical injury. As negligence would not be an issue at the trial setting, there would be no need to maintain institutional or individual silence.<sup>83</sup> Thus, the necessary internal, academic, and quality assurance collaborations could take place in order to address the practices that lead to medical error and injury. Again, with less fear of stigmatization, physicians and health care institutions could involve a greater number of parties in a transparent patient-injury review process in order to more effectively address patient safety concerns.<sup>84</sup> While consistently striving to improve patient safety in this manner, the discussion of medical error could be normalized in an accountable medical institution.

The administrative efficiency of such a system could save untold sums in terms of avoiding the traditional adversarial malpractice litigation process.<sup>85</sup> The exorbitant costs of expert witness testimony and the lengthy trial process could be eliminated, and costs associated with delayed compensation and contingency fee arrangements could be substantially reduced. The emotional pain and suffering associated with the trial experience would be eliminated.

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> While recovery for each individual injury could arguably be less than what successful litigants are awarded at trial under a Workers' Compensation-type system, a far greater number of injured patients would actually receive compensation as compared to the litigation route.

<sup>83</sup> See *supra* notes 29-40 and accompanying text (discussing institutional silence surrounding treatment related injuries).

<sup>84</sup> See INST. OF MED., TO ERR IS HUMAN, *supra* note 32, at 10.

<sup>85</sup> Reductions in claim resolution time and judicial overhead costs have been cited in the no-fault systems in place in Virginia and Florida. BOVBERG & RAYMOND, *supra* note 26, at 19-20.

Medical models for such a system already exist in Virginia and Florida,<sup>86</sup> two states that have enacted administrative compensation schemes for severely injured newborns. In an attempt to reduce malpractice liability and insurance premiums for practicing obstetricians, Virginia established a no-fault system in 1987 and Florida one in 1988.<sup>87</sup> Recent studies have shown that these models provide rapid compensation with reduced administrative cost when compared to the litigation process.<sup>88</sup> Further, reduced malpractice premiums for providers in the area can be attributed to such systems.<sup>89</sup>

The biggest challenge for the no-fault system would be making determinations of medical error versus disease progression or negative outcome.<sup>90</sup> No-fault systems would not provide compensation for all adverse outcomes in the medical setting, only those attributable to preventable medical error.<sup>91</sup> Countries utilizing no-fault systems have addressed this issue by using sophisticated medical panels to weigh in on issues of medical preventability.<sup>92</sup> In addition, while any notion that a no-fault compensation system unfairly limits the ability of recklessly injured patients to recover damages, access to the traditional civil tort system<sup>93</sup> for suits alleging willful and wanton behavior on behalf of medical providers could be maintained.

### *B. Universally Undercovered: The Push for Universal Health Care in America*

While the dispute over medical malpractice liability reform rages on, the battle for universal access to health care is waged on a different front. The presidential administrations of Truman, Nixon, and Clinton each attempted to create a national health care safety net for all Americans but each failed.<sup>94</sup> While most Americans support a right of health care for all citizens<sup>95</sup> and many

<sup>86</sup> *Id.* at 19. At the federal level, a no-fault compensation scheme exists under the National Childhood Vaccine Injury Act. *E.g.*, Josephine Y. King, *No Fault Compensation for Medical Injuries*, 8 J. CONTEMP. HEALTH L. & POL'Y 227, 233-34 (1992).

<sup>87</sup> *Id.* See, *e.g.*, King, *supra* note 86, at 234, 234 n.34.

<sup>88</sup> *Id.* at 234.

<sup>89</sup> *Id.*

<sup>90</sup> *Cf.* BOVBJERG & RAYMOND, *supra* note 26, at 20 (discussing the alternatives for the administrative determination of preventable injury from natural disease progression).

<sup>91</sup> *See id.*

<sup>92</sup> *Id.*

<sup>93</sup> Willful and wanton negligence could also be deterred and addressed by the criminal justice system when necessary.

<sup>94</sup> *E.g.*, Randall R. Bovbjerg & Frank C. Ullman, *Health Insurance and Health Access: Reengineering Local Safety Nets*, 22 J. LEGAL MED. 247, 251 (2001).

<sup>95</sup> Polls show that sixty to seventy percent of Americans would support a publicly financed universal health care system. *See, e.g.*, *Washington Post-ABC News Poll: Health Care*, WASHINGTONPOST.COM, Oct. 20, 2003, at No. 47, available at <http://www.washingtonpost.com/wp-srv/politics/polls/vault/stories/data102003.html> [hereinafter *Washington Post-ABC News Poll*] (showing that sixty-two percent of Americans would prefer universal health care

physicians and public health administrators feel that a universal system of health care is long overdue in the United States,<sup>96</sup> progress stalls over how to best implement a universal health care plan.

The issue of health care financing stands as a significant hurdle in the fulfillment of establishing universal health care in America.<sup>97</sup> As one of the richest countries in the world, the United States clearly has the financial capability to implement a quality system of universal health care for its citizens.<sup>98</sup> The fact that the most innovative medical research, technological development, and highest levels of professional training take place within the United States highlights this capability further.

Yet the burden of cost remains one of the most formidable hurdles for universal health care reform. The United States already spends one-sixth of its budget on health related expenses, with a projection of growth of health costs in sight. The fact that we already spend twice as much as other industrialized nations with universal health care and fail to achieve similar patient outcomes is disheartening. Thus with huge health expenditures already being made in a flawed system, Americans are reluctant to support new taxes to fund universal health care.

In addition to the issue of cost, proponents of universal health care disagree about whether to increase health care coverage utilizing a pragmatic approach or one of radical and revolutionary change.<sup>99</sup> Pragmatism in health politics and administration is the status quo and has been effective in obtaining important health benefits for select segments of the population.<sup>100</sup> Advocates of pragmatic health reform cite these measures along with the existing public confidence in the Medicare and Medicaid systems.<sup>101</sup> In addition, pragmatists ar-

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based on a five-day poll taken in October 2003). *See also* John R. Battista & Justine McCabe, *The Case For Single Payer, Universal Health Care For The United States*, Address Before the Ass'n of State Green Parties, Moodus, Connecticut (June 4, 1999), *outline available at* [http://chealth.server101.com/the\\_case\\_for\\_universal\\_health\\_care\\_in\\_the\\_united\\_states.htm](http://chealth.server101.com/the_case_for_universal_health_care_in_the_united_states.htm).

<sup>96</sup> *See, e.g.*, Mohammad Akhter, *APHA Policies on Universal Health Care: Health for a Few or Health for All?*, 93 AM. J. PUB. HEALTH 99, 100 (2003) (discussing public health professional and political support for achieving universal health care access and also highlighting the fact that many other countries provide universal health care services "at a cost to the sponsoring governments and the public that is modest compared with the annual expenditures for health care in the United States.").

<sup>97</sup> *Id.*

<sup>98</sup> Canada and many European nations provide universal health coverage for far less cost than the United States spends on health care. *See supra* note 3 and accompanying text (demonstrating that other countries provide universal health care access to their citizens for less than the United States currently spends on health care and have better public health outcomes).

<sup>99</sup> Akhter, *supra* note 96, at 99.

<sup>100</sup> For instance children under the State Children's Health Insurance Program ("SCHIP"), the elderly, the impoverished, and dialysis patients suffering from end-stage renal disease, amongst others.

<sup>101</sup> *See, e.g.*, John Tooker, *Affordable Health Insurance for All Is Possible by Means of a Pragmatic Approach*, 93 AM. J. PUB. HEALTH 106, 106 (2003) (arguing for the pragmatic expansion of the current health system toward universal coverage).

gue that any attempt to radically upset the status quo will meet overwhelming resistance from health care players still making a great deal of profit in the current system, such as insurance companies and large provider networks.<sup>102</sup> Pragmatic health reform policies include: 1) implementing premium subsidies and tax credits to increase access to health care, 2) fostering greater competitive pressure between existing health plans, 3) enacting greater regulation of insurance rates in the small-group market, 4) mandating employer-based health coverage, and 5) establishing purchasing groups for individuals seeking health insurance outside of their employment context.<sup>103</sup> Most of these plans represent incremental tweaks of the system that may produce a small impact on the number of individuals without health insurance, but they still allow many citizens to purchase inadequate levels of care or to be priced out of health coverage entirely.<sup>104</sup>

*C. The Physicians' Working Group Proposal for Single-Payer National Health Insurance: "[The] [p]ursuit of corporate profit and personal fortune have no place in care-giving."*<sup>105</sup>

More idealistic health reformers stress the need for immediate change, highlighting the eighteen thousand preventable deaths that occur every year due to a lack of health insurance,<sup>106</sup> the continuously growing number of underinsured and uninsured citizens burdening our current system of health care, and the public health dangers individuals who fail to obtain medical care present.<sup>107</sup>

Reformers draw attention to the inequities present in a system that delivers the highest quality of care in the world, while at the same time denying citizens access to basic primary care services, prenatal care, and simple immunizations.<sup>108</sup> At the same time, they stress that immediate and universal access to quality health care will not only improve public health and social equity, but

<sup>102</sup> Akhter, *supra* note 96.

<sup>103</sup> Tooker, *supra* note 101, at 107. See also *Physicians' Working Group*, *supra* note 1.

<sup>104</sup> *Physicians' Working Group*, *supra* note 1.

<sup>105</sup> *Id.* at 799.

<sup>106</sup> See *supra* note 9.

<sup>107</sup> *Physicians' Working Group*, *supra* note 1, at 798.

<sup>108</sup> Akhter points out that nearly two-thirds of the uninsured come from low income families and nearly half are represented by racial and ethnic minorities. Akhter, *supra* note 96, at 99. The inequities apparent in an economic and racial analysis of health care access are painful (thirty-three percent of all Hispanics, nineteen percent of all black Americans and ten percent of all white Americans are uninsured). *Physicians' Working Group*, *supra* note 1, at 798. An additional argument that supports a more radical approach in lieu of the pragmatic expansion of health care access is that with the lack of concentrated political power among socially and economically marginalized groups, incremental reforms are unlikely to ever reach these socially disadvantaged citizens. See also Robert Putsch & Linda Pololi, *Distributive Justice in American Healthcare: Institutions, Power and the Equitable Care of Patients*, 10 AM. J. MANAGED CARE SP45 (2004).

also that it will improve the financing of health care in America.<sup>109</sup>

The most promising proposals to immediately ensure quality health care for all Americans are those that establish a national system of health care under a single-payer national health insurance program. The comprehensive Physicians' Working Group for Single-Payer National Health Insurance Proposal for such a system includes the following: 1) preventative, primary, and specialty care, 2) long-term nursing, rehabilitative, and at home care, 3) mental health and dental care, and 4) coverage of pharmaceuticals and medical supplies.<sup>110</sup> By eliminating the myriad of private insurance providers, the plan minimizes billing complexities<sup>111</sup> and the for-profit administrative expense of marketing, promotion, and health care profiteering. A national single-payer program cuts the administrative waste of private health insurers, for-profit hospitals, and HMOs that operate with administrative costs of twelve to twenty-five percent as compared to administrative costs for the public Medicare or the Canadian national health insurance programs (which enjoys administrative costs of less than 3.2%).<sup>112</sup> The plan would also cut administrative overhead for providers, who would not have to spend as much time and energy on billing schemes<sup>113</sup> or obtaining reimbursement from multiple health care plans.

Large administrative savings would also be stimulated by the increased bargaining power under a single-payer plan. A national health insurance system would be in a strong bargaining position in relation to the hospitals, pharmaceutical companies, and provider organizations with which it would establish negotiated fee schedules.<sup>114</sup> With such bargaining power, stronger steps could be taken to remove the private profit motives that lead to billions of dollars being spent on marketing and advertising. Additionally, global budgeting<sup>115</sup> could shift resources to improving patient care by eliminating the administrative costs of individual billing for these health care entities.<sup>116</sup>

Global administration would improve patient care in other ways as well. Patient need, rather than market motivation, would motivate capital invest-

<sup>109</sup> *Physicians' Working Group*, *supra* note 1, at 798-99.

<sup>110</sup> *Id.*

<sup>111</sup> Efficiency is obtained as single-payer health plans rely on tax collection mechanisms rather than separate billing schemes. P. Hussey & G.F. Anderson, *A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform*, 66 HEALTH POL'Y 215, 216 (2003).

<sup>112</sup> *Physicians' Working Group*, *supra* note 1, at 799; David U. Himmelstein & Steffie Woolhandler, *National Health Insurance or Incremental Reform: Aim High, or at Our Feet?* 93 AM. J. PUB. HEALTH 102, 103 (2003).

<sup>113</sup> A single-payer system funded with general tax revenues eliminates the costs associated with the administration of alternative collection systems. See Hussey & Anderson, *supra* note 111.

<sup>114</sup> *Id.* at 219.

<sup>115</sup> Global budgeting is essentially paying hospitals a monthly lump sum so that billing patients individually is unnecessary. *Physicians' Working Group*, *supra* note 1, at 800.

<sup>116</sup> *See id.*

ments. Rather than wasting expenditures on advertising executives to maintain superfluous services, increase market shares, or crash commercially-untapped-but-adequate-health-care-areas, experienced health care administrators could conduct periodic technological and infrastructure reviews and wisely re-invest in increased access and improved care. This would prevent wasteful duplication of health care services, medical technology, and other health resources. Planning based on need, rather than profit motivation, would increase health equity and extend adequate health care into isolated social, geographic, or racially segregated areas that private markets typically do not reach.<sup>117</sup>

National single-payer health insurance could foster greater health equity in other ways as well. A national single-payer health insurance plan would eliminate the problematic practice of risk avoidance through adverse patient selection demonstrated by private insurance companies.<sup>118</sup> Private health insurers have the incentive to avoid high risk patients or those with preexisting health conditions that have high health care utilization patterns. Thus sicker patients find it difficult to obtain adequate and affordable health coverage in the present system, or any health insurance coverage at all.<sup>119</sup> As national health insurance would provide adequate coverage for all citizens, adverse selection would cease.

Despite the administrative cost savings and health equities a national single-payer health insurance plan would provide, policy pragmatists suggest that the public is wary of a large and radically different system of health care finance.<sup>120</sup> Single-payer advocates counter this wariness with the evidence that

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<sup>117</sup> *Id.* at 799.

<sup>118</sup> Hussey & Anderson, *supra* note 111, at 218.

<sup>119</sup> *Id.*; see also Putsch & Pololi, *supra* note 108, at SP47.

<sup>120</sup> Poll data from the last several years shows that fifty-six to sixty-two percent of the public prefers "a national health plan, financed by taxpayers, in which all Americans would get their insurance from a single government plan," over the present employment based health insurance system. ABC NEWS, HENRY J. KAISER FAMILY FOUND. & USA TODAY, UNIVERSAL HEALTH INSURANCE—HEALTH CARE POLL—SEPTEMBER 2006, available at <http://kaisernetwork.org> (search "Health Poll Search" under "Advanced Keyword Search" for Keyword, "Universal Health Insurance," View Date "Sep 07, 2006," Then Poll Question Titled "Which do you prefer...") (fifty-six percent prefer universal health insurance); ABC NEWS & WASH. POST, UNIVERSAL HEALTH INSURANCE—POLL—OCTOBER 2003, available at <http://kaisernetwork.org> (search "Health Poll Search" under "Advanced Keyword Search" for Keyword, "Universal Health Insurance," View Date "Oct 09, 2003," Then Poll Question Titled "Which do you prefer...") (sixty-two percent prefer universal health insurance). By comparison, interestingly, approximately forty percent of the public currently favors a national health plan when the survey failed to explicitly contrast it with any other health care insurance system, including the current one. HENRY J. KAISER FAMILY FOUND. & HARV. SCHOOL OF PUB. HEALTH, HEALTH CARE AGENDA FOR THE NEW CONGRESS SURVEY—NOVEMBER 2004, available at <http://kaisernetwork.org> (search "Health Poll Search" under "Advanced Keyword Search" for Keyword, "National Health Plan," View Date "Nov 04, 2004.") (thirty-seven percent favor a national health plan); HENRY J. KAISER FAMILY FOUND., HARV. UNIV. KENNEDY SCHOOL OF

most health care in America is already financed by public funds, representing approximately sixty percent of total health care spending in the United States.<sup>122</sup>

And in addition to the widespread improvements in health equity and coverage that would benefit the majority of the population, a national single-payer plan provides increased funding for the preventative care benefits necessary to improve the public health. While such initiatives are frequently called for by the general public and in the legislature, they are seldom effectuated as it is hard to bill individual patients for such services in the private health care setting (a sort of medical *tragedy of the commons*). National coordination of health care and health policy also allows for such innovations as national patient data systems to improve research and recordkeeping, and global patient safety data tracking, thereby eliminating the practical inefficiencies of data transfer upon a patient's change of health plan in the private market.

Lastly, a national health insurance program could lead to increased notions of *social solidarity*.<sup>123</sup> While fostering a "shared sense of responsibility for providing health care to specific groups such as the elderly, the poor, or people with chronic conditions,"<sup>124</sup> a national health insurance program perpetuates the notion that access to adequate health care is a human right for a society of people that has made a pact to provide, ensure, and protect all of the necessities and benefits of a civil life. Evidence of such solidarity is demonstrated across class lines in America with the public support of the Medicare program and in Canada with citizens' pride over their nation's universal health care program.

#### V. THE COMBINATION OF A NO-FAULT MEDICAL MALPRACTICE COMPENSATION ACT WITH A NATIONAL SINGLE-PAYER HEALTH INSURANCE PLAN

The ongoing debate over the best way to reform the American health care system often pits patients and providers against one another in a politically adversarial framework and leaves them caught in the cross-fire of the debate. While citizens remain skeptical of tort reform as an unnecessary limit on their already tenuous health care rights, providers lack adequate incentives to demand universal health care. The combination of a no-fault medical malpractice

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GOV'T & NAT'L PUB. RADIO, NATIONAL HEALTH PLAN—HEALTH CARE SURVEY—MARCH 2002, available at <http://kaisernetwork.org> (search "Health Poll Search" under "Advanced Keyword Search" for Keyword, "National Health Plan," View Date "Mar 28, 2002.") (forty percent favor a national health plan).

<sup>122</sup> *Physicians' Working Group*, *supra* note 1, at 802.

<sup>123</sup> Hussey & Anderson, *supra* note 111, at 222.

<sup>124</sup> *Id.*; see also Himmelstein & Woolhandler, *supra* note 112 ("[S]olidarity is stronger than charity.") (citing Professor Vicente Navarro, M.D.). The notion of this idea is that public support of a national program serving all citizens would be far greater than piecemeal incremental programs that support only the most vulnerable patient populations (the "charity" cases). See *id.*

compensation act with a grassroots public health movement for universal health care, however, may provide the necessary inducement for both patients and providers to support both measures. A dual policy approach to American health care reform may spur the necessary mix of social activism, industry acquiescence, and political timing that would lead to the best system of health care in the world.

*A. The Patient's Perspective on Medical Malpractice Liability Reform*

Citizens and patient advocacy groups are sustaining a remarkable battle against local and national tort reform measures, which are largely based on the support and lobbying of trial lawyers.<sup>125</sup> Citizens are reasonably wary of any action that impinges upon their legal rights, especially at a time when they have suffered a medical injury. Thus citizens are likely opponents of the most recent widespread tort reform efforts that create further obstacles for injured patients seeking adequate compensation for their injuries and institutional accountability for the circumstances that lead to their injuries. At the same time, most patients, like their provider-adversaries, abhor the litigation experience and appreciate a quicker and more efficient means to achieve their desired goals in litigation.<sup>126</sup>

*B. The Provider's Perspective on a National Single-Payer System of Health Care*

Although generally in favor of universal health care in the United States, providers voice fear over a radical overhaul of the American health care system.<sup>127</sup> While approving of increased health care access for patients, providers may fear that the burden of cost to increase this access will be placed on them. Still stinging from repeated cuts in reimbursement rates and rising malpractice insurance premiums in recent years, providers would not favor large salary cuts.<sup>128</sup> In addition, providers fear the notion that the government, like private health managers in the business world before them, will unduly interfere in the delivery of health care in the practice setting.<sup>129</sup> While it is unlikely that the

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<sup>125</sup> See BOVBERG & RAYMOND, *supra* note 26, at 3.

<sup>126</sup> See AMERICA'S HEALTH INSURANCE PLANS, *supra* note 50.

<sup>127</sup> See, e.g., Ronald T. Ackerman & Aaron E. Carroll, *Support for National Health Insurance Among U.S. Physicians: A National Survey*, 139 ANNALS OF INTERNAL MED. 795 *passim* (2003).

<sup>128</sup> See, e.g., MARK S. GORDEN & JOHN P. DUMOULIN, AM. C. OF PHYSICIANS—AM. SOC'Y OF INTERNAL MED., REIMBURSEMENT PROBLEMS UNDERMINE MEDICARE 7 (2002), available at [http://www.acponline.org/hpp/med\\_reim.pdf](http://www.acponline.org/hpp/med_reim.pdf) (discussing the negative impact decreased Medicare and Medicaid reimbursement rates have had on the uninsured).

<sup>129</sup> The loss of professional autonomy is of particular concern to physicians. KAISER FAMILY FOUND., *supra* note 52. It is arguable, however, that a great deal of professional autonomy was lost with the introduction of managed care systems and that management under a gov-



reimbursement process and billing administration would be worse than it is in the private multi-payer system, providers also fear being subjected to possibly more paperwork and administrative oversight.<sup>130</sup> Lastly, the fear continues that provider liability for medical injury will remain unbridled in the malpractice liability system and that malpractice insurance premiums will continue to rise at alarming rates, placing increased pressures on providers seeking economic security. Such fears of increased litigation are likely to become even more pronounced as access is expanded to patients who are traditionally more sick and likely to suffer worse health outcomes.<sup>131</sup>

*C. The Proposal: Combining a No-Fault Medical Malpractice Compensation Act with a National Single-Payer Health Insurance Plan*

To capitalize on the overlapping interests of patients and providers, it may be useful to combine the best policy proposals in the seemingly diverse areas of tort reform and increased health access in order to realize the full extent of benefits that reforms in either area may provide. Combining a no-fault medical malpractice compensation act with a national single-payer health insurance system could establish the catalytic incentive for patients and providers to align themselves and provide the necessary push to realize both universal health care and an effective system of medical malpractice liability in the United States.

By advocating for a no-fault Workers' Compensation model of medical malpractice liability reform<sup>132</sup> and utilizing the proposal for single-payer national health insurance submitted by the Physician's Working Group<sup>133</sup> to promote universal health care, both patients and providers may align themselves in a manner that will see to it that they both enjoy a high quality of life and access to the most responsive, innovative, and comprehensive system of health care in the world. While both patients and providers could view advocacy for this combined set of comprehensive health care reforms as a necessary trade-off to obtain their respective goals, the alignment of patient and provider interests actually seems to produce a mutually beneficial arrangement for all parties.

*D. How Patients Will Benefit from the Proposal*

In exchange for having limitations placed on the right to bring a civil negligence suit against medical providers in a court of law, patient-citizens would obtain an excellent, equitable, affordable, and continuous system of universal

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ernmental system would minimally resemble and ideally improve upon this model.

<sup>130</sup> The majority of physicians report that managed care arrangements have adversely increased the amount of paperwork and other administrative activities unrelated to patient care. *Id.*

<sup>131</sup> See, e.g., Jeffrey O'Connell, *Blending Reform of Tort Liability and Health Insurance: A Necessary Mix*, 79 CORNELL L. REV. 1303, 1303 (1994).

<sup>132</sup> See *supra* text and references accompanying notes 76-93.

<sup>133</sup> See *supra* text and references accompanying notes 105-23.

health care, truly the best that the world would have to offer. At the same time, however, patients would obtain a fair, equitable, and rapid system of recovery in the event that the health care received was less than adequate and led to medical injury. Now separated in different systems, the dual goals of malpractice litigation, compensation, and deterrence could be more adequately fulfilled.

A far greater number of injured patients would receive compensation for their preventable injuries, and they would do so at a greater speed, in a less adversarial manner, outside of the courtroom. In addition, no-fault liability would allow greater accountability amongst providers and institutions that may now more openly admit fault and address the circumstances in the system or practices that led to medical error. This creates more positive incentives for providers and institutions to prevent medical error and injury. While basking in improved community and individual health and admiring the more equitable and economically streamlined nature of American health care delivery, patients will enjoy the improved atmosphere of patient safety and the security of knowing that if they are injured, they will have an improved ability to recover for their injuries. At the same time, they will maintain their important role in holding institutions and providers accountable for subpar medical practice.

#### *E. How Providers Will Benefit from the Proposal*

In exchange for participating in and serving as leaders during a radical overhaul of the American health care delivery system, providers would enjoy drastically reduced malpractice liability and a reduction in the malpractice insurance premium rates associated with it. In addition to the great relief that limited interaction with judges, courts of law, and trial lawyers would bring, providers would be the beneficiaries of a new and less complicated practice of medicine. Providers would also be able to return to the collaborative and open academic environment where mistakes are discussed more openly and freely, and innovative mechanisms are set in place to improve the delivery of health care with fewer mistakes. Providers would deal with fewer forms, less administrative complication with reimbursement and billing, and more economic security in their medical practices. While salary reductions would be likely for the most successful free market medical specialists, most providers will readily trade a measure of income for a reduction in the level of paperwork and tort liability.<sup>134</sup> With consistent and uniform reimbursement rates and without fear of surprise insurance premium hikes, providers can focus on the practice of medicine without being pressured by the bottom line economically. Providers who work hard, culture their expertise, and maintain a reputation for excellent bedside manner would still attract the most patients and make the highest sala-

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<sup>134</sup> One Massachusetts study supports this notion, though a wider sampling of physicians' views definitely needs to be gauged. Danny McCormick et al., *Single-Payer National Health Insurance: Physician's Views*, 164 ARCH. OF INTERN. MED. 300, 301 (2004).

ries.<sup>135</sup> In addition, with a universal single-payer health care system, providers would maintain consistent patient populations and could feel proud to be part of a health care system that does not delist physicians from health plans for providing too much care or drop sick patients because they need high levels of care.<sup>136</sup> Lastly, providers can strive to be effective practitioners at the community and population level, as well as at the individual level, enjoying the funds and support to provide necessary preventative health services.

## VI. CONCLUSION: A RECOMMENDATION OF REVOLUTIONARY IMPLEMENTATION: MOVING FORWARD WITH A DUAL POLICY APPROACH

A great deal of common ground and shared interest between patients and providers emerges when considering a shared proposal combining a no-fault medical malpractice compensation act with a national single-payer health insurance system. Both patients and providers are dissatisfied with the current inequity, inefficiency, and inadequacy that characterizes the American health care delivery system. Forty-five million Americans suffer without health insurance in one of the richest countries in the world, while countless medical injuries repeat themselves due to the shroud of silence brought about by unrestrained medical malpractice liability. A broad plan coupling a universal system of national single-payer health insurance with a no-fault system of medical malpractice compensation may provide the necessary bridge to bring the champions of universal health care and tort reform together in the interests of establishing the best possible system of health care in the world. The most important steps in advocating for this dual reform approach are detailed below.<sup>137</sup>

### A. *Mobilizing the Patient and Provider Communities to the Same Side of the Health Care Reform Debate*

In order to achieve this partnership, patients will need to relinquish their shot at the ticket in the litigation lottery and get behind a grassroots movement to improve the public health. This will secure their personal, economic, and health security and ensure a fair and equitable civil justice system; there is no

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<sup>135</sup> In addition, the private market could remain for providers performing elective or uncovered medical procedures such as plastic surgery, botox or collagen injections, or corrective eye surgery.

<sup>136</sup> "Clinical decisions [could then] be driven by science and compassion, not the patient's insurance status or bureaucratic dictum." *Physicians' Working Group*, *supra* note 1, at 802.

<sup>137</sup> Many of these steps are modeled after the pragmatic policy implementation advice offered by John Tooker, *supra* note 101, the recommendations of the *Physicians' Working Group*, *supra* note 1, at 802, and by the description of grassroots reform movements by Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 75 (2003).

justice when one injured patient wins millions and countless others are left without health security or redress for their injuries. Providers will need to allow greater transparency in the institutional processes that analyze medical errors while taking a greater stand in securing sustainable, universal, and affordable access to high quality medical care. Providers must accept their humanity and fallibility and address the mistakes that they will undoubtedly make in practice. Both parties must exercise the courage necessary to implement this widespread and revolutionary change.

*B. Establishing the Necessary Links in the Academic, Public Health, Governmental, and Administrative Communities*

Providers and patient advocates must take leadership positions not only in the field of health care, but also in governmental and administrative institutions. Using a combination of professional and grassroots power and a bipartisan approach, patients and providers must sell this revolutionary change as the pragmatic approach. A policy incorporating a combined no-fault medical malpractice compensation act and a national single-payer health insurance system represents a compromise of interests and provides mutual benefits for all participants. Such compromise is the hallmark of pragmatism.

*C. Preparing an Early Counterattack Against the Insurance Lobbyists and the Trial Lawyers*

A strong patient-provider alliance can garner the necessary public support and draw attention away from the powerful insurance and trial lawyer interests. At the same time, attempts to build inroads into these highly organized political groups must be made. They are literally fighting for their lives and well-beings as they know it; it will be important to stress to them the important role they will play after the overhaul of the American health care delivery system. Many new governmental agents will be needed to process claims and serve as support personnel in national public health, home health, and preventative medicine efforts.<sup>138</sup> For attorneys, new areas of law will emerge in a statutory system of medical injury compensation, analogous to practice under the Workers' Compensation system. Thus, attorneys will continue to play a significant role in the functional administration of the program and in advocating for justice for those patients injured due to the willful and wanton and criminal conduct of the few, though significantly wayward, health providers.

*D. Arranging a Simple Yet Appropriate and Effective Marketing Strategy*

It is important to take note of the importance of marketing. The failure of

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<sup>138</sup> *Physicians' Working Group*, *supra* note 1, at 802.

the Clintons' health plan,<sup>139</sup> and a general lack of consumer confidence in many public programs, stems in part from the refusal to stimulate and maintain patient confidence and system morale. While this policy movement seeks to remove the majority of the marketing costs from the private administration of health care (especially in the pharmaceutical industry), the importance of marketing, even for public systems of health, should not be underestimated.<sup>140</sup> It is guaranteed that opponents of health reform will spend a great deal on such strategies.<sup>141</sup>

### *E. Obtaining Grassroots Support and Excellent Movement Leadership Efforts*

Strong leadership, a structured organization, and powerful communication are the hallmarks of social change. Although successful social movements always portray charismatic leaders, effective grassroots participation stimulates institutional "change from below."<sup>142</sup> Grassroots organization is how progressive policy change happens.<sup>143</sup> Widespread rallying and organizing will have to take place in the fields of medicine and public health, social academia, and throughout the remnants of the progressive American labor movement.

Patients and providers must demonstrate the initiative and courage to run for office and advocate for change. Politics must not be left only to the moneyed business interests. Incorporating a true dedication to distributive justice and striving to incorporate the diversity of economic classes and racial and ethnic groups disproportionately affected by the lack of access to health care services is vital. Not only are these groups most in need of institutional change, but they add power, wisdom, and insight to a diversified movement.

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<sup>139</sup> The lack of effective response to criticisms of the Clintons' plan (for instance comparing health care under their plan to service at the Department of Motor Vehicles) was one factor that played a role in the plan's demise. Tooker, *supra* note 101, at 107.

<sup>140</sup> *Id.*

<sup>141</sup> An estimated \$300 million dollars was spent on political opposition campaigns against the Clinton health plan. KANT PATEL & MARK E. RUSHEFSKY, HEALTH CARE POLITICS AND POLICY IN AMERICA 285 (1999). This includes expenditures of fourteen million dollars alone on the Health Insurance Association of America's Harry and Louise advertisements, which showed actors posing as a white, middle class couple discussing the limits placed on patient choice, medical rationing, and the huge bureaucracy that would develop under the Clinton plan. See Raymond L. Goldstein et al., *Harry and Louise and Health Care Reform: Romancing Public Opinion*, 26 J. HEALTH POL. POL'Y & L. 1325 *passim* (2001) (discussing the ads and the importance of public opinion in health care reform).

<sup>142</sup> Hoffman, *supra* note 136.

<sup>143</sup> For effective examples of grassroots leadership, advocacy and change, look to the examples of Mothers Against Drunk Driving ("MADD") or the American Association of Retired Persons ("AARP").

