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RESEARCH SUMMARY

FORTRESS AND FRONTIER IN AMERICAN HEALTH CARE

For decades America's health care debate has pitted Left against Right, federal against state, public against private. All sides, however, have shared a similar, inhibiting mindset—an excessive aversion to risk and deference to medical insiders—instead of stressing the ideal goal of better health care for more people at lower cost on a continuous basis.

A new study published by the Mercatus Center at George Mason University shows how this "Fortress"-like mentality has limited innovation in health care, constraining medical advances and raising costs. Shifting to a "Frontier" approach—one that tolerates risk and opens the field to other participants and disciplines—would bring to health care the kinds of creativity seen in many other fields, such as information technology.

The study illustrates these ideas in part through a set of unconventional characters, including a Hollywood actress who figured out how to stop Nazis from jamming American torpedo controls, a small-town doctor who pioneered stem-cell therapy, an injured carpenter and a puppet-maker who saw $40,000 prosthetic hands and produced a workable alternative that costs less than $50, a dying rodeo enthusiast who successfully battled the Food and Drug Administration (FDA), and—on the other side of the coin—a well-meaning educator who helped destroy African-American medical education.

Below is a brief summary. Please see "Fortress and Frontier in American Health Care" to read the study and learn more about author Robert F. Graboyes, a senior research fellow at the Mercatus Center.

Key Findings

- *From Fortress to Frontier*. To replicate the kinds of revolutionary innovation seen in other fields, health care policymakers need to discard the constraints of their Fortress mentality and adopt a Frontier attitude, which tolerates calculated risks and welcomes competition from diverse practitioners and disciplines.

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- *Address supply as well as demand.* America's health care debate has focused almost exclusively on demand: how many people have health coverage, and how providers are paid for which currently offered services. Successful reforms must ease limitations on *both* demand and supply, promoting innovations that can alter the nature of health care delivery and lower costs.

- *Step-by-step reform.* This does not require wholesale, politically unrealistic changes in the health care sector. Indeed, reformers should instead advance through many small, incremental, and simultaneous steps, seizing opportunities to break down barriers to reform, possibly achieving quick victories.

- *Breaking down barriers.* A vast range of such opportunities are at hand. The Fortress mentality has erected numerous obstacles to health care innovation. These obstacles are readily identifiable and can be overcome with targeted reforms that do not require a sweeping overhaul of the health care sector. The idea is to identify every potential limit on the supply of health care services, and then eliminate it. If the United States doesn't do this, other countries will, and America will lose its leadership position in medical innovation.

Summary

TWO WORLDVIEWS: FORTRESS AND FRONTIER

The Fortress is an institutional environment that avoids risk and protects established producers (insiders) against competition from newcomers (outsiders). The Frontier, in contrast, tolerates risk and allows outsiders to compete against established insiders.

- In recent decades, numerous industries have experienced remarkable and unexpected advances through a process of "disruptive innovation"—technological change driven by outsiders that yields previously unthinkable quality gains and massive price reductions. This is the Frontier approach.

- An example is the original Internet, called ARPANET, created by an agency within the Department of Defense and at first tightly constrained. Once opened to outsiders, it spawned millions of websites and applications and profoundly changed human society.

- In contrast, NASA was initially a great innovator. But after its heyday—the moon-landing era—the agency grew more and more risk averse (especially after the *Columbia* disaster). Now private innovators are competing to develop freight and passenger spacecraft, and markets reach above earth's atmosphere for the first time.

A BRIEF HISTORY OF THE FORTRESS IN HEALTH CARE

In health care, the foundation of the Fortress was laid in 1910, with a report by an educator commissioned by the American Medical Association to evaluate the nation's medical schools. The report

rapidly led to actions that made medical education more exclusive, standardized, centralized, and expensive.

- Following this report, however, half of the country's medical schools—and most African-American medical schools—were forced to close, constricting the supply of doctors and boosting their incomes. The report also led to an excessive homogenization of medical practice. Essentially, doctors came to believe that, for any set of symptoms (and certain patient data), there is only one correct, deterministic treatment pathway. This stifled the variation that innovation requires.

- Other structures developed, such as health coverage that was not so much insurance as prepaid medical care. In 1938 and again in 1962, driven by the tragic consequences of thalidomide and tainted sulfanimides, the FDA's control over pharmaceuticals grew, and state controls expanded.

ISLAND-HOPPING: A STRATEGY FOR REFORM

During World War II, American operations in the Pacific Theater pursued many islands simultaneously and somewhat autonomously. To shift health care from Fortress to Frontier, reformers should pursue a similar island-by-island strategy rather than a wholesale approach. This will avoid the same centralized overreach that characterizes both the Affordable Care Act and "Repeal and Replace" proposals.

- Successful reformers will identify legions of obstructions to supply and innovation and then eliminate them piecemeal, gaining incremental and possibly rapid victories.

- Reformers could move state by state to remove particular barriers (e.g., certificate-of-need laws), or policy by policy within the states or the federal government. Issue-specific coalitions could form around each problem and could simultaneously deal with federal, state, and private limits on the supply of health care. This decentralized approach would eliminate the need for one grand bargain—or for total control of Washington, DC, by one party.

LIMITS ON SUPPLY AND DEMAND

To achieve the kind of advances seen in other fields, health care innovators must be free to supply new goods and services and consumers must be free to purchase them.

- *FDA limits and delays*. The FDA's slow and burdensome approval process inhibits the development and dissemination of new products and stifles innovation by exerting authority over too many goods and services. This could be partly overcome by methods such as approving drugs in stages so patients with serious, time-critical illnesses could gain early access, and "right to try" legislation that would grant terminally ill patients early access to drugs still in the approval process.

- *Limits on providers*. Various restrictions, such as medical licensing and scope-of-practice limitations, constrict the supply of physicians and medical services. Among potential

remedies are allowing nurse practitioners and other professionals to practice independently (as they already do in numerous states) and authorizing pharmacists to write certain prescriptions independently of physicians. Reciprocity agreements or interstate licensing compacts could make it easier for doctors to move from state to state.

- *Malpractice law*. Tort law invites lawsuits and discourages innovation while also raising costs. The vagaries of tort law also discourage the production of vaccines and the development of new drugs and devices. Potential remedies include capping awards for noneconomic damages and shortening the statute of limitations on malpractice suits.

- *Taxes*. Federal tax law favors employer-based coverage, which artificially lowers the cost of group insurance and raises the cost of individual plans. This may be the single most anticompetitive factor in the health insurance market, limiting the variety of available health plans. Breaking down these barriers could start with establishing tax parity for health insurance premiums and individual contributions to health savings accounts.

- *Homogenized medical education.* Medical schools remain focused on individual knowledge rather than the interdisciplinary teams and networks that characterize much of modern medicine. This results in an overly specialized field. Potential remedies include interweaving classroom and clinical components of medical education and removing obstacles (e.g., licensing requirements) to alternative approaches, such as osteopathic medicine and for-profit, offshore medical schools.

- *Government controls and mandates.* Most public and private health plans model their benefit structures on Medicare, which overpays for some services and underpays for others, misallocating the supply of countless health care services. In addition, the Affordable Care Act requires small-group and individual health insurance plans to cover a Washington-defined set of essential health benefits. This will homogenize the design of health coverage and limit innovation in the provision of medical services and health insurance. Reform options include allowing Medicare to reimburse for imported or offshore medical services and for email and telephone consultations, removing the essential health benefits and eliminating state benefit mandates, and allowing health insurers to sell policies across state lines.