REFORMING HEALTH CARE TO MAKE IT AFFORDABLE, ACCOUNTABLE, AND UNIVERSAL

The time has come for a universal health care system that covers everyone, cuts costs, and provides better care. The number of uninsured Americans has risen to 45 million.[1] Insurance is how Americans access the health care system, with the uninsured living sicker and dying younger. Even families with insurance today face rapidly rising premiums and are at a greater risk of losing coverage. Individuals and small businesses often face high premiums and sometimes cannot get coverage at any price.

John Edwards has proposed a comprehensive reform plan to strengthen America's health care system and insure all Americans by 2012. His plan is based on the principle of shared responsibility: businesses, families, and governments must each do their part to reach universal health coverage. Insurance premiums will be affordable for all and a new public insurance plan will offer families an alternative to private insurers.

Today, Edwards released new details on how his plan will reduce total national health care spending by $130 billion—with family savings of $2,000 to $2,500—by taking on insurance and drug companies and improving the quality and efficiency of American health care. Edwards announced affordability initiatives in four key areas: the delivery of care, insurance markets, pharmaceutical drugs, and much-needed investments to reduce costs and improve quality.

THE NEED FOR AFFORDABLE AND ACCOUNTABLE HEALTH CARE

The U.S. health care system is needlessly expensive. The growth in health care costs has exceeded general inflation for every year since 1970.[2] Over the past five years, families with coverage through their employer have seen premiums grow by 87 percent while benefits have been cut.[3] About half of middle-class adults report having had "somewhat serious" or "very

[1] U.S. Census Bureau. "Press Release." (March 24. 2007), http://www.census.gov/Press-Release/www/releases/archives/health_care_insurance/009789.html.
[2] K. Wilson. "Snapshot: Health Care Costs 101." California Healthcare Foundation, (2006), http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=119856. Growth in the National Health Care Expenditures have exceeded the Consumer Price Index(CPI-U) every year since 1970.
[3] Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits Survey 2001." (2001), http://www.kff.org/insurance/20010906a-index.cfm; Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits Survey 2006." (2006), http://www.kff.org/insurance/7527/index.cfm.

serious" trouble paying medical bills in the past two years.[4] More than a quarter of middle- to low-income households with credit card debt have relied on credit for medical expenses.[5]

At the same time, the quality of care is inconsistent. The United States spends more per capita on health care than any other country. Yet 33 other countries have lower rates of infant mortality and 28 other countries have a longer life expectancy.[6] Despite the excellence of our doctors and nurses, patients receive optimal care little more than half of the time.[7] Health care administrative costs totaled $294 billion in 1999, or $1,059 per capita, and more than one-quarter of the U.S. health care labor force works in administration.[8] Better, more consistent performance could save 100,000 to 150,000 lives and $50 billion to $100 billion a year, according to the Commonwealth Fund Commission on a High Performance Health System.[9]

John Edwards believes that we can control the growth in costs while also improving quality. Relying on the principle of shared responsibility, Edwards will ask everyone in the health care system – hospitals, doctors, nurses, government, insurers, employers, and patients – to work together to make health care more effective and more efficient.

REFORMING THE DELIVERY OF CARE

A NEW ERA IN CHRONIC CARE

Our society faces a tremendous challenge from chronic diseases, which affect 90 million Americans. Chronic diseases are ongoing, generally incurable illnesses or conditions like diabetes, asthma, and cancer, and they routinely go untreated or undetected.[10] They can result in emergencies that cause patient suffering and unnecessary medical costs, and they account for seven in 10 deaths and 75 percent of our national health care spending – about $1.5 trillion a year.[11] The percentage is even higher for public programs like Medicare and Medicaid.[12]

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[4] C. Schoen, M.S., S. K. H. How, M.P.A., I. Weinbaum, M.Sc., J. E. Craig, Jr., M.P.A., and K. Davis, Ph.D. "Public Views of US Health Care System." The Commonwealth Fund, Vol 31 (August 17, 2006), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=394606.

[5] C. Zeldin, M. Rukavina. "Borrowing to Stay Healthy." Demos, The Access Project, (2007).

[6] U.E. Reinhardt, P.S. Hussey, G.F. Anderson. "US Health Care Spending in an International Context." *Health Affairs*, 23(3), (2004):10-25; R.J. Blendon, C. Schoen C, C.M.DesRoches, R. Osborn, K. Zapert, E. Raleigh. "Confronting Competing Demands to Improve Quality: A Five-Country Hospital Survey." *Health Affairs* 23(3), (2004):119-135; J. Furman. "Our Unhealthy Tax Code." Democracy Journal, (Summer 2006), Democracyjournal.org.

[7] Rand Corporation. "The First National Report Card on Quality of Health Care in America." Research Highlights (2004), www.pugetsoundhealthalliance.org/documents/RandBriefQUALITY2004.pdf.

[8] S. Woolhandler et al. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* Vol. 349 (August 21, 2003):768-75.

[9] The Commonwealth Fund Commission on a High Performance Health System. "Why Not the Best? Results from a National Scorecard on U.S. Health System Performance." The Commonwealth Fund Volume 34, (September 20, 2006), http://www.cmwf.org/publications/publications_show.htm?doc_id=401577.

[10] The Partnership to Fight Chronic Disease, "About the PFCD." *The Partnership to Fight Chronic Disease.* http://www.fightchronicdisease.com/about/index.cfm (2007).

[11] CDC. National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/nccdphp/index.htm; American Academy of Family Physicians. "AAFP Takes Lead in

Chronic diseases are the primary cause of death and disabilities and the number-one driver of health care costs, according to the Partnership to Fight Chronic Disease.[13]

Helping patients manage these illnesses and avoid unnecessary medication errors and hospitalizations can improve health and dramatically reduce health care costs. For example, appropriate primary care for diabetes complications would avoid nearly $2.5 billion in hospital costs.[14] The potential savings from proper preventive care and disease management for other chronic conditions, such as asthma and heart disease, are also substantial.

To help promote better chronic care, Edwards will take aggressive steps to:

- **Revolutionize the Treatment of Chronic Conditions:** To offer better chronic care to millions of Americans, Edwards will require insurers offering health plans through Health Care Markets and other public plans to manage chronically ill patients' health across all their product lines in order to avoid unnecessary problems and hospitalizations. The Health Care Markets will also promote disease management programs. For example, to better treat diabetes, plans will ensure that doctors regularly check up on their patients with diabetes and treat them proactively, cover nutritional counseling, and help them monitor and control their blood sugar levels.

- **Help Doctors Communicate with Their Patients and Each Other:** In 2002, 90 percent of Medicare spending (which accounts for one-fifth of the nation's total health care spending) was on people with three or more conditions.[15] Patients with multiple

Vermont's Blueprint for Better Chronic Disease Care

Vermont is shifting the focus of its health care system from reactive to proactive. The state understands that helping people manage chronic disease is paramount to containing costs in a universal health care system. Three-quarters of the money spent on health care in the state goes to caring for people with chronic conditions.

The state's Blueprint for Health aims to rehabilitate the existing health care system to better serve people with chronic disease by enhancing cooperation between providers, patients, the community, and insurers. It will also support health care providers to deliver world-class care through improved information technologies and training in chronic care issues.

State health officials plan to optimize treatment options for people with chronic disease by linking them to community resources, classes, and activities that improve quality of life. Vermont is setting an example for the nation.

Source: Vermont Department of Health Services. http://healthvermont.gov/blueprint.aspx#fact

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Launching National Chronic Disease Coalition." (May 25, 2007), http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20070525pfcdlaunch.html.

[12] G.F. Anderson, J. Horvath, "The Growing Burden of Chronic Disease in America." *Public Health Reports*, Vol. 119(3):263-270. 2004. G.F Anderson, "Are Physicians Appropriately Trained to Treat Chronic Conditions*?" Johns Hopkins Advanced Studies in Medicine*, Vol. 4(1): 47-48 (January, 2004). G.F. Anderson, "Medicare and Chronic Care", *New England Journal of Medicine* (2005).

[13] The Partnership to Fight Chronic Disease, www.fightchronicdisease.org.

[14] *Id.*

[15] K. E. Thorpe and D. H. Howard. "The Rise In Spending Among Medicare Beneficiaries: The Role Of Chronic Disease Prevalence And Changes In Treatment Intensity." *Health Affairs*, 25(5): w378-w388, (September/October 2006).

chronic illnesses are typically under the care of multiple physicians. These doctors may not know what tests their patients have already undergone or what medications they have been prescribed. Failure to communicate can be dangerous and cause unnecessary expense when tests or treatments are duplicated. Edwards will invest in programs that encourage doctors to communicate with each other, and in technologies that allow them to quickly and easily gain access to all relevant patient information.

Chronic Care:
Health Coaches Are Helping Protect Patients and Public Resources

In Los Angeles County, the public hospitals are the backbone of the health care safety net. All too often, these hospitals see the most difficult and costly uninsured cases.

Mauricio Hernandez visited the Los Angeles County-USC Medical Center emergency room so frequently for his chronic condition that treatment cost taxpayers $37,500 in just four months. Hernandez has been using the ER frequently for four years.

Working with COPE Health Solutions, the hospital has been able to develop an innovative program to promote the use of clinics that are able to provide better primary and chronic care services than the ER, and at a lower cost. Working with COPE's health coaches, Hernandez's costs were cut in half within seven months.

Source: Sam Quinones, "Saving the ER for real emergencies; Costly `frequent fliers' are being encouraged to visit clinics in L.A. test," Los Angeles Times. *January 22, 2007. COPE Health Solutions website, http://www.copehealthsolutions.com.*

- **Improve Chronic Care Through Medicare and All Health Plans:** The 23 percent of Medicare beneficiaries with five or more chronic conditions account for 68 percent of costs.[16] On average, care for each of these patients involves 13 different physicians and 50 prescriptions every year.[17] Yet Medicare makes almost no effort to coordinate care to ensure that doctors do not provide duplicative treatments and do not unknowingly undercut each other's efforts. While Medicare today focuses on covering hospital care for patients with emergencies, Edwards knows Medicare must effectively manage illnesses over the long term. For Medicare beneficiaries with chronic conditions, Edwards will use technology to help patients manage their conditions and will offer support to patients such as a case manager to help make sure patients comply with prescribed treatments and see the right doctor as needed. Incentives will be offered to private plans to do the same.

- **Create a Patient-Centered "Medical Home"**: Health care in the United States is highly fragmented and centered around episodic care. There is little integration of care --with little incentive for physicians to provide this coordination.[18] Typically, physician visits are short and focused on diagnostics, not the wellness and education that a chronic disease requires.[19] This situation puts everyone at risk, but for those with chronic conditions, if physicians working for the same patient work at cross purposes, certainly, it

[16] Gerard F. Anderson, Ph.D. "Medicare and Chronic Conditions." *New England Journal of Medicine*, (July 21, 2005), http://www.allhealth.org/BriefingMaterials/medicareandchronicconditions-135.pdf.
[17] *Id.*
[18] American College of Physicians, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care." Policy Monograph. (2006).
[19] Chen et al, "Best Practices in Coordinated Care, Mathematica Policy Research, Inc., March 2000.

means that some will receive redundant care.[20] Research compiled by the American College of Physicians shows that patients who receive greater levels of primary care are likely have fewer complications and receive better chronic care.[21]

To help transform the health care system, top physician groups have called for the creation of an "advanced medical home."[22] Under this innovative concept, a person will have a personal physician who directs and coordinates care. The "home" is a physician practice where all the care for one person is centered. As a model for the rest of the nation, the Edwards plan will call for Medicare to develop new payment systems to help make sure that beneficiaries have a medical home with a doctor who knows them and coordinates their care.

INVESTING IN PREVENTIVE CARE

Primary and preventive care greatly reduces future health care costs, as well as improving patients' health. But our health care system is focused on treating diseases, not preventing them. Less than 5 percent of the $1.4 trillion spent on U.S. health care in 2002 went toward preventive care.[23] As a result, many people do not receive the tests and immunizations that can prevent major illnesses and save money.

It is time to invest more in prevention. Diabetes alone cost Americans $132 billion in direct and indirect medical costs in 2002.[24] The U.S. Census Bureau projects the number of people diagnosed with diabetes could increase to 14.5 million by 2010 and to 17.4 million by 2020, increasing disease costs in 2002 dollars to an estimated $156 billion by 2010 and to $192 billion by 2020.[25] To promote preventive care, John Edwards will:

- **Require Insurance Companies to Cover Prevention:** Insurance companies have little incentive to cover the costs of preventive services because people frequently change jobs and insurers. One employer survey found that only 64 percent of insurers cover cholesterol screening and only 16 percent cover weight-loss counseling.[26] Edwards' new

[20] American College of Physicians, "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care," Policy Monograph , 2006.
[21] Remarks by Lynne M. Kirk, President of the American College of Physicians, Washington DC, (March 23, 2007), http://www.acponline.org/hpp/kirk07.pdf.
[22] American College of Physicians. "Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More Than 300,000 Physicians." Press Release, (March 5, 2007). The groups include: The American Academy of Family Physicians, The American Academy of Pediatric, the American College of Physicians, and the American Osteteopathic Association.
[23] E. Kelley, E. Moy, B. Kosiak, D. McNeill, C. Zhan, D. Stryer, et al. "Prevention Health Care Quality in America: Findings From the First National Healthcare Quality and Disparities Reports." (July, 2004), http://www.cdc.gov/pcd/issues/2004/jul/04_0031.htm; Lambrew, J. "A Wellness Trust to Prioritize Disease Prevention." *Hamilton Project Discussion Paper*, (April 2007), http://www.brookings.edu/views/papers/200704lambrew.htm
[24] American Diabetes Association. "The Economic Costs of Diabetes in the U.S. in 2002." *Diabetes Care*, 917-932 (2003), http://care.diabetesjournals.org/cgi/content/abstract/26/3/917.
[25] Id.
[26] M. Bondi et al. "Employer Coverage of Clinical preventive services in the United States." *American Journal of*

Health Care Markets will lead the effort to better align incentives in the health care system by requiring participating plans to comprehensively cover preventive care.

Prevention:
Healthy Employees, Healthy Economy

Freddie Mac, a leading home loan company, estimates it is saving $900,000 annually since opening an on-site clinic for preventive services and a gym with wellness services at its headquarters.

"We've really been emphasizing that we want people to take a more active role in their health and wellness," Julie Peterson, vice president of compensation and benefits at Freddie Mac, told the *Washington Post*.

Source: Amy Joyce, "A Prescription for Workers' Health," The Washington Post, *(October 9, 2006.)*

- **Strengthen the Primary Care Workforce:** A strong system of primary care is an essential element in Edwards' prevention strategy. The number of U.S. medical school graduates entering family practice residencies dropped by 50 percent from 1997 to 2005.[27] One reason is a payment system that doesn't properly reward primary care. Thirty minutes spent performing a diagnostic, surgical, or imaging procedure often pays three times more than a 30-minute visit with a patient with diabetes, heart failure, headaches, or depression.[28] Edwards will help transform how health care is delivered by changing reimbursement rules to emphasize primary care.

- **Encourage Individuals to Pursue Preventive Care:** Plans offered through Health Care Markets will encourage people to stay healthy by offering primary and preventive services, like screening for cancer and heart disease, at little or no cost. Health Care Markets will also offer lower premiums for those who get physicals and enroll in healthy living programs. Federal insurance programs will be redesigned to include appropriate incentives for families to use wellness programs. In addition, government programs will cover education efforts that help beneficiaries understand their health so they can help take better care of themselves and stay healthy without costly hospitalizations.

- **Invest in Public Health Promotion:** Health promotion depends on developing interventions through both our medical and public health systems.[29] Inexpensive public health interventions like immunizations and nutrition programs can have profound impacts. Unfortunately, funding for public health is insufficient and unevenly distributed across states.[30] In addition, in recent years preparation for threats like pandemic flu and bioterrorism has strained America's already overtaxed public health infrastructure.[31] To renew the focus on community health and wellness that is essential to controlling costs and expanding access to health care, Edwards will:

Health Promotion. Vol. 20(3): 214-2 (2006).
[27] T. Bodenheimer. "Primary Care – Will It Survive?" *New England Journal of Medicine* 355 (2006): 861-864.
[28] *Id.*
[29] J. M. Lambrew. "A Wellness Trust to Prioritize Disease Prevention." *Hamilton Project Discussion Paper*, (April 2007), http://www.brookings.edu/views/papers/200704lambrew.htm.
[30] J. Levi, C. Juliano. "Shortcoming America's health, 2006: A state-by-state look at how public health dollars are spent." Trust for America's Health, (2006).
[31] National Governors' Association. "Preparing for a Pandemic Influenza." (2006), http://www.nga.org/Files/pdf/0607PANDEMICPRIMER.PDF.

- Increase public health funding and improve coordination among local, state and national public health departments.
- Promote workplace interventions, such as wellness programs and on-site vaccinations.
- Support smoking cessation efforts.
- Encourage community innovative efforts, such as safe streets, walking and biking trails, and safe parks where children can play. Programs may be needed to ensure urban families have access to fruits and vegetables.[32]

- **Encourage the Best Practices of the Diabetes Prevention Program:** It is possible for diet and exercise to delay the onset of diabetes. In a study of more than 3,200 participants, lifestyle changes were effective in reducing diabetes.[33] Patients pursuing lifestyle changes reduced their risk of developing diabetes by 58 percent by being given intensive counseling on diet and exercise. John Edwards will promote the techniques of the Diabetes Prevention Program in private plans and require the use of its best principles in public programs.

SUPPORTING HEALTHY LIFESTYLES: TAKING ON OBESITY

Obesity is now an epidemic in the United States. According to the National Center for Health Statistics, 30 percent of U.S. adults are obese.[34] This impact is even greater on children; currently one-third of our children are obese or at risk of becoming obese.[35] The cost of obesity includes direct medical costs of $93 billion, or 9 percent of our national medical bill.[36] The urgent need to address obesity is clear. Former Surgeon-General Richard Carmona declared, "Because of increasing rates of obesity... we may see the first generation that will... have shorter life expectancy than their parents."[37]

The choices we make about food, work, play, and our environment have significant consequences on our lifestyle and health. Edwards will ask individuals, families, schools, employers, and officials from all levels of government to share responsibility in addressing this epidemic.

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[32] Efforts could include those promoted by Healthy Eating, Active Communities, http://www.healthyeatingactivecommunities.org/.

[33] National Institute of Diabetes & Digestive & Kidney Disease. "Diet and Exercise Delay Diabetes and Normalize Blood Glucose." National Diabetes Information Clearinghouse (NDIC), Diabetes Prevention Program Website, Press Release, (February 6, 2002), http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/index.htm.

[34] Centers for Disease Control. "Preventing Chronic Disease: Investing Wisely in Health." Centers for Disease Control, (July 2005), http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/pdf/obesity.pdf.

[35] A.A. Hedley, C. L. Ogden, C. L. Johnson, M. D. Carroll, L. R. Curtin, and K. M. Flegal. "Prevalence of Overweight and Obesity Among US Children, Adolescents, and Adults, 1999-2002" (2004); Institute of Medicine. "Progress in Preventing Childhood Obesity: How Do We Measure Up?" *Institute of Medicine Report Brief*, (September 2006), http://www.iom.edu/Object.File/Master/36/984/11722_reportbrief.pdf.

[36] Matthew Herper. "The Hidden Cost of Obesity." *Forbes.com*, (November 24, 2006), http://www.forbes.com/business/2006/07/19/obesity-fat-costs_cx_mh_0720obesity.html.

[37] Office of the Surgeon General. "The Growing Epidemic of Childhood Obesity." (March 4, 2004), http://www.surgeongeneral.gov/news/testimony/childobesity03022004.htm

- **Work with Schools to Remove Unhealthy Foods:** Although many states are beginning to look at issues of childhood obesity, a national effort is needed to evaluate food nutrition standards for food served and sold in today's schools. In a bipartisan effort, California passed new laws to ensure that students have access to healthier snacks, meals and beverages in public schools and provide a framework for addressing school nutrition. Edwards will form a national taskforce to address school nutrition guidelines that emphasize healthy food options for kids.

- **Support Physical and Healthy Lifestyle Education:** Edwards believes that we need to maintain and improve funding for physical education, healthy lifestyle programs, and after-school programs that promote physical activity.

- **Encourage Worksite Programs to Promote Better Health:** Employers are beginning to provide screening, wellness programs and gyms at work. Edwards will support tax incentives to support businesses that promote healthy living programs.

- **Encourage Healthy Lifestyles:** About half of all adults do not exercise enough to gain health benefits from the activity.[38] Promotion of timely check-ups, immunizations, healthy eating choices, and physical activity can increase healthy and active lifestyles. Edwards will establish a nationwide healthy lifestyles campaign to promote individuals' healthy choices.

BRINGING INFORMATION TECHNOLOGY TO HEALTH CARE

Less than a quarter of hospitals and a fifth of physicians' offices have health information technology systems.[39] Outdated methods of providing patient care are both dangerous and wasteful.[40] Edwards will support the implementation of health information technology, while ensuring that patients' privacy rights are protected, by:

[38] Centers for Disease Control and Prevention. "Physical Activity and Good Nutrition, Essential Elements to Prevent Chronic Diseases and Obesity." U.S. Department for Health and Human Services, (April 2007), http://www.cdc.gov/nccdphp/publications/aag/pdf/dnpa.pdf.

[39] R. Hillestad, J. Bigelow, A. Bower, F. Girosi, R. Meili, R. Scoville, and R. Taylor. "Can Electronic Medical Record Systems Transform Healthcare? An Assessment of Potential Health Benefits, Savings, and Costs." *Health Affairs*, Vol. 24, No. 5 (September 14, 2005).

[40] F. Girosi et al. "*Extrapolating Evidence of Health Information Techonology and Savings," RAND HEALTH,* (2006), www.rand.org/pubs/monographs/2005/RAND_MG410.pdf; America's Health Insurance Plans. "An Updated Survey of Health Care Claims and Processing Receipts, May 2006." (2006), http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

- **Adopting Electronic Medical Records:** Our country needs a paperless medical records system that eliminates administrative waste, prevents duplicative testing and services, and allows important health information to travel with people. The outdated "paper chase" causes tragic errors when doctors don't have access to patient information or misread handwritten charts. The new system must protect patient privacy. Electronic medical records could save up to $162 billion annually: $81 in increased prevention and chronic disease management, $77 billion in increased efficiency, and $4 billion in increased safety standards.[41] Edwards will require all those who want to participate in federal insurance programs to use interoperable information technology that protects privacy. The plan will offer financial aid to doctors and hospitals that need it.

Electronic Medical Records: Helping Patients and Reducing Costs

Under the Edwards plan, the success of the Dartmouth-Hitchcock Medical Center (DHMC) would be duplicated throughout the country. According to Hospital and Health Networks, DHMC is one of the most "wired" hospitals in the nation. Patients can go online to access pricing, their medical records, test results, and communicate with their doctors.

The doctors can obtain a patient's medical record form anywhere, easily communicate with other physicians and order prescriptions electronically to reduce possible errors. They can also work on mobile handheld devices using the hospital's secure wireless network. The approach is paying off. The hospital has found it saves the $5 it used to take to retrieve each paper record, in addition to improving patient care and safety.

Source: DHMC Press Release, "DHMC Named Among "Most-Wired" Hospitals," July 17, 2006. www.dhmc.org. Hospital and Health Networks Magazine, http://www.hhnmag.com.

- **Eliminating Administrative Waste:** It is estimated that 30 cents of every dollar spent on health care goes toward administration and system waste.[42] It may be the fastest growing part of health care costs.[43] Information technology and electronic medical records will make the system more efficient and help eliminate waste.

- **Helping Doctors Implement New Advances and Evaluate Quality:** In a 2003 physician survey, only one-quarter of physicians reported using electronic clinical decision support systems and only 6 percent used them routinely.[44] These systems both improve patient care and help track the quality of care, which can help us learn which treatments are the most effective. Edwards will:

    - Financially support new technologies, such as handheld devices, computer translators, and electronic medical records, to give doctors information at their fingertips.

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[41] R. Hillestad. "Health Care IT Adoption Could Save." *World Hospitals and Health Services*, Vol. 42, No. 2, (2006): 38-40; F. Girosi et al. "*Extrapolating Evidence of Health Information Techonology and Savings," RAND HEALTH*, (2006), www.rand.org/pubs/monographs/2005/RAND_MG410.pdfs.

[42] S. Woolhandler et al. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* Vol. 349 (August 21, 2003):768-75.

[43] *Id.*

[44] A. Audet et al. "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine* (Dec. 7, 2004).

- Require doctors receiving technology grants to report key quality measures. Only one-third of physicians have any data about the quality of care they provide.[45]

- **Support Building Infrastructure:** Edwards will provide the resources hospitals need to implement information systems that improve patient safety and hospital efficiency. Those changes include:

    - Adopting automated medication dispensers that can quickly and accurately fill prescriptions, freeing pharmacists to work more with patients and reducing the risk of prescription errors.[46]
    - Developing systems to promote patient-doctor communication, such as email and group consultations and support groups for individuals suffering from the same disorder.[47]
    - Saving money and lives through computerized physician order entry to eliminate lost paperwork and illegible writing.[48] Leaders in efforts at health reform, such as those in California and New Hampshire, have called for massive expansions in the use of e-prescribing.[49]
    - Developing computerized patient reminder systems to improve compliance with treatments, such as automatic phone calls to remind patients to take needed medication to help keep them healthy and out of the hospital.
    - Using wireless devices to allow hospital staff to communicate results directly to physicians, instead of wasting time trying to find a doctor with urgent information.[50]

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[45] A. Audet et al. "Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement." *Health Affairs* 24(3), (May/June 2005): 843–53.

[46] M. C. Nahata. "2006 Rho Chi Lecture: Unparalleled Opportunities for Improving Medication-Related Health Outcomes." *Journal of Pharmacy Education*, (August, 2006), http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1636973.

[47] S. G. Anand et al. "A Content Analysis of E-mail Communication Between Primary Care Providers and Parents." *Pediatrics,* (May 2005): 1283 - 1288.

[48] D. F. Doolan and D.W. Bates. "Computerized Physician Order Entry Systems in Hospitals: Mandates and Incentives." *Commonwealth Fund*, (July 1, 2002), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221505.

[49] Office of Governor Arnold Schwarzenegger. "Gov. Schwarzenegger Tackles California's Broken Health Care System, Proposes Comprehensive Plan to Help All Californians." Health Reform, (January 8, 2007), http://gov.ca.gov/index.php?/press-release/5057/.

[50] O. Aziz, S. Panesar et al. "Improving Hospital Communication: Do Mobile Phone Networks Hold the Key?" *International Journal of Surgery*, Vol 2, Issue 2, (August 2005): 125-126; J. Borzo. "Taking Control A New Physician's Assistant: Handheld Devices Are Becoming Critical Tools for Some Doctors and Nurses." *The Wall Street Journal* (October 10, 2005), http://www.patientkeeper.com/wallstreet_10_10_05.html.

ENCOURAGING BEST PRACTICES AND EVIDENCE-BASED MEDICINE

Quality Care Costs Less

A 37-year-old man was admitted to Pittsburgh hospital for an inflammation of the pancreas. His treatment was relatively simple, until after four days, he developed an infection, requiring him to undergo several surgeries and spend 87 days in the hospital. The patient's hospitalization cost $241,000. Without the infection, it would have been less than $6,000.

The Centers for Disease Control and Prevention estimates that hospital-acquired infections add $5 billion a year to the nation's health care bill.

Universal adoption of best practices like those developed by the Donald Berwick's Institute for Healthcare Improvement could save tens of thousands of lives and billions of dollars.

"Most patients are convinced that good care is more expensive than poor care, when the opposite is actually true," says David Calkins, MD, a senior fellow at IHI.

Source: Institute for Healthcare Improvement, http://www.ihi.org/ihi

Despite having some of the best doctors, nurses, and hospitals in the world, Americans receive the best possible care in their doctors' offices only about half of the time.[51] Nearly a third of patients seeking treatment experience medical mistakes, medication errors, or inaccurate or delayed lab results.[52] Treatments that have been proven to be superior and cost-effective are not evenly available across our health care system. Better, more consistent performance could save 100,000 to 150,000 lives and $50 billion to $100 billion a year.[53]

Improving quality is key to making John Edwards' goal of universal health care affordable and sustainable in the long run. To help doctors, hospitals, clinics and plans to improve the quality of health care, Edwards will:

- **Create a New Source of Objective Information on Medical Advances:** Only a small fraction — likely less than 0.1 percent — of each health care dollar is currently devoted to systematic research and assessment of the comparative effectiveness of various diagnostic and therapeutic options.[54] Edwards will establish a non-profit or public organization – possibly within the Institute of Medicine – to research the best methods of providing care, drawing upon data from Medicare, Health Care Markets and medical experts from across the nation. It will test devices and drugs head-to-head to see which work best and for whom. This new organization will quickly and widely disseminate its unbiased, scientific findings to physicians and patients.

- **Promote Evidence-Based Medicine:** Though we have some of the best health care technology in the world, effective new treatments can take years to be widely adopted. For example, until recently, many patients did not receive beta blockers after heart attacks even though they are cheap and highly effective. Similarly, doctors sometimes

[51] Rand Corporation. "The First National Report Card on Quality of Health Care in America." Research Highlights (2004), www.pugetsoundhealthalliance.org/documents/RandBriefQUALITY2004.pdf.
[52] A. Gauthier and M. Serber. "A Need to Transform the U.S. Health Care System: Improving Access, Quality, and Efficiency." The Commonwealth Fund, (October 2005). http://www.cmwf.org/publications/publications_show.htm?doc_id=302833
[53] *Id*.
[54] J.M. McGinnis. "Case for Evidence-Based Medicine." Background paper for the Institute of Medicine (April 23, 2007), http://www.iom.edu/CMS/28312/RT-EBM/33553.aspx.

prescribe name brand drugs despite the availability of equally effective, less expensive generic drugs. As new diagnostics, procedures and drugs are introduced, Edwards' new objective medical research organization will help doctors make sense of what works best. Government programs will offer incentives for the use of evidence-based care and treatments.

Iowa:
Working on a Transparent Future

In 2004, the Iowa Healthcare Collaborative was formed to promote sharing data and best practices to improve care. The Collaborative has been working hard to encourage hospital transparency and public reporting of health outcomes to measure progress and improve performance.
Source: www.ihconline.org

- **Improve the Health Care Delivery System:** The quality and quantity of care Americans receive often depends more on their zip code than their health needs.[55] If health care in all states performed at the same level as the five best performing states, the American health care system would have outcomes as good as any system in the world.[56] Spreading proven best practices from a few pockets of excellence to the entire U.S. health system is a critical step in improving outcomes. Edwards will develop partnerships among academic medical centers, Medicare, and other federal agencies to disseminate best practices and make sure every American has access to high quality care.

- **Reward High Quality Care:** Our health care system is predominantly fee-for-service: providers are paid for each treatment, regardless of its necessity or quality.[57] For example, a hospital that makes a medical error is often paid for the error and then paid again to fix it. Our system should pay for results, rewarding better, more efficient care. Under Edwards' plan, Medicare, Health Care Markets, and other government programs will lead the way by paying higher rates to plans and providers that provide the very best care and penalizing plans that fail to meet critical, quantifiable goals such as childhood immunization rates.

- **Prevent Medical Errors:** Up to 98,000 patients die each year due to medical errors, costing an estimated $17 billion to $29 billion.[58] A study of medical records looking at just 18 hospital error categories found that these errors alone caused $9 billion in additional costs and over 32,000 deaths in the United States annually.[59] Edwards will support public-private collaborations to reorganize patient care, improve internal communications, reduce errors through electronic prescribing, and establish basic quality benchmarks.

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[55] Institute of Medicine. "Learning What Works Best: The Nations Need for Evidence on Comparative Effectiveness in Health Care." http://www.iom.edu/ebm-effectiveness.
[56] K. Davis. "President's Message: The Best Health Care System in the World." Commonwealth Fund Annual Report, (2006), www.ahme.org/files/publications/news/2007winter.pdf.
[57] J. M. Lambrew. "A Wellness Trust to Prioritize Disease Prevention." *Hamilton Project Discussion Paper*, (April 2007), http://www.brookings.edu/views/papers/200704lambrew.htm
[58] Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington D.C.: The National Academies Press, 2000.
[59] C. Zhan, M. R. Miller. "Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization." *Journal of the American Medical Association* 290(14) (2003): 1868-74.

HEALTHY CHOICES THROUGH TRANSPARENCY

Finding reliable information to compare doctors and hospitals on price and performance is harder than finding it for a new car.[60] Every American should have easy access to this information. To empower patients, Edwards will:

- **Create a "Consumer Reports" for Health Care:** This new publication will be a universal and easy-to-use report card that helps Americans evaluate doctors' and hospitals' effectiveness. It will be readily available on the Internet and in hard copy. Informed patients will make better choices and drive health care providers to offer better services for lower costs. To create this national benchmark, Edwards will:

- Require health plans to disclose the percentage of premiums spent on patient care and administration.

- Require doctors and hospitals to provide information on several quality measures, including hospital infection rates, nurse-to-patient ratios, and the frequency of preventable medical errors.

The Wrong Direction: Health Savings Accounts

While there are many ways to contain costs, the Health Savings Accounts (HSAs) touted by President Bush and others are a dangerous approach. Under these plans, individuals set up tax-free accounts that are used to pay the deductible of high-deductible insurance plans. At a minimum, a family using an HSA would have a deductible of about $5,000.

HSAs assume that families can find low-cost, high quality care, but that is difficult today. Cost-sharing can lead people to reduce care they need as much as care they don't need. The individuals likely to use HSAs are those who are healthy, leaving our health insurance risk pool skewed towards the sick and driving up premiums for traditional insurance even higher. A recent survey found that those in HSAs are dissatisfied with the plan and confused about its operations.

HSAs are more about tax avoidance for the rich rather than improving health care. A major investment firm once called HSAs "the triple crown of tax planning." MIT Professor Jon Gruber has said that HSAs offer "the largest benefits to the highest-income taxpayers."

Sources: FamiliesUSA, "Six Reasons to be Wary of High-Deductible HAS Plans," December 2006. California Department of Insurance, "Dangerous Prescription," January 2006. Vanessa Fuhrmans, "Health Savings Plans Start to Falter," Wall Street Journal*, June 12, 2007.*

[60] Healthcare Commision. "The State of Health Care 2006." Commission for Healthcare Audit and Inspection (October 2006), www.wales.nhs.uk/documents/State_of_Healthcare_2006.pdf.

COMMON-SENSE MEDICAL MALPRACTICE REFORMS

While patients injured by their doctors' negligence deserve fair compensation, frivolous malpractice suits benefit no one. John Edwards will reduce the cost of practicing medicine with common-sense reforms that help doctors and patients.

- **Stop Frivolous Lawsuits:** To discourage frivolous suits, Edwards will require lawyers to have an expert testify that actual malpractice has occurred before bringing a suit. There will be mandatory sanctions for lawyers who file frivolous cases, and any lawyer who files three frivolous cases will be forbidden from bringing another suit for the next 10 years.

- **Create Competition Among Insurers:** To reduce malpractice insurance premiums for doctors, Edwards will revisit the insurance company exception to the nation's antitrust laws. Antitrust laws are designed to stop collusion and encourage lower prices through competition, yet insurers enjoy a broad exemption because of an obscure 1945 law and intense industry lobbying. This allows them to explicitly fix prices and divide up market share, routinely using trade groups to share loss calculations.

- **Reduce Malpractice:** Only 5 percent of doctors have paid malpractice claims more than once since 1990. This same 5 percent are responsible for over half of all claims paid.[61] Edwards will give resources and incentives to state medical boards for more responsible discipline. He will also create a knowledge bank that encourages doctors to report medical errors voluntarily, making other caregivers and hospitals aware of preventable mistakes.

TAKING ON EXCESSIVE INSURANCE PREMIUMS

Private insurance companies have been central to America's health care system since soon after the first one was created at Baylor Hospital in 1929.[62] Most Americans are covered by private plans, and private companies also help administer Medicare and Medicaid. However, all too often, insurance companies take advantage of the public. For example:

- Insurance company CEOs are often paid tens of millions of dollars a year even as businesses and families struggle to afford premiums and some patients are denied care they need.[63] Since 2000, premiums paid for group coverage through employers have shot up over 87 percent.[64]

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[61] S. Wolfe. "A Free Ride for Bad Doctors." *New York Times*, (March 4, 2003). The statistic is compiled by the National Practitioner Data Bank of the Department of Health and Human Services.
[62] J. Cohn. *Sick*. New York, NY: HarperCollins Publishers, 2007.
[63] AFL-CIO. "Corporate PayWatch DataBase." AFL-CIO, http://www.aflcio.org/corporatewatch/paywatch/ceou/database.cfm.
[64] Kaiser Family Foundation and Health Research and Educational Trust. "Employer Health Benefits Survey 2001." Kaiser Family Foundation, (2001), http://www.kff.org/insurance/20010906a-index.cfm; Kaiser Family Foundation

- Confusing forms and procedures and tangled dispute processes keep patients from claiming the benefits they deserve.[65] Some patients go so far as hiring special consultants to deal with the paperwork.[66]

- Insurers can use complex and unfair rules to deny coverage that has already been paid for by families.[67] Blue Cross of California was recently caught illegally dropping enrollees who needed expensive treatments.[68]

Insurance Profiteers

In 2006, it was reported that the CEO of one of the world's largest insurers, UnitedHealth Group, had been awarded $1.1 billion in stock options. Soon, a scandal erupted when it was discovered that accounting irregularities accounted had boosted the value of the options.

This is just one example of the unconscionable efforts by insurance companies to profiteer from the sick. The $1 billion at stake here would have be enough to provide about 750,000 uninsured children with health insurance for a year.

Source: Eric Dash and Milt Freudenheim, "Chief Executive at Health Insurer Is Forced Out In Options Inquiry," New York Times*, Oct. 16, 2006.*

- In 280 of 294 markets recently surveyed, one health insurer owns at least 30 percent of the market for health maintenance organizations (HMOs) and preferred provider organizations (PPOs), raising concerns about patient care with the Department of Justice.[69]

- Private insurers have high overhead costs, which average 12 percent, compared to 4 percent for Medicare.[70]

- Some insurers charge more for out-of-network doctors even when they work at in-network hospitals. Even patients who are trying to follow the rules can unwittingly receive out-of-network care and be stuck with thousands of dollars in charges. [71]

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and Health Research and Educational Trust. "Employer Health Benefits Survey 2006." Kaiser Family Foundation, (2006), http://www.kff.org/insurance/7527/index.cfm.

[65] C. Pryor et al. "The Illusion of Coverage: How Health Insurance Fails People When They Get Sick." The Access Project, (2007), http://www.accessproject.org/adobe/the_illusion_of_coverage.pdf.

[66] K. Hafner. "Treated for Illness, Then Lost in Labyrinth of Bills." *New York Times,* October 13, 2005.

[67] C. Pryor et al. "The Illusion of Coverage: How Health Insurance Fails People When They Get Sick." The Access Project, (2007), http://www.accessproject.org/adobe/the_illusion_of_coverage.pdf.

[68] California HealthLine. "Blue Cross Accused of Illegally Cancelling Policies." Summary of Girion, *Los Angeles Times*, March 28, 2006.

[69] American Medical Association. "2005 Update: Competition in Health Insurance, A Comprehensive Study of US Markets." (May 4, 2006), http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.

[70] S. Woolhandler et al. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* Vol. 349 (August 21, 2003):768-75.

[71] Carol Pryor et al. "The Illusion of Coverage: How Health Insurance Fails People When They Get Sick." The Access Project, (2007), http://www.accessproject.org/adobe/the_illusion_of_coverage.pdf.

REFORMING INSURANCE LAW

As a senator, John Edwards championed the Patients' Bill of Rights to fight health care abuses. Now more than ever, the insurance industry needs to be kept honest. To make sure that insurance companies work to help people, Edwards will:

- **Ensure that Premiums Help Patients:** Without new rules, insurance companies could continue to charge hardworking families excessive premiums, pocketing the savings from health care reform instead of delivering more to patients. Insurers call the amount of premiums spent helping families a "loss." Edwards will set national accounting standards requiring insurers to spend at least 85 percent of their premiums on patient care. The plan will force insurers to cut wasteful spending and pass savings from other Edwards proposals on to families and employers. Many states currently require certain loss ratios.

- **Empower Consumers:** Insurers must be upfront about what their policies cover. People should be able to learn about any loopholes or gaps in their coverage before it is too late. Edwards will establish strong national "truth-in-insuring" rules for explaining private insurance products and new standards for understandable health care bills.

- **Enforce Antitrust Laws:** High market concentration in the insurance market reduces consumer choices and raises prices. But insurance companies currently enjoy a broad exemption from antitrust laws. Edwards will direct the U.S. Department of Justice to conduct an immediate and comprehensive review of the health insurance market and make recommendations on how to ensure a competitive market.

- **Enacting an Updated Patients' Bill of Rights:** Now more than ever, Americans need a Patients' Bill of Rights for insurance companies and managed care. John Edwards will get the job done. In 2001, the original Bill of Rights called for many common-sense protections often available in managed care. An updated Bill of Rights is needed to solidify the protections discussed in 2001 and reflect today's needs under insurance companies. All consumers deserve to have bills that are understandable. All persons in managed care should be able to see a doctor of their choice who is responsible for medical decisions.

- **Avoid Inequitable Treatment among Doctors:** People who are sick in the hospital can't be expected to check the insurance of every doctor who sees them. Edwards will enact rules that put the burden on health plans to work with hospitals to make sure that patients are not penalized for reasonably but unknowingly using out-of-network doctors.

COMPETITION BETWEEN PUBLIC AND PRIVATE INSURERS

Health insurance plans operated by a government are often able to achieve lower administrative costs by saving on advertising, underwriting, and claims processing. Medicare's administrative costs are only about 4 percent of its budget, compared to an average of about 12 percent among

private insurers.[72] To test whether the government can deliver better care at a lower cost, Edwards will:

- **Create a Choice Among Public and Private Insurers:** Edwards will create Health Care Markets, non-profit purchasing pools that give individuals a choice of competing insurance plans, and offer a public insurance plan through them. The markets will be available to everyone who does not get comparable insurance from their jobs or a public program and to employers that choose to join rather than offer their own insurance plans.

- **New Competition for Private Insurers:** Edwards' uniquely American solution will reward the sector that offers the best care at the best price. Families and individuals will choose the plan that works best for them, and private insurers will face new competitive pressures to hold down their costs and deliver better coverage. Over time, the system may evolve toward a single-payer approach if individuals and businesses prefer the public plan.

- **Stop Overpayments to Medicare Private Plans:** Today, Medicare beneficiaries have access to "Medicare Advantage," a program offering health benefits through private insurance companies, instead of the traditional fee-for-service program.[73] However, Medicare overpays private managed care plans for the services delivered to beneficiaries.[74] Edwards will stop these overpayments by paying similar rates for traditional Medicare as private managed care. The funds saved would be used in part to make sure that low-income Medicare beneficiaries have access to the care they need and deserve.[75]

The Wrong Direction: Privatizing Medicare

America's insurance companies are working to privatize Medicare. Last year alone, America's Health Insurance Plans, the insurance trade group, spent more than $4 million to lobby Congress. Due in part to that effort, private health plans are part of Medicare, even though it costs US taxpayers 12% more to have a person cared for by a private plan than it does to provide care through traditional Medicare. John Edwards would stand up to the special interests and make sure Medicare dollars are used to care for America's seniors, and not to support insurance company executives. Medicare must not be privatized.

Source: John Godfrey , "Liberal groups campaign against Medicare insurance subsidy," MarketWatch, June 8, 2007.

[72] S. Woolhandler et al. "Costs of Health Care Administration in the United States and Canada." *New England Journal of Medicine* Vol. 349 (August 21, 2003): :768-75.
[73] Marsha Gold. "Medicare Advantage in 2006-2007: What Congress Intended?" *Health Affairs*, (May 15, 2007), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.4.w445.
[74] "Rep. Stark Says Private Medicare Advantage Fee-for-Service Plans at 'Top' of His List for Reductions in Medicare Reimbursements." *Medical News Today,* (May 23, 2007), http://www.medicalnewstoday.com/medicalnews.php?newsid=71937.
[75] E. Park and R. Greenstein. "Curbing Medicare Overpayments To Private Insurers Could Benefit Minorities And Help Expand Children's Health Coverage." Center on Budget and Policy Priorities, (revised May 14, 2007), http://www.cbpp.org/5-10-07health.htm.

MAKING PRESCRIPTION DRUGS MORE AFFORDABLE

Crippling prescription drug costs have become one of the biggest barriers to basic health care for our nation's families. Drug costs have risen three times faster than inflation since 1994.[76] The top drug companies spend more than twice as much on marketing and administration as they do on research and development.[77] Edwards will take the fight for affordable prescription drugs to the most abusive practices of the pharmaceutical industry – one of the largest and most powerful industries in America.

REFORMING THE FDA

- **Bring Generic Biologics to Market:** Biologics are very expensive, complex drugs that show enormous promise for treating conditions and diseases previously thought untreatable. Sales of biologics totaled $38 billion last year.[78] Their use is growing at twice the rate of regular drugs, but today they cost nearly 30 times more.[79] Edwards will give the FDA authority to approve safe and effective generic alternatives which will create more choices and lower costs. One study estimates that competition from biogenerics would result in more than $43 billion in savings between 2011 and 2020.[80]

- **Combat Counterfeiting and Illegal Drug Wholesaling:** Groups of small brokers (known as drug diverters) can gain control of billions of dollars worth of discounted medicines intended for nursing homes, hospices, and AIDS clinics. The safety and quality of these drugs is compromised by inadequate storage conditions, the passage of time, and fraudulent branding. Further work is needed by the FDA to ensure that electronic pedigrees accurately document the sales path of a drug.[81]

- **Independently Evaluate the Effectiveness of Pharmaceuticals:** The abundance of "me-too" drugs creates confusion for physicians and consumers, who do not have the resources to determine which drug is best for them. In addition, drug companies responsible for testing drugs prior to FDA approval have an inherent conflict of interest between their desire to profit from new treatments and the public's interest in ensuring safety and efficacy. Edwards will move toward requiring fully independent testing of

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[76] Kaiser Family Foundation. "Prescription Drug Trends Fact Sheet, May Update 2007". (May 2007)
[77] FamiliesUSA. "Profiting from Pain: Where Prescription Drugs Dollars Go." FamiliesUSA, (2002), www.familiesusa.org/assets/pdfs/PPreport89a5.pdf.
[78] E. Ehrlich and E. Wright. "Biogenerics: What They Are, Why They Are Important, And Their Value to Taxpayers and Consumers." Citizens Against Government Waste, (May 2, 2007), www.cagw.org.
[79] Generic Pharmaceutical Association. "Support the Life-Saving Medicine Act." (2007) http://www.gphaonline.org/AM/Template.cfm?Section=FDA_Science&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=1948
[80] E. Ehrlich and E. Wright. "Biogenerics: What They Are, Why They Are Important, And Their Value to Taxpayers and Consumers." Citizens Against Government Waste, (May 2, 2007), www.cagw.org.
[81] Kaiser Daily Health Reports. "Federal Court Grants Injunction To Delay Part of Counterfeit Prescription Drug Law." Kaiser Daily Health Reports, December 5, 2006. Summary of: Won Tesoriero, *Wall Street Journal*, December 5, 2006.

drugs, including the testing of drugs compared to existing alternatives. Information about comparative effectiveness would be required to be made available to the FDA and to the public.

Physicians, Payments, and Prescriptions

Drug companies continue to offer financial incentives to doctors that prescribe their drugs, which creates a clear conflict of interest.

For example, the *New York Times* reported that at a group of six cancer doctors received $2.7 million last year from a major biotech firm for prescribing $9 million worth of its drugs. Overall, in the competitive anemia market, it is estimated that two major industry leaders pay hundreds of millions of dollars to doctors every year in return for loyalty.

If a drug is the best thing for a patient, there should be no need to pay the doctor to prescribe it.

Source: Alex Berenson, Andrew Pollack. "Doctors reap millions from anemia drugs." New York Times. *May 9, 2007.*

ACCURATE INFORMATION FOR CONSUMERS

- **Prevent Misleading Drug Advertisements:** Pharmaceutical ads have become a multi-billion dollar industry, with America's seven largest drug manufacturers spending more than twice as much on marketing, advertising and administration than they do on research and development.[82] Edwards believes we must ensure that advertising does not unnecessarily drive up costs for consumers. Edwards' plan will require new restrictions on drug advertisements to ensure that they provide the whole truth to the public about drug side-effects and efficacy compared to placebos and cheaper alternatives. As a result, drug companies will no longer be able to advertise costly me-too drugs without disclosing the existence of less costly, equally effective alternatives. Edwards will also double FDA resources dedicated to enforcing direct-to-consumer advertisement rules, repeal federal rules that unnecessarily slow down action on misleading drug advertisements, grant FDA authority to levy civil fines after due process for violation of federal advertising rules, and require independent, head-to-head testing of drugs as a condition of FDA approval.

- **Stop Sales of Physician Prescribing Patterns and Gift Giving to Physicians by Drug Makers:** Drug makers spend more than $23 billion per year marketing to physicians, and physician profiling -- the use of detailed data from pharmacies and clinical practices to target and influence physician prescribing habits -- is a widespread pharmaceutical marketing practice.[83] Profiling and the practice of giving physicians gifts, such as reimbursement for continuing medical education or travel, food or lodging for medical meetings, can influence prescribing behavior and therefore how much Americans spend on prescriptions.[84] Edwards believes these practices create significant conflicts of interest that are unfair to patients, and he will institute rules against them.

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[82] Families USA. "No Bargain: Medicare Drug Plans Deliver High Prices." Families USA, (January 9, 2007), http://www.familiesusa.org/resources/publications/reports/no-bargain-medicare-drug.html.

[83] D. Grande. "Prescriber Profiling: Time to Call It Quits." *ANN INTERN MED* 146, (2007): 751-752. http://www.annals.org/cgi/content/full/146/10/751.

[84] R. Steinbrook. "For Sale: Physician's Prescribing Data." *N Engl J Med.* 354(26) (June 29, 2006): 2745-7. http://content.nejm.org/cgi/content/full/354/26/2745.

- **Hold Pharmacy Benefits Managers Accountable:** Pharmacy Benefits Managers (PBMs) are the HMOs of the prescription drug industry. While many have achieved positive results, some have engaged in abuses familiar from the history of HMOs.[85] Edwards will require PBMs to disclose backroom deals with the drug industry. When a PBM contracts with the federal government and is able to get a lower cost for a drug due to a rebate, he will require the PBM to offer consumers lower drug prices.

REFORMING PATENT LAWS

Patents are valuable because they encourage the invention of new prescription drugs. However, by allowing drug companies to charge monopoly prices, they deny drugs to many patients who could benefit from them. Moreover, under our current patent laws, it is often more profitable for companies to pursue "me too" drugs that make only incremental improvements over existing drugs rather than to pursue breakthrough drugs. In 2005, only a quarter of the drugs that won FDA approval were actually new molecular entities.[86]

- **Promote Competition from Generic Drugs:** The practice of patenting minor or even cosmetic changes to drugs whose patents are about to expire – known as "evergreening" – prevents competition from generic drugs. Drug companies also pay generic drug companies not to go market by abusing the 180-day generic exclusivity provision intended to speed drugs, further delaying access to generic drugs.[87] Innovation must be rewarded, but profiteering must stop. Edwards will eliminate these and other loopholes in federal law, giving Americans generic alternatives to high cost brand name drugs.

- **Pursue Prizes as Innovation Incentives:** Edwards will convene an expert panel to identify whether there are discoveries where prizes – not patent monopolies—would offer new incentives to researchers, guaranteed gains to companies, and lower costs to patients. Drug companies would know that if they generated a life-saving breakthrough, they would be guaranteed a significant payment in exchange for allowing competition in manufacturing and distribution. With prizes, the government will pay more up front, but it will save taxpayers in the end because companies will generate breakthrough drugs more quickly and provide it to patients at a lower cost. Key questions about the pricing of prizes, the appropriateness of prizes for different diseases, and the relationship to patent protections remain to be resolved, but prizes are a promising innovation that Edwards will pursue.[88]

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[85] Testimony of Ronald J. Tenpas, Associate Deputy Attorney General before House Committee on Government Oversight and Reform. "Allegations of Waste, Fraud and Abuse in Pharmaceutical Pricing: "Financial Impact on Federal Health Programs and the Federal Taxpayer." (February 9, 2007), http://oversight.house.gov/documents/20070209123557-61395.pdf

[86] S. Woolley. "Prizes Not Patents." *Forbes*, (April 18, 2006).

[87] M. Kaufman. "Drug Firms' Deals Allowing Exclusivity." *The Washington Post*, (April 25, 2006), http://www.washingtonpost.com/wp-dyn/content/article/2006/04/24/AR2006042401508.html.

[88] S. Woolley. "Prizes Not Patents." *Forbes*, (April 18, 2006); J. Stiglitz. "Prizes, Not Patents." Project Syndicate (2007), http://www.project-syndicate.org/commentary/stiglitz81; Consumer Project on Technology. "Medical Prize Innovation Fund." (2007), http://www.cptech.org/ip/health/prizefund/cptech-articles.html.

- **End "Policy Laundering" for Drug Patents:** As a senator, Edwards fought to close loopholes in the Hatch-Waxman bill that allowed brands to extend their monopolies at the expense of generic drugs. Today, pharmaceutical companies have taken this tactic offshore, using international trade agreements to get patent rules they could not get in domestic law. These include unlimited patent extensions and bans on generic research of a drug under patent.[89] Edwards' trade policies will close these loopholes as well, restoring the balance between innovation and access achieved at home.

Drug Costs: Medicare Part D versus Department of Veterans Affairs

Drug	Lowest Annual VA Price	Lowest Annual Medicare Part D Price
Fosamax (70 Mg)	$250.32	$763.56
Zocor (20 mg)	$127.44	$1,485.96
Nexium (40 mg)	$848.45	$1433.16

Source: Families USA, "No Bargain: Medicare Drug Plans Deliver High Prices." (January 9, 2007).

A FAIR DEAL FOR TAXPAYERS

- **Use America's Purchasing Power to Pay a Fair Price on Drugs:** A recent study found that Medicare Part D pays 58 percent more for the 20 most commonly prescribed drugs than the lowest price negotiated by the Department of Veterans Affairs. For some drugs, the difference is substantially higher.[90] If private companies can use their size to help get a fair price for drugs, Medicare should get the same advantages. Edwards will work with Congress to repeal the provision preventing Medicare from negotiating drug costs with drug makers for Medicare Part D and empower states to use Medicaid's leverage to purchase drugs at lower prices by allowing states to consolidate purchasing power. Edwards will also give Medicare beneficiaries a chance to obtain their prescription drugs through traditional Medicare, not a private company. This will force private companies to compete with the government to see who is more efficient. Edwards will also prohibit the strong-arm marketing tactics reportedly being use by private plans in Medicare.[91]

- **Allow Reimportation of Safe Prescription Drugs:** Reimportation of prescription drugs could save consumers $50 billion over 10 years.[92] Edwards has long supported the safe reimportation of drugs from Canada. He supports efforts in Iowa, Wisconsin, Illinois, Boston and elsewhere to contain drug costs through reimportation.

- **Protect Patients Against Dangerous Medicines:** When the arthritis drug Vioxx was withdrawn from worldwide markets in 2004 due to concerns it may cause adverse cardiac

[89] Generic Pharmaceuticals Association. "Free Trade Agreements." (2007), http://www.gphaonline.org/AM/Template.cfm?Section=International&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=1931

[90] Families USA. "No Bargain: Medicare Drug Plans Deliver High Prices." Families USA, (January 9, 2007), http://www.familiesusa.org/resources/publications/reports/no-bargain-medicare-drug.html.

[91] V. Colliver. "Medicare Plans Under Scrutiny: Complaints are Adding up from Seniors Upset with Private Health Care Packages." *San Francisco Chronicle*, January 26, 2007; Robert Pear. "Hard Sell Cited as Insurers Push Plans to Elderly." *New York Times*, May 7, 2007.

[92] C. Lee. "Senate Likely to Back Drug Reimportation," *Washington Post*, May 4, 2007, http://www.washingtonpost.com/wp-dyn/content/article/2007/05/03/AR2007050301161.html.

events, it raised serious concerns about drug safety in the United States. Edwards will help protect the public by:

- Restricting direct-to-consumer advertising for new drugs to ensure that consumers are not misled about the potential dangers of newly marketed drugs.

- Strengthen the FDA's ability to monitor new drugs after they reach the marketplace. He will also ensure that researchers evaluating medical devices and drugs are truly independent.

- **Make Sure That Drug Companies Play By the Rules:** Drug companies have a history of overcharging the government for prescriptions.[93] Edwards will immediately ask the Department of Justice to launch a comprehensive investigation into drug costs paid by the government. He will also create mandatory new fines and penalties for law-breaking companies and their executives.

ADDITIONAL INVESTMENTS TO IMPROVE COST AND QUALITY

ADDRESSING THE NURSING CRISIS

Nurses are the backbone of our health care system, but America has far too few nurses. By the year 2020, America will be short 340,000 registered nurses.[94] The result of the nursing shortage will be millions of Americans paying more and getting less from their health care.

- Hiring more nurses could save 6,700 lives in hospitals and 4 million days of hospital care and dramatically reduce adverse outcomes like hospital-acquired pneumonia and cardiac arrest.[95]
- Patients undergoing routine surgeries in American hospitals are at a 31 percent greater risk of dying if they are treated in a hospital with a severe nursing shortage.[96]

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[93] Kaiser Network Daily Health Policy Report. "Prescription Drug Makers Overcharge Federal Programs, Officials Say." Kaiser Network Daily Health Policy Report, (February 22, 2007), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=43103.

[94] D. I. Auerbach, P. I. Buerhaus and D. O. Staiger. "Better Late Than Never: Workforce Supply Implications Of Later Entry Into Nursing," *Health Affairs*, 26, no. 1 (2007), http://content.healthaffairs.org/cgi/content/abstract/26/1/178.

[95] J. Needleman, P. I. Buerhaus, M. Stewart, K. Zelevinsky, and S. Mattke. "Nurse Staffing In Hospitals: Is There A Business Case For Quality?" Health Affairs, 25, no. 1 (January/February 2006), http://www.massnurses.org/news/2006/01/BusinessCaseforStaffing-HealthAffairs.pdf.

[96] L. H. Aiken, S. P. Clarke, D. M. Sloane, J. Sochalski, J. Silber. "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction." *Journal of the American Medical Association* 288(16) (October 23/30, 2002): 1987-93.

Many hospitals have responded to the nursing shortage by increasing the number of patients that each nurse is responsible for and forcing nurses to work overtime.[97] One result has been high rates of nurses leaving the profession.[98] Edwards will address the national nursing crisis by investing the resources we need to add 100,000 new nurses over the next five years. The Edwards plan will bring back 50,000 nurses who have left the profession and bring 50,000 additional young people into nursing. He will:

- **Retain 50,000 Trained Nurses Leaving the Profession:** Nearly 500,000 registered nurses are not working as nurses today, deterred by low pay, long hours, unsafe workplaces, and a lack of respect. Edwards will improve workplace conditions for nurses through federal challenge grants to support "magnet hospitals" with better work environments, training nurses to take on new and more challenging rules, mentoring young nurses, and giving nurses a voice in hospital administration. He will also improve workplace safety through collaborative efforts led by the Department of Health and Human Services and eliminate mandatory overtime for nurses.

Innovative Nurse Training Programs Work Across The Country

Across the country, there is growing focus on developing training programs to increase the number of nurses. In Michigan, accelerated nursing programs help address a worsening nursing shortage by focusing on training displaced workers.

In California, SEIU has partnered with Los Angeles County to implement a jointly-administered training program, the Health Care Workforce Development Program. Created through an unprecedented federal, state, and county collaboration, the HCWDP offers career ladder programs that utilize innovative "grow your own" strategies to address critical staffing needs in nursing and other allied health professions.

Source: Kaiser Daily Health Report, "Nursing Programs Offered for Displaced Autoworkers in Michigan (Feb 16, 2007).

- **Recruit 50,000 Additional Nurses:** Despite the nursing shortage, there are too few seats at nursing schools. Nearly 150,000 qualified applicants were turned away from nursing schools in 2005.[99] Edwards will increase support for nursing schools and for partnerships between these schools and hospitals to increase the seats at nursing schools by 30 percent over five years. He will also help pay tuition for nursing students who agree to serve where they are needed most, such as rural hospitals and urban public hospitals.

[97] V. Lovell. "Solving the Nursing Shortage Through Higher Wages." Institute for Women's Policy Research (2006), http://www.iwpr.org/pdf/C363.pdf.
[98] G. Lafer, H. Moss, R. Kirtner, and V. Rees. "Solving the Nursing Shortage." AFSCME (2003), http://www.afscme.org/publications/2208.cfm.
[99] National League of Nurses. "Despite Encouraging Trends Suggested by the NLN's Comprehensive Survey of all Nursing Programs, Large Numbers of Qualified Applicants Continue to be turned down." (December 9, 2005), http://www.nln.org/newsreleases/nedsdec05.pdf. A study by the American Association of Colleges of Nursing also found a shortfall, as reported at Kaisernetwork.org. "Nursing Schools Reject Increased Number of Applicants Over Lack of Faculty Members." Healthcare News, (October 5, 2006), http://www.news-medical.net/?id=20403.

EXPANDING THE INFRASTRUCTURE FOR LONG-TERM CARE

The United States will experience an unprecedented growth in its elderly population. The number of Americans over the age of 65 is expected to increase by over 15 percent between 2000 and 2010; the number of Americans over the age of 85 will grow by 40 percent.[100]

The cost of long-term care for our seniors is large and growing. The average cost of a private room in a nursing home is more than $75,000 a year.[101] Moreover, the long-term care system is poorly equipped to provide seniors with the independence that -- enabled by advances in health care – they now demand. The problem of long-term care places enormous burdens on parents caring for their own parents as well as their children, creates the tragedy of families spending themselves into poverty to pay for nursing homes, and is worsened by a shockingly low quality of care in some nursing homes.

Edwards will reform our long-term care system. He will emphasize choice for families, the importance of allowing seniors to stay in their homes and communities whenever possible, and dignity and respect for workers and families.

- **Fund State Efforts to Expand Home Care and Reform the Long-Term Care System:** Edwards supports state home- and community-based care programs. He will help finance innovative state-level reforms such as tax credits for long-term care, asset and income protection programs that prevent families from having to spend down their incomes, and experiments with long-term care insurance.

- **Support Innovative Alternatives to Nursing Home Care:** Not all seniors need the intensive care of nursing homes and they should have choices that fit their needs. Edwards will help states and communities streamline development financing and replicate best practices in adult day health care and senior villages that offer much-needed and often less expensive alternatives for families and allow seniors to live at home with their loved ones.

- **Improve the Quality of Nursing Homes and Home and Community Based Care and Crack Down on Elder Abuse:** We need to help nursing homes do the right thing and stop those that abuse their patients. Edwards will establish national standards for nursing home care, increase national enforcement against abusive nursing home chains, expand inspections, and increase penalties for homes that fail to provide decent care. He will also offer excellence awards and grants to help homes improve their quality of care with measures like reducing patient-staff ratios, improving care provider training, and expanding recreational opportunities for residents.

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[100] U.S. Census Bureau. "Population." U.S. Department on Aging, Aging Stats (2004), http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2004_Documents/Population.pdf

[101] A semi-private room averages more than $66,000 per year, nationally. MetLife. "The MetLife Market Survey Nursing Home & Home Care" (September 2006), http://www.metlife.com/WPSAssets/18756958281159455975V1F2006NHHCMarketSurvey.pdf.

- **Offer Respite Care and Other Support to Families Who Care for Loved Ones:** Enormous burdens are placed on ordinary Americans who provide full-time care for loved ones with debilitating conditions like Alzheimer's disease. Edwards will support respite care services for nurses or other aides to give caregivers much-needed breaks. Part of his effort will establish an Internet clearinghouse to give families more information about available services.

- **Recruiting and Retaining Nursing Home and Home Care Workers:** When we ask nurses' aides and home health aides to deliver care with dignity, we need to treat those workers with dignity too. Edwards will provide resources to improve wages, training, and working conditions for aides. Critical to getting the best workers is making sure that they are paid a living wage. Edwards will cover agency-employed home health aides under the nation's minimum wage and overtime protections, effectively reversing the *Long Island Care at Home v. Coke* Supreme Court decision.

EXPANDING TELEMEDICINE

Small-town America should have access to the same high-quality health care that is available in big cities. Telemedicine is a modest investment that can make an enormous difference in the quality of health care for millions of Americans. Studies of patients battling diseases ranging from pediatric asthma to congestive heart failure have shown that telemedicine can improve health and reduce costs for patients and our health care system.[102] Edwards will:

- **Purchase More Telemedicine Systems for Rural Hospitals:** Edwards would help rural hospitals and health centers to purchase and implement telemedicine systems. Telemedicine hardware can be expensive, especially for the small rural providers who need it the most.

- **Help Hospitals Use Telemedicine:** Edwards will create at least 15 Regional Telemedicine Centers across the country to share best practices and facilitate the expansion of telemedicine to providers who are unfamiliar with it. Major existing telemedicine centers would be able to apply to serve as a Telemedicine Resource Center and would receive federal funding to help providers develop telemedicine systems.

Telemedicine: Accessing the Best Care Anywhere, Anytime

Paramedics rushed Paul Brigette to the emergency room at Jordan Hospital in Plymouth, Mass., at 2:40 a.m. The doctor on duty suspected a stroke and ordered a brain scan, but the small hospital didn't have a neurologist on call.

Massachusetts General Hospital's "telestroke" service enabled a doctor in Boston to diagnose and offer life-saving treatment for Brigette from 43 miles away.

Source: Liz Kowalczyk, "Going the distance in stroke treatment," Boston Globe. *(April, 3, 2006).*

[102] American Telemedicine Association. "New Research Shows Impact of Telemedicine on Delivery of Healthcare." American Telemedicine Association, (May 6, 2006), http://www.americantelemed.org/news/KeyResearchFindings2.pdf.

- **Cut Red Tape:** Too often, red tape limits patients' access to the full benefits of telemedicine. For example, licensing requirements may prevent a doctor in one state from treating a patient in another. Edwards believes we should make it easier for patients to get the care they need while still ensuring the highest standards. He will encourage states to work together to eliminate barriers to telemedicine and bridge programs in other states, expanding the number of doctors who would be able to serve patients in a given area.

PREPARE FOR A FLU EPIDEMIC AND OTHER OUTBREAKS

John Edwards believes we must improve our preparations for serious public health threats including the flu and a potential bioterrorist attack. He will:

- **Create One National Office Dedicated to Disease Control Coordination:** Multiple Cabinet departments and government offices are involved in coordinating the response to disease outbreaks.[103] The bureaucratic morass prevents adequate planning and fast response to crisis. Edwards has called for the creation of a single disease control office with authority to direct and coordinate the government's response to disease outbreaks. This new office based at the Department of Health and Human Services will closely coordinate with state and local officials as well.

- **A National System to Track Outbreaks and Vaccines:** Currently, it takes several days for the government to learn about two key factors in any disease outbreak: the progression of the disease through different communities and the availability of vaccine to respond to the disease. Edwards will establish a real-time, unified national tracking system for diseases and for vaccines. That system will be easily accessible to public health officials so they can learn how a disease is moving and where to get vaccines.

- **Faster Vaccine Production:** Today, it takes months to produce flu vaccine, making it impossible to respond to an immediate need. Edwards will direct the National Institutes of Health to research more efficient vaccine production methods. While we have avoided shortages in the past two years, system failures in 2002 and 2003 show that better infrastructure is needed to make the system work.

- **Increase Annual Reserves of Needed Flu Vaccines:** It is inexcusable that some of the most vulnerable in society go without vaccinations. Edwards will establish a national plan to produce sufficient vaccine and increase our annual reserves of needed vaccine.

- **Support a Well-Funded Public Health System:** Even after September 11th, fiscal challenges have forced many states to cut support for public hospitals and health departments. While states have started to devote money to public health, shortcomings

[103] Trust for America's Health. "Animal-Borne Epidemics Out of Control: Threatening the Nation's Health." Issue Brief, (August 2003), http://www.healthyamericans.org/reports/files/Animalreport.pdf.

remain. Edwards will offer additional federal support to states to build their public health systems, including strengthening lab capacity.