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After Walter Reed: How to Fix Military Medicine

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Congress must move quickly to fix the military health care system. It should forgo finger-pointing and political point scoring in the aftermath of the revelations of shortcomings in outpatient treatment at the Walter Reed Hospital in Washington and change policy. Two principles should guide congressional action. First, America's fighting men and women who become war casualties should get the very best medical care. Second, the problem needs to be solved immediately.

A New Policy. The military health care system appears to be overwhelmed by physical and mental illness and injury of our military personnel in combat zones. The resources to support dedicated physicians, nurses, medical technicians, and other staff appear to be stretched to their limits.

The capacity to treat the myriad injuries and illnesses related to combat, however, is not restricted to military facilities. That ability exists throughout the nation in countless settings, especially in outstanding academic health science centers. So one policy solution is obvious: Give wounded combat service personnel the ability to select the medical facility of their choice for the continuation of their care.

This policy would have two advantages. It would immediately reduce the pressure on the apparently overstressed military health care system. In addition, it would also introduce the welcome and salutary stimulus of competition for value and benefit into military medicine. When the institutions in which very capable military support staff deliver care become directly accountable to patients, conditions will improve, quality will go up, and service will get better—or the patients will go elsewhere.

Two Approaches. Congress can give combat servicemen and women new options in a variety of ways. Two approaches appear most promising:

First, the Department of Defense could give academic health centers and other medical facilities around the nation the option to compete for Department of Defense payments. The providers would offer services according to a benefit payment schedule or as a complete package to manage specific types of injuries and illnesses. With a benefit payment schedule system, the government would maintain a payment schedule for a variety of services. Providers of all types would know what they would be paid for care rendered.

Second, for "packaged" care, various medical professionals could come together to offer a specific array of services as a package tailor-made to each soldier's medical needs for an agreed-upon price. If the patient opts for that package, then the Department of Defense would pay for it. This medical case management approach would be especially valuable in areas such as limb amputation, burns, and stress

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disorders. Professor Regina Herzlinger of Harvard Business School, a nationally prominent health policy analyst, has outlined the enormous potential of provider organizations acting as "focused factories" to furnish this type of specialty care.

In the process of creating these options, some mixture of the two approaches could occur. For example, the package approach could apply to the most common treatments, while the benefit payment schedule would be available for unforeseen developments, such as a heart attack in a person being treated for a gunshot wound.

Long-Term Reform. The scandal at Walter Reed should also provoke congressional deliberations on a long-term fix to the financing and delivery of care—not only for active military personnel, but also for military families. Military personnel, dependents, retirees, and veterans should have the same flexibility as other federal employees and their dependents in selecting the kind of health coverage they want, from fee-for-service medicine and health savings accounts to care delivered through preferred provider organizations and health maintenance organizations. The system for financing the delivery of care to the military "family" should include options that reward the patient for utilizing medical services in a cost-effective way, just like other federal employees and retirees have today in the Federal Employee Health Benefit Plan (FEHBP). The result has been high levels of satisfaction among federal employees and retirees.

The recent events at Walter Reed, as well as stories of bureaucratic indifference in other parts of the country, should prompt a broader reconsideration of how to deliver care to men and women in and out of uniform. Members of Congress who routinely advocate a primary role for the government, with its heavy bureaucratization, in providing all health care should pause to reflect on this latest example of what they insist is a superior system of medical care.

The very same government that operates the Military and Veterans Administration health care systems also operates a huge experiment in consumer-driven health-care financing, the FEHBP. The FEHBP has very little bureaucracy and, compared to other government health programs, very few regulations. There is no bureaucratic micromanagement or price controls. It puts the same defined contribution into a beneficiary's choice of health plan no matter what choice the beneficiary makes. The beneficiary typically has multiple choices, with the annual opportunity to change plans if dissatisfied. This makes accountability of medical plans, and the doctors engaged in them, flow back to the patient, exactly as it should.

Conclusion. The military is served by many well-trained, skilled, and caring physicians, nurses, and other medical professionals. But more and more wounded service personnel are surviving horrific injuries. Ironically, that success further strains the system. While the overwhelming majority of military medical personnel are dedicated men and women, the problems with the military health care system are systemic. A large system that has a track record of inefficiency, high costs, and poor service is likely to be characterized by central control and a lack of choice for beneficiaries. Military medicine is simply another example of this phenomenon. Change is imperative.

Government tends to rely on centralized bureaucratic decision-making. Bureaucracy is often paternalistic, and in the case of health care delivery, the root assumption of the decision-makers is that patients are too stupid to make sound decisions for themselves. The result is now visible at Walter Reed. There is a better answer: Put military patients in the driver's seat.

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