mortgage deduction and the child tax credit left in their payroll taxes every two weeks. They would not need to wait for rebates after April 15. More take-home pay would show up in every paycheck. Working Americans who pay no income taxes would not be the only citizens who would be helped by the Total Tax Credit system. Many income tax payers would have a larger personal tax base against which to claim credits.

Wouldn't this blow a hole in Social Security revenues? Indeed, it would. But the hole could be filled partly by lifting the cap on the payroll tax and—if more revenue is necessary—by an infusion of general revenues, perhaps augmented by a value-added tax (VAT) or another federal consumption tax. Medicare already is paid for by a mixture of payroll taxes and general revenues, and there is no reason why this could not be as well.

Rare is the single reform that can accomplish several important objectives at once, by methods that are simple, straightforward and politically attractive. The cap-and-share Total Tax Credit system is such a reform. It would make the Social Security payroll tax more progressive, while retaining it rather than abolishing it; and it would allow millions of households that pay no income tax to enjoy tax breaks for home ownership, children and other purposes. Best of all, instead of requiring the establishment of new programs, the Total Tax Credit system would require only the modification of existing laws. That's a combination that's hard to beat. **D**

Reinvent Medicare

David Kendall

Runaway health care costs are breaking the back of workers, hurting U.S. companies' global competitiveness, and squeezing out government spending for other public needs. As the nation's largest health care program, Medicare both reflects and contributes to the problem of rising health care costs. In the face of a fiscal tsunami from the retirement of Baby Boomers, Medicare can no longer afford to sit passively on the sidelines, paying medical bills without question. It needs to lead the charge in the battle to improve the productivity and value of health care delivered in each community across the country. It needs to be reinvented so that instead of just paying medical bills, Medicare is directly accountable for improving the value of the health care delivered in each community.

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To do this, we need to change the incentives of the entire system and decentralize Medicare into regions. Instead of micromanaging provider payments, members of Congress should set broad policy goals and guidelines, and let newly empowered regional medical managers do the hard work of demanding more for our health care dollars.

It is ironic that, because so much of Medicare is managed from Washington, the result is a fragmented health care delivery system. Researchers at Dartmouth Medical School, led by Jack Wennberg, have discovered enormous waste and geographic variation in Medicare spending. In many places, doctors receive a fee for every procedure or test they do, and no single doctor takes responsibility for all the services patients need to stay healthy. Patients with chronic or complex health problems shuttle among different doctors, none of whom have a complete medical record or receive a payment to coordinate care. This drives up costs, but also drives down quality: Patients receive the recommended care only 55 percent of the time, according to a groundbreaking 2003 study by RAND.

Medicare needs to be reinvented so that instead of just paying medical bills, it is accountable for improving the value of health care delivered.

But Wennberg's team also found evidence pointing to a solution. While some areas of the country are fraught with high costs and low quality of care, others have low costs and high quality of care. For example, they posited that if all Medicare patients could receive their care in Rochester, Minnesota, home of the Mayo Clinic, then Medicare spending would drop by 15 percent, and the quality of care would rise. Doctors and hospitals in other areas of the country like Salt Lake City and Portland, Oregon, deliver Medicare benefits for nearly one-third less than the national average.

What makes these places work? In each, local medical leaders have made all the difference. Empowered to exert control over much of the care provision in their region, they have struggled to improve care for patients, which invariably leads to lower health care costs because people need less of it. And by creating a regional structure, they have overcome a tradition of independent medical practices that drive up costs elsewhere through duplication and a lack of coordination. For example, the Mayo Clinic, which acts as a *de facto* regional coordinator for health care in the Rochester, Minnesota region, pays its doctors a salary, and they work together as a team. They take the time to get the diagnosis correct first so they don't waste time and money treating the wrong disease. They coordinate their care so they don't duplicate tests,

or even worse, hurt patients with overtreatment. They use electronic health records to assess quality and check for needed care that patients or their doctors may have missed.

To replicate the success of low-cost, high-quality delivery systems throughout the country, Medicare should be broken into regions and overseen by regional medical directors. These directors would then join with local coalitions of consumers and employers to experiment with new ways of paying for care and assessing the quality. Following the lead of Mayo and other regional coordinators, they would develop new payment models that require doctors and hospitals to be accountable for the cost and quality of care.

There is a federal precedent for the regionalization of federal health care programs: From 1994 to 1998, the Veterans Administration (VA) cut hospitalization rates in half and improved care for all veterans, thanks to a Clinton Administration initiative that brought VA hospitals and clinics under regional management. According to research published in the *New England Journal of Medicine*, this sweeping change involved beefed-up access to primary care for veterans with chronic illnesses in order to avoid hospital care. The results showed that veterans were no worse off, and in several areas such as heart disease, they were actually better off. Now, it's time to do the same for Medicare. **D**

Deepen Gun Ownership

Jim Kessler

In recent election cycles, the greatest feat of liberal tight-rope walking has occurred not over abortion, but gun safety. Candidates talk about renewing the assault weapons ban, then mumble something about the rights of hunters. But there is a better way to take on this issue—one that would yield real reductions in violence without adversely impacting law-abiding gun owners.

There are 280 million firearms in private hands in America, and last year there were about 300,000 gun crimes. That means that at least 279,700,000 guns did nothing wrong. We also know that in 89 percent of crimes, the person using the gun was not the person who originally bought it. In 34 percent of crimes, the firearm was bought in one state and used in a crime in another. And in 32 percent of crimes, the firearm was less than three years old.

This indicates that the root of America's gun crime problem is not the number of guns in the hands of Americans, but an extensive web of gun trafficking

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