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INTRODUCTION

Last year Americans spent over two billion dollars a day on health care.<sup>1</sup> For 1992, the nation's annual health care bill will soar well beyond \$800 billion.<sup>2</sup>

Eight hundred billion dollars is more than enough to provide all the health and long-term care Americans need. Yet instead of mounting efforts to do just that, a growing number of politicians and health care experts seem bent on elevating health care rationing to a national policy. We have always rationed care by our wallets: those with the thickest wallets get the best care and many of those with empty wallets get little or none. For the future, many experts propose to distribute care "more intelligently" and "more fairly" by subjecting most of the population to the rationing now reserved for the poor.<sup>3</sup>

Rationing is a macabre dance of despair, choreographed by the failure of half-hearted efforts to rein in health care costs, by extravagant waste, by refusing to provide timely care to the poor, and by self-indulgent lifestyles. The willingness of Americans to spend more than \$800 billion on health this year should be an opportunity to release the poor from rationing and give all Americans all the care they need. Instead, the new melody rising to the top of the health policy charts is rationing care—this time, by rules orchestrated by many of the same politicians, bureaucrats and physicians who created the current crisis. Wanting to play God rather than serve Him, they now claim the wisdom to decide who should suffer how much pain how long; who should walk and who

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<sup>1</sup> See U.S. DEP'T OF COMMERCE, U.S. INDUSTRIAL OUTLOOK '92, at 43-1 (1992).

<sup>2</sup> See *id.*

<sup>3</sup> See, e.g., Daniel Callahan, *Rationing Medical Progress: The Way to Affordable Health Care*, 322 NEW ENG. J. MED. 1810 (1990); David C. Hadorn, *Setting Health Care Priorities in Oregon*, 265 JAMA 2218 (1991); John La Puma & Edward F. Lawlor, *Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers*, 263 JAMA 2917 (1990).

should limp; and who will live, who will die, and when.

Pressure to ration is fueled by ever-expanding expenditures for a health care system that still leaves many without access to care. Health care spending is rising two and one-half times faster than GNP.<sup>4</sup> Last year, health care spending was approximately 13% of GNP<sup>5</sup> compared to 11.6% in 1989.<sup>6</sup> This year health care will approach 14% of our GNP,<sup>7</sup> a figure that will rise to more than 16% by the end of the decade.<sup>8</sup>

These increases are not buying better health for Americans, or any care at all for many of them. Since the late 1970s, health care's share of GNP has jumped more than 50%<sup>9</sup> while the proportion of poor people with access to care has dwindled. At its peak, Medicaid covered 75% of the poor; today, less than half of the poor are covered.<sup>10</sup> The number of Americans without health insurance has climbed to some 35.7 million.<sup>11</sup>

But it is an unconscionable cop-out to resort to rationing by any means—the current scheme of wealth, or any new one based on age, a lottery of diseases or computer quantifications of pain—when we can have care for all our people with a little efficiency, prudence, and prevention. Studies indicate that at least 25% of the money we spend on health care is wasted.<sup>12</sup> Which means that more than \$200 billion will be wasted this year, including more than \$40 billion taxpayer dollars<sup>13</sup>—far more than the cost of the most expensive health reform plans currently under discussion. Instead of

<sup>4</sup> See Kathy Sawyer, *Health-Care Spending May Reach 14% of GNP*, WASH. POST, Dec. 30, 1991, at A6, A6.

<sup>5</sup> See *id.*

<sup>6</sup> See HHS NEWS (U.S. Dep't of Health & Human Servs., press release, Apr. 22, 1991).

<sup>7</sup> See Sawyer, *supra* note 4, at A6.

<sup>8</sup> See THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM 6 (Presidential White Paper, released Feb. 6, 1992).

<sup>9</sup> See Mark S. Freeland & Carol E. Schendler, *Health Spending in the 1980s: Integration of Clinical Practice Patterns with Management*, HEALTH CARE FINANCING REV., Spring 1984, at 1, 7.

<sup>10</sup> See Health Ins. Ass'n of Am., *Medicaid Trends and Children 1* (1990) (unpublished chartbook on file with author) (charting number of persons covered by Medicaid and number of poor persons over time).

<sup>11</sup> See *U.S. Uninsured Population Reaches 35.7 Mil. in 1990*, HEALTH NEWS DAILY, Jan. 23, 1992, at 3, 3.

<sup>12</sup> See Robert H. Brook, *Practice Guidelines and Practicing Medicine*, 262 JAMA 3027, 3028 (1989).

<sup>13</sup> See Katharine R. Levit et al., *National Health Care Spending, 1989*, HEALTH AFF., Spring 1991, at 117, 128 (providing data on government health expenditures and noting that 1989 expenditures were \$178.4 billion).

restricting care, we can expand access if we shrink overcapacity, streamline the health care bureaucracy, emphasize prevention, rationalize the medical malpractice system, and eliminate perverse incentives for doctors and hospitals.

### I. EXCESS CAPACITY

Hospitals operate at an average of two-thirds of their capacity, with many at less than 50%.<sup>14</sup> We have up to 400,000 excess hospital beds, at an unnecessary cost of up to \$12 billion.<sup>15</sup>

We also suffer from excess technology. There are 10,000 mammography machines in operation, four times the number actually needed.<sup>16</sup> To recover the cost of this excess capacity, owners charge an average of more than \$100 for each mammogram.<sup>17</sup> Without excess capacity, that cost would be \$50 or less.<sup>18</sup>

I am no Luddite. Those gangs that smashed machines in English textile mills over a century ago solved nothing in their day; their modern day descendants will solve nothing in our time. New technology with its miraculous diagnoses and cures is necessary. But does every community hospital need a multi-million dollar magnetic resonance imager or a two million dollar lithotripter? Even when new technologies are proven effective and appropriate, they do not always replace the old technologies they were designed to supersede. A study done for Medicare found that new techniques are not replacing established medical procedures.<sup>19</sup> Over a three year period the use of three new procedures—magnetic

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<sup>14</sup> See *Hospital Use Declined in the 1980's, Outpatient Visits Rose, AHA Says*, BNA DAILY REP. FOR EXECUTIVES, Nov. 19, 1991, at A-11, A-11.

<sup>15</sup> These figures are notoriously difficult to estimate. See George D. Pillari, *Those Pliable Occupancy Rates*, MODERN HEALTHCARE, May 29, 1991, at 6, 6. These approximations are loosely based on currently available estimates of the cost per excess bed and of the total number of beds currently available in the United States. See AMERICAN HOSP. ASS'N, HOSPITAL STATISTICS: 1989-90 EDITION 8 (1989) (estimating the number of hospital beds in the United States at well over one million); Governor's Task Force on Health Care Cost Containment, State of Md., Estimated Cost of Excess Capacity in Maryland 5 (Sept. 28, 1984) (unpublished paper, on file with the author) (estimating the cost of each excess hospital bed at approximately \$43,000 per year).

<sup>16</sup> See Burt Schorr, *News in Brief*, HEALTH POL'Y WEEK, Oct. 1, 1990, at 3, 3-4.

<sup>17</sup> See *id.* at 4.

<sup>18</sup> See *id.*

<sup>19</sup> See John M. Eisenberg et al., *Substituting Diagnostic Services*, 262 JAMA 1196, 1198 (1989).

resonance imaging, lithotripsy, and coronary angioplasty—grew steadily, but use of the procedures they were supposed to replace also continued to grow.<sup>20</sup>

## II. BUREAUCRACY

Red tape produces billions of dollars of red ink. Policy makers have created a Dante's Hell of regulation and manipulation. Insurance company medical auditors and government bureaucrats push and shove each other to look over the shoulder of every doctor whose bills they are asked to pay. Their monitoring of every patient, provider, procedure and prescription has forced doctors and nurses to become masters of the universe of regulatory manipulation rather than masters of the universe of medicine.

The cost to doctors and hospitals to document the eligibility of patients, obtain approval of hospital admissions and other procedures, and bill patients, climbed to \$62 billion in 1983.<sup>21</sup> With the proliferation of pre-admission screens and other review mechanisms in the second half of the 1980s, this year will top \$100 billion.

## III. PERVERSE INCENTIVES

The insurance coverage system also impacts health care access perversely. A doctor who believes that a patient requires a complete physical exam will often diagnose shortness of breath or some other common complaint to justify payment by the insurance company.<sup>22</sup> Medicare reimbursement leads doctors to commit patients to hospitals because the individual simply cannot afford to pay for outpatient care.

The absence of insurance coverage for poor patients whom doctors treat for free and the failure to reimburse fairly for Medicaid patients often lead physicians to manipulate charges so

<sup>20</sup> See *id.* at 1198-99.

<sup>21</sup> See Robert G. Evans et al., *Controlling Health Expenditures—The Canadian Reality*, 320 NEW ENG. J. MED. 571, 573 (1989).

<sup>22</sup> See Elisabeth Rosenthal, *Health Insurers Say Rising Fraud is Costing Them Tens of Billions*, N.Y. TIMES, July 5, 1990, at A1, B7 ("Many doctors acknowledge that minor deception is commonplace . . . to squeeze money out of tight-fisted insurers who . . . balk at paying for . . . preventative services. 'If a patient needs a mammogram to screen for cancer, you put "brest lump" on the form,' said Dr. Robert Lawrence . . .").

they are borne by those who have coverage.<sup>23</sup> Insurers say they must set traps for fraudulent and abusive claims, claims which cost them and the government \$60 billion in 1989—10% of health care spending that year.<sup>24</sup>

Blue Cross and Blue Shield of Illinois has installed a computer program designed to detect an estimated \$25 million a year in overcharges resulting from unbundling—the practice of breaking a major procedure into smaller components and billing separately for each.<sup>25</sup> Caterpillar, the heavy equipment manufacturer, developed its own software with Boston University to detect overcharges.<sup>26</sup> As a result, consulting companies offer seminars on how to maximize reimbursement for doctors.<sup>27</sup> A newsletter advises physicians on billing strategies.<sup>28</sup> Against this backdrop, the rising number of Americans without health insurance presses doctors and hospitals to scramble for ways to recoup some of the costs of uncompensated care.

#### IV. UNNECESSARY TESTS AND PROCEDURES

Millions of unnecessary procedures and tests are performed each year. Almost half the coronary bypasses, the majority of Caesarean sections, and a significant proportion of many other procedures, such as pacemaker implants and carotid endarterectomies, are unnecessary or of questionable value.<sup>29</sup> A former editor of the *Journal of the American Medical Association* is convinced that more than half of the forty million medical tests performed each day “do not really contribute to a patient’s diagnosis or therapy.”<sup>30</sup> Doctors order many procedures and tests to protect

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<sup>23</sup> See *id.* (describing a variety of ways physicians manipulate charges to increase and/or ensure insurance payments).

<sup>24</sup> See *id.*

<sup>25</sup> See Ron Winslow, *Illinois Blue Cross is Trying to Halt Code ‘Unbundling’*, WALL ST. J., Dec. 6, 1989, at A8, A8.

<sup>26</sup> See Rhonda L. Rundle, *How Doctors Boost Bills by Misrepresenting the Work They Do*, WALL ST. J., Dec. 6, 1989, at A1, A8.

<sup>27</sup> See *id.*

<sup>28</sup> See *id.*

<sup>29</sup> See Constance M. Winslow et al., *The Appropriateness of Performing Coronary Artery Bypass Surgery*, 260 JAMA 505, 505 (1988); LYNN SILVER & SIDNEY M. WOLFE, UNNECESSARY CESAREAN SECTIONS: HOW TO CURE A NATIONAL EPIDEMIC at v (1989); Allan M. Greenspan et al., *Incidence of Unwarranted Implantation of Permanent Cardiac Pacemakers in a Large Medical Population*, 318 NEW ENG. J. MED. 158, 160-61 (1988); Mark R. Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures*, 258 JAMA 2533, 2535-37 (1987).

<sup>30</sup> See Glenn Ruffenach, *Medical Tests Go Under the Microscope: Insurers Refuse to*

themselves from potential medical malpractice liability.<sup>31</sup> Some procedures are performed because doctors simply do not know the precise circumstances under which many procedures work.<sup>32</sup>

Last year, researchers reported that four tests to assess a patient's need for cataract surgery were unnecessarily performed 250,000 times on Medicare beneficiaries in 1987—at a cost of \$16 million.<sup>33</sup> Guidelines being drafted for the federal government will recommend prostatectomy for only 100,000 of the 400,000 men who receive the operation each year; the cost of the excess procedures is \$2 to \$3 billion.<sup>34</sup>

How doctors are paid is a factor contributing to rising health care costs. In a study of 30,000 California newborns with serious medical problems, researchers found that those born to uninsured parents received 28% less services than those with private insurance, despite the fact that the uninsured newborns had significantly greater medical problems.<sup>35</sup> Privately insured patients are also far more likely to receive sophisticated coronary care than uninsured or Medicaid patients.<sup>36</sup> The odds of a privately insured patient of receiving angiography are 80% higher than uninsured patients; the odds are 40% higher for coronary bypass operations and 28% higher for angioplasty.<sup>37</sup> We do not know with certainty how many of the procedures were appropriate or inappropriate because the study did not carefully examine outcomes. One thing is clear: medical procedures follow reimbursement the way an alley cat tracks the scent of fish in the garbage.

*Pay For Work Judged Needless*, WALL ST. J., Feb. 7, 1989. at B1, B1 (quoting Edward R. Pickney).

<sup>31</sup> See *id.*; Deborah W. Garnick et al., *Can Practice Guidelines Reduce the Number and Costs of Malpractice Claims?*, 266 JAMA 2856, 2856 (1991); Lynn Wagner, *Defensive Medicine: Is Legal Protection the Only Motive?*, MODERN HEALTHCARE, Sept. 16, 1990, at 41, 41.

<sup>32</sup> See John Wennberg, *Which Rate Is Right?*, 314 NEW ENG. J. MED. 310, 311 (1986) (noting considerable disagreement about when certain operations are appropriate); Ruffenach, *supra* note 30, at B1 (reporting the belief among insurers that "doctors must be better educated about when tests are appropriate").

<sup>33</sup> See *Cataract Preoperative Tests Show Little Value*, *Clinical Practice Guidelines*, HEALTH NEWS DAILY, May 1, 1991, at 1, 1.

<sup>34</sup> See Paul Cotton, *Case for Prostate Therapy Wanes Despite More Treatment Options*, 266 JAMA 459, 459 (1991).

<sup>35</sup> See Paula A. Braverman et al., *Differences in Hospital Resource Allocation Among Sick Newborns According to Insurance Coverage*, 266 JAMA 3300, 3303 (1991).

<sup>36</sup> See Mark B. Wanneker et al., *The Association of Payer With Utilization of Cardiac Procedures in Massachusetts*, 264 JAMA 1255, 1255 (1990).

<sup>37</sup> See *id.*

Doctors who operate their own equipment—such as X-ray and ultrasound—use diagnostic imaging four times more often than those who refer patients to radiologists.<sup>38</sup> These doctors also charge more for the same procedures.<sup>39</sup> The authors of this study examined 66,000 episodes of care provided by 6,400 physicians.<sup>40</sup> They concluded: “The potential to self-refer patients . . . must surely complicate physicians’ decisions and perhaps jeopardize their obligation to place their patients’ interests above their own.”<sup>41</sup>

## V. MEDICAL MALPRACTICE

The medical malpractice system does more than generate unnecessary tests and procedures and drive some of the best doctors from the profession.<sup>42</sup> It is also supremely inefficient. Of the roughly \$7 billion in annual premiums paid by doctors and hospitals, less than half wind up in the hands of injured patients.<sup>43</sup> Moreover, only a fraction of patients who actually suffer injuries ever receive any compensation.<sup>44</sup>

Last year, a team of researchers from the Harvard School of Public Health released the most comprehensive study of medical malpractice conducted in the United States.<sup>45</sup> They tracked the experience of over 30,000 patients in fifty-one hospitals in New York State.<sup>46</sup> They found that almost 4% of those hospitalized experienced injury because of their medical treatment and that one-fourth of the injuries were due to negligence.<sup>47</sup>

The Harvard researchers estimated that less than 2% of injuries due to negligence led to malpractice claims.<sup>48</sup> The vast majority

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<sup>38</sup> See Bruce J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 NEW ENG. J. MED. 1604, 1608 (1990).

<sup>39</sup> See *id.*

<sup>40</sup> See *id.* at 1604.

<sup>41</sup> See *id.* at 1608.

<sup>42</sup> See Lisa Belkin, *Many in Medicine Are Calling Rules a Professional Malaise*, N.Y. TIMES, Feb. 19, 1990, at A1, A13 (discussing the consequences of the current system, including the fact that “many doctors are leaving medicine entirely”).

<sup>43</sup> See American Medical Ass’n. Ctr. for Health Policy Research, *Trends in Medical Liability 11* (undated, unpublished manuscript, on file with the author).

<sup>44</sup> See *infra* notes 47-49 and accompanying text.

<sup>45</sup> See A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245 (1991) (disclosing the results of the study).

<sup>46</sup> See *id.* at 245.

<sup>47</sup> See *id.* at 246.

<sup>48</sup> See *id.* at 248.

of patients injured in hospitals never received any compensation.<sup>49</sup> Researchers found that the losses due to all injuries in 1984, whether or not attributable to negligence, were about equal to the amount of malpractice insurance New York doctors and hospitals paid that year—about \$1 billion.<sup>50</sup> These losses include lost wages and benefits, unreimbursed health care costs, and other expenses, but not compensation for pain and suffering.<sup>51</sup> So, for the price of compensating a small fraction of those injured in hospitals under our current tort system, a no-fault system could compensate everyone who suffered injury.

Whether or not we adopt a no-fault system, we can do much to revamp the medical malpractice system. Medical professionals should be held accountable for negligence and incompetence, but not for disappointment and grief over events only God can control. States should limit the amount of financial recovery to modest payment for pain and suffering (as California has), link legal damages to costs of health care and compensation for lost income and lingering disability, and sharply reduce contingent legal fees.

## VI. DEFENSIVE MEDICINE

Malpractice premiums and the cost of defensive medicine which these premiums fuel, together may account for some \$30 billion a year in health care spending.<sup>52</sup> Defensive medicine flourishes because there are no agreed-on standards for what constitutes appropriate care. Many tests and procedures are widely adopted before there is any definitive evidence of their effectiveness.<sup>53</sup> Once these tests and procedures are adopted, hospitals and

<sup>49</sup> See *id.* at 249.

<sup>50</sup> See *Faulting the Medical Malpractice System*, HARV. PUB. HEALTH REV., Fall 1990, at 20, 21.

<sup>51</sup> See *id.*

<sup>52</sup> Estimates for this figure vary widely. See, e.g., Garnick, *supra* note 31, at 2856 (estimating the cost of malpractice premiums at \$7 billion and the “[i]ndirect costs of the malpractice system [which] include the costs of defensive medicine, ie, the increased use of diagnostic procedures by physicians who are concerned about the possibility of being sued” at “many times the direct cost of the insurance”); Wagner, *supra* note 31, at 41 (noting the AMA’s estimate that defensive medicine cost \$20 billion in 1988 and that “[o]ther estimates run as high as 15% to 30% of the nation’s annual health care bill”).

<sup>53</sup> See John McKinlay, *From ‘Promising Report’ to ‘Standard Procedure’: Seven Stages in the Career of a Medical Innovation*, 59 MILBANK MEMORIAL FUND Q. 374, 374 (1981); William L. Roper, *Effectiveness in Health Care*, 319 NEW ENG. J. MED. 1197, 1197 (1988).

physicians cling to them, even in the face of studies by their colleagues which show a procedure to be useless or highly questionable.<sup>54</sup>

The Department of Health and Human Services Inspector General reports that 23% of upper gastrointestinal (GI) endoscopies performed on Medicare patients are not medically necessary.<sup>55</sup> A 1990 study found no value in routine hospital testing for diarrheal diseases;<sup>56</sup> eliminating such tests could save \$20 to \$30 million each year.<sup>57</sup> A recent report of the NIH-funded Coronary Artery Surgery Study showed no difference in survivorship of patients with clogged heart arteries and mild chest pain who were treated for ten years with drugs compared to those who underwent expensive bypass surgery.<sup>58</sup>

It is essential to find out what works in what circumstances. Appropriate standards can provide a safe harbor for physicians, protecting them from malpractice claims. This year, Maine is launching a five year experiment in which physicians who comply with certain guidelines and protocols will be able to use compliance as an affirmative defense in malpractice suits.<sup>59</sup> This voluntary program will initially be limited to anesthesiology, emergency medicine and obstetrics/gynecology, but if the results are as expected, it could be expanded to other specialties.<sup>60</sup>

## VII. MEDICAL MONOPOLY

The physician monopoly over the practice of medicine was once a legitimate and much needed reform that came out of the Flexner report.<sup>61</sup> Today it is also an economic monopoly that denies

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<sup>54</sup> See Jonathan Lomas et al., *Do Practice Guidelines Guide Practice?*, 321 NEW ENG. J. MED. 1306, 1310 (1989) (citing a study in which physicians failed to implement recommendations on the treatment of breech births).

<sup>55</sup> See *Outpatient Upper GI Endoscopies: More Than 20% Are Medically Unnecessary*, HEALTH NEWS DAILY, Nov. 13, 1990, at 1, 1.

<sup>56</sup> See Don L. Siegel et al., *Inappropriate Testing for Diarrheal Diseases in the Hospital*, 263 JAMA 979, 981 (1990).

<sup>57</sup> See *id.*

<sup>58</sup> See Edwin L. Alderman et al., *Ten Year Follow-up of Survival and Myocardial Infarction in the Randomized Coronary Artery Surgery Study*, 82 CIRCULATION 1629, 1633 (1990).

<sup>59</sup> See Diana L. Madden, *Maine Experiment Ties Guidelines to Liability*, MEDICAL BENEFITS, July 15, 1990, at 7, 7 (reprinted from THE INTERNIST, May 1990).

<sup>60</sup> See *id.*

<sup>61</sup> Cf. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 131 (1982) (describing the Flexner report as "a withering investigation of deceit by

Americans the efficiencies of modern technology. Nurses and physician assistants are prohibited from performing many common procedures and making many routine examinations and diagnoses—tasks which they could do far less expensively and just as competently as doctors.<sup>62</sup>

These health care professionals can perform a host of tasks which include examining, diagnosing and treating many wounds, sprains, and common respiratory ailments, but they are rarely used to their full capacities.<sup>63</sup> Nurse-midwives can handle normal deliveries as effectively as doctors at less cost.<sup>64</sup> Indeed, midwives are increasingly used in rural areas and where malpractice insurance premiums have made the practice of obstetrics prohibitively expensive.<sup>65</sup>

Physician assistants, most of whom complete a two-year training program and a national examination, are performing everything from the most basic primary care to high-tech surgical procedures.<sup>66</sup> In some operating rooms, physician assistants wield scalpels and sutures alongside of experienced surgeons.<sup>67</sup> In rural areas, physician assistants and nurse practitioners provide virtually all primary care, sometimes under the supervision of physicians who are up to fifty miles away.<sup>68</sup> Perhaps most importantly, physician assistants are paid a fixed salary ranging between \$35,000 and \$60,000 a year, less than half the average annual income of doctors.<sup>69</sup>

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commercial interests that contributed to the consolidation of professional authority"); *id.* at 224-25 (discussing early attempts by the profession to control the problem of "lack of any standards or regulation in the practice of . . . specialties").

<sup>62</sup> See Sandy Lutz, *Practitioners are Filling in for Scarce Physicians*, MODERN HEALTHCARE, May 13, 1991, at 24, 25.

<sup>63</sup> See Elisabeth Rosenthal, *That Person in the White Smock Is Not a Doctor*, N.Y. TIMES, Jan. 10, 1991, at B11, B11.

<sup>64</sup> See Lutz, *supra* note 62, at 30.

<sup>65</sup> See *id.*

<sup>66</sup> See Pamela J. Podger, *Physician Assistants Lend a Thrifty Hand*, WALL ST. J., July 18, 1990, at B1, B1.

<sup>67</sup> See Rosenthal, *supra* note 63, at B11.

<sup>68</sup> See *id.*

<sup>69</sup> See *id.*

## VIII. PREVENTION

Two-thirds of all disease and premature death is preventable,<sup>70</sup> but less than three-tenths of one percent of our national health bill pays for health promotion and disease prevention.<sup>71</sup> American health priorities should be obvious: quit smoking, stick to proper diet, control drinking, stay away from drugs, exercise, learn to handle stress, and take preventive measures such as regular checkups.

Americans dislike being preached to, but they can be persuaded. Prevention messages, presented creatively and persistently, can change behavior and reduce our need for high cost medical interventions. The dramatic reduction in national smoking rates from well over 40% in 1964 to less than 30% today<sup>72</sup> attests to that. There are plenty of other opportunities for prevention savings. A 1990 study reported that among women, 40% of heart attacks and angina are the result of excessive body weight.<sup>73</sup> For the one-fourth of American women aged thirty-five to sixty-four years who are 30% or more overweight, 70% of heart disease is due to excess weight.<sup>74</sup> The cost of teen pregnancies, another preventable health risk, is \$22 billion a year in food stamps, welfare, and Medicaid benefits.<sup>75</sup>

Prevention does work. Johnson & Johnson's employee health promotion program produced a net financial benefit of \$316 by the fifth year of operation.<sup>76</sup> The risk of heart attack among women

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<sup>70</sup> See Richard D. Lamm, *Brave New World of Health Care*, 52 ANNALS OF THORACIC SURGERY 369, 373 (1991); Henry J. Kaiser Family Found. Health Promotion Program, Kaiser Family Foundation Announces New Grant Program in Health Promotion (Apr. 2, 1986) (press release, on file with author).

<sup>71</sup> See *Foundation Seeks to Prevent Needless Deaths*, UPI, Apr. 2, 1986, available in LEXIS, Nexis Library, UPI File (quoting Kaiser Family Foundation President Alvin Tarlov); Henry J. Kaiser Family Found. Health Promotion Program, 1.3 Million Deaths a Year Are Preventable Kaiser Family Foundation Reports (Apr. 2, 1986) (press release, on file with author).

<sup>72</sup> See Michael Specter, *Less-Educated, Poor More Likely to Smoke*, WASH. POST, Jan. 6, 1989, at A3.

<sup>73</sup> See JoAnn E. Manson et al., *A Prospective Study of Obesity and Risk of Coronary Heart Disease in Women*, 322 NEW ENG. J. MED. 882, 888 (1990).

<sup>74</sup> See *id.* at 885-86.

<sup>75</sup> See Spencer Rich, *Teen Pregnancies' Costs to Taxpayers Tallied*, WASH. POST, Sept. 24, 1990, at A10, A10.

<sup>76</sup> See OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, U.S. DEP'T OF HEALTH & HUMAN SERVS., DISEASE PREVENTION/HEALTH PROMOTION: THE FACTS 328 (1988). The company also predicted a \$677 per employee benefit by year nine. See *id.*

who quit smoking declines rapidly; within three to four years of quitting, it becomes approximately the same as that for women who have never smoked.<sup>77</sup> In 1990, a new study showed strong scientific evidence that life-style changes alone can begin to reverse even severe coronary artery disease after only one year, without the use of cholesterol-lowering drugs.<sup>78</sup>

## IX. ADDICTION

Addiction is public health enemy number one. The economic cost of addiction easily exceeds \$300 billion in health care, disability payments, lost productivity, accidents, and crime; the true cost in health care alone is probably \$100 billion.<sup>79</sup> Yet the federal government research effort amounts to only \$500 million out of a budget of over \$10 billion for the war on drugs.<sup>80</sup>

Consider the number of people involved: 54 million Americans are hooked on cigarettes, 102 million are current users of alcohol, and at least 48,000 are addicted to heroin.<sup>81</sup> At least 10 million abuse barbiturates and other sedative-hypnotic drugs; 66 million have used marijuana, and 10 million report recent usage; 23 million have tried cocaine, and 2.4 million are considered "hard-core addicts"; more than half a million use hallucinogens like LSD and PCP; at least half a million use crack.<sup>82</sup> No one knows how many millions of them are dependent, in one way or another, on these drugs.

We need a National Institute on Addiction in the National Institutes of Health. Such an institution would combine the research work of the National Institutes of Drug Abuse and Alcohol

<sup>77</sup> See Lynn Rosenberg et al., *Decline in the Risk of Myocardial Infarction Among Women Who Stop Smoking*, 322 NEW ENG. J. MED. 213, 215 (1990).

<sup>78</sup> See Dean Ornish et al., *Can Lifestyle Changes Reverse Coronary Heart Disease?*, 336 THE LANCET 129, 132 (1990).

<sup>79</sup> See H.J. HARWOOD ET AL., ECONOMIC COSTS TO SOCIETY OF ALCOHOL AND DRUG ABUSE AND MENTAL ILLNESS: 1980 (1984); see also Dorothy P. Rice et al., *The Economic Costs of the Health Effects of Smoking, 1984*, 64 MILBANK Q. 489, 491-506 (1986) (discussing various ways to evaluate costs).

<sup>80</sup> See OFFICE OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT: FISCAL YEAR 1992, H. DOC. NO. 3, 102d Cong., 1st Sess. pt. 2, at 123 (1991)

<sup>81</sup> See Press Office of the Nat'l Inst. of Drug Abuse, Department of Health & Human Servs., Overview of the 1990 National Household Survey on Drug Abuse 21 (press release, Dec. 1990).

<sup>82</sup> See *id.* See also SENATE COMMITTEE ON THE JUDICIARY, DRUG USE IN AMERICA: IS THE EPIDEMIC REALLY OVER? 23 (1990).

Abuse and Alcoholism, and conduct research on all substance abuse and multiple addiction, including cigarette smoking. It has been difficult to get our best minds persistently concentrated on preventing and treating addiction, in part, because the problem is so infernally complex and, in part, because the level of commitment of research funds has been erratic. Creating one national institute for all addiction would help generate a steady stream of money for research, make clear our national commitment, and attract more of our best minds to the effort.

### CONCLUSION

Unfortunately for our health care system, purchasers of care are so frustrated by relentlessly rising costs that they spend more time figuring how to dump costs on one another than figuring how to provide quality medicine to all at a reasonable cost. The federal government seeks to dump more Medicaid costs on the states, the states on the big cities, and government at all levels on the private sector. Much of the business community is now engaged in an attempt to dump costs on the government.

The federal government's view of health care policy is driven by the politics of the budget deficit. The level of quality and extent of access are circumscribed by the political games people in Washington play. At the regulatory level, Medicare increasingly tailors reimbursement for procedures according to its budget goals. In Congress, the basic health care policy is made in the legislative structure of the budget reconciliation process, not in the context of what makes good sense as a matter of health care policy.

Instead of scheming how to get someone else to pay the health care bill or constructing bureaucratic mazes to ration care, we should be focusing on how to eliminate the senseless waste in our health care system and reallocate those resources to benefit all our citizens. If we converted to productive use only a portion of the \$200 billion we will waste this year, we could afford even the ambitious proposals of the Pepper Commission.<sup>83</sup> The cost of the Commission's proposal to provide health insurance to the uninsured and long-term care to the elderly amounts to less than half of the 25% of our health care bill that goes for unnecessary health

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<sup>83</sup> See THE PEPPER COMMISSION, U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, A CALL FOR ACTION: FINAL REPORT 120-21 (1990) (summarizing the nine recommendations of the Commission).

services.<sup>84</sup>

Rationing is not a solution to the problems we face, it is a capitulation of despair. Yet, unless we act promptly to manage our health care resources prudently, we may well face a grim future of triage. Many workers and retirees will lose their employer-based coverage or have it drastically reduced; Medicare beneficiaries will wait in longer and longer lines for lower and lower quality care; millions of citizens will continue to be denied access to basic health care, millions more will fall victim to addiction; and only the wealthiest Americans will be able to afford long-term care.

This future is not a fantasy and it is not far away. Fortunately, the money needed to avoid it is already allocated to health care. We need only spend that money wisely. If we do, we can provide higher quality health care for all our citizens at the same price we are now paying to provide a declining quality of care for only some.

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<sup>84</sup> See *id.* at 137 (estimating the cost of implementing the proposal in 1990 at \$69.6 billion).