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ESSAY

MISALLOCATING HEALTH CARE AND SOCIETAL RESOURCES

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The future will be controlled by those nations which most intelligently allocate their resources. Our nation's capital is the stored flexibility needed by our children to meet the future. How we allocate our nation's limited resources and capital will dictate the kind of lives our children will lead. We are not correctly or intelligently allocating our nation's health care resources. There are serious internal contradictions in a society that no longer produces the radios, televisions, or video recorders it invented, yet pays for all patients receiving lung transplants and artificial hearts. While moving our basic value-producing industries — steel and automobiles — abroad, we continue to manufacture MX missiles and artificial hearts. We give heart transplants to smokers, but we close our steel mills. We spend freely on military and medicine, yet we refuse to spend enough to succeed in international trade. We overtreat sick people but undertreat our sick economy. Like the fading southern family in William Faulkner novels that "takes sick," as a nation we are treating our illnesses at the expense of our livelihoods.

I. INFINITE NEEDS AND FINITE RESOURCES

Both as individuals and as makers of public policy, our individual and collective wants clearly exceed our resources. This is particularly true in medicine, where medical technology has outpaced the ability of the public to pay. In medicine the infinite needs of the public have collided with our society's finite resources. Commentators have aptly observed that the divergence between what is good for the patient and what is efficient for society is crucial to current concerns over

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health care spending. No set of expenditures can rise faster than the Gross National Product forever. The U.S. cannot maintain its present rate of growth in health care spending while simultaneously investing to restore productivity, growth, and international competitiveness.

Our societal resources should be directed towards the well-being of the public, the education of our children, the maintenance of our infrastructure, and the retooling of our economy. Each of these values requires financial support. Health care, however, receives virtually all the funding needed at the expense of other societal needs. Health care costs are cannibalizing our state and federal budgets. For example, in 1950 government spending for health care was 45.9 percent of that of education; in 1984 (update) health care spending was equal to all government spending for education. Our whole fiscal system is tilting toward health care expenditures. New hospitals are built at the expense of better education, repaired highways, and additional housing.

The sad irony is that twenty-five years of virtually unlimited funding for health care has not significantly improved the well-being of our society. We maintain the most expensive health care system in the world, yet we have only average health status. One study of health care concluded that American health outcomes were *no better* than those in many countries that spend ⅛ the amount on health care that the U.S. spends. The study noted an inverse correlation between the number of doctors and the general health of the nation: West Germany had the highest per capita number of doctors and the worse health outcomes, while Japan had the smallest per capita number of doctors and the best health outcomes. If any state health department spent eight times as much as another state to achieve the same results, any governor would have to fire the health director for not adequately managing public money.

We are trustees of America's limited resources and capital. If we are to bequeath a tolerable society to our children and grandchildren, we must have institutions that spend our resources as effectively as possible. The basic question our society must address is how to allocate our scarce capital to provide the maximum amount of health care and the maximum amount of well-being.

II. Our Health Care Priorities

The basic question is: What public policies will make Americans healthier? The answer is *not* more health care spending. The big killers of Americans are the result of eating too much, drinking too much, and refusing to wear seat belts. As a society, we need to understand that national health can be achieved by other routes, rather than merely increasing the number of doctors and of hospitals.[1] Among industrialized nations there is little correlation between a nation's health care expenditures and the health of its people. Health and well-being usually results from factors such as lifestyle, rather than from health care spending.

The U.S. misallocates much of its health care dollar. We set our health care priorities based on emotion, not on reason. Public health policy cannot be made by asking what is proper for all individual patients. Treatment that may be ethically proper for one patient may produce an impossible public policy. The sum total of a myriad of individual ethical decisions can be an unethical public policy.

Our current health care priorities result in a conflict between the national interest in all social goods, such as education, jobs, and prisons and the individual interest in health care. In addition, there is also a conflict between individuals. When a doctor receives a patient, the doctor also receives a moral problem. The physician will ask himself, what does this patient need right now? The doctor cannot see the broader picture at that moment. The doctor fails to see that in a society of limited means, every resource committed to an individ-

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1. The Graduate Medical Education National Advisory Committee (GEMENAC) has estimated there will be 63,000 more physicians than needed by 1990. An earlier report by this group projected 145,000 more physicians than needed by the year 2000. Based on this report, the Duke University Medical School announced a 13% reduction in its class size over five years. Dr. David Sabiston, Chairman of the Medical School, wrote in Duke's *Faculty Newsletter*:

> [E]ven with the minimal number of physicians projected for the year 2000, there will be considerable excess, and a high number is more likely. The impact of these figures upon total medical costs is obvious and places in further jeopardy the intelligent appropriation of the nation's resources, with the strong possibility of creating excessive and almost certainly unnecessary expenditures.

Sabiston cited a 1978 report by the U.S. Department of Health, Education and Welfare that estimated each physician in practice increased the nation's health care costs by $300,000 annually. He concluded, "Thus, with an average career spanning forty years, a single physician would create health care costs of some $12 million."

ual patient is not available to other citizens. These individual health care resources often could be better used for the total good of our society. For example, more lives might be saved by using an underutilized hospital to lock up drunk drivers than by using this building as a hospital. Perhaps we should consider adding a $2-a-pack tax to cigarettes rather than add $100 billion in tax money to health care.

A decision by one doctor to give a patient extraordinary care is simultaneously a decision *not* to treat other patients. Consider these facts: almost 17 percent of Americans — some 35 million people — don't have access to health care insurance. In Los Angeles County, an estimated 18 percent of pregnant women did not receive prenatal care. In addition, over 60 percent of the unemployed have family medical problems that are currently going untreated. It is undisputed that while a few lucky patients receive all that American medicine has to offer — whether they are responsible for their own poor health, whether they have any hope of recovery, and regardless of costs — millions of the unemployed and the working poor don't even receive basic health care from this system. The National Citizen's Inquiry into Health in America found that America's health care system has become "incapable of meeting ordinary health care needs."

Ironically, the way we determine health care priorities usually leads to the highest possible costs. Each individual doctor or patient makes a series of decisions channeling health care resources to that patient. Very often, the maximum amount of treatment and medical resources is used for that patient. When millions of patients receive this type of "cost is no object" care, the result is a collective economic tragedy. Heroic medicine produces horrific spending. The economy cannot support that kind of shortsighted allocation of resources. Because extraordinary medicine is such a dramatic and publicized event, we ignore the people and programs that must sacrifice to pay for it. For example, California recently eliminated 250,000 people from Medicaid because the program was becoming too expensive. One reason for the increased expense was the legislature's decision — in the same session — to pay for organ transplants. In effect, the legislature voted to cut back on prenatal care and pediatric care to fund organ transplants. This decision is not socially responsible. It is partially understandable, however, for the medical profession and the media have glamorized surgeons and transformed the desperately ill into celebrities of the moment.

It is increasingly common for medically-indigent women to show up at hospital emergency rooms in active labor. Having had no prenatal care, an increased number of babies may have low birth weights and resultant complications. These babies may be rushed to tertiary care centers to receive the latest in technological medical care, at an average cost of $40,000 per baby. It is ironic that our society will pay $40,000 to treat each low birth weight baby yet refuses to pay for adequate prenatal care. In Colorado, for instance, it was estimated that $40,000 could be used to provide prenatal care and supplemental food for as many as 60 medically-needy women. The Institute of Medicine estimates that for every dollar spent on prenatal care for mothers at high risk of having low birth weight babies, $3.38 would be saved by reducing the amount of care their infants required. A premature baby struggling to survive touches each of us, and instinctively we find money for all the neonatal intensive care the baby needs. This is a very expensive solution to inadequate preventive care. Medical priorities and spending are too often determined by emotion rather than by reason.

Similarly, our society pays for lung transplants and coronary bypass operations, but not for smoking cessation programs. Despite our surgical expertise, we lack an effective treatment for those trying to stop smoking. Such a program could prevent far more heart and lung disease than could ever be cured, and at much less cost. Meanwhile, the federal government continues to subsidize the tobacco industry. Is this an effective or rational allocation of societal resources? Should taxpayers pay for transplants for those who have damaged themselves by years of physical neglect or self-abuse? Health care resources could be used in less dramatic ways with far greater benefit, but we refuse to make dispassionate choices among various health care priorities.

This is not the perspective of a medical Luddite, nor is it to suggest that surgery is unimportant. The miracles of modern medicine are truly admirable. But how should our limited health care resources best be used? Dollars spent for intensive hospital services cannot be spent on primary health care. While surgery and other medical services are being rewarded with adequate or increased amounts of funding, preventive care has not shared this bounty. In the early 1970's expenditures for preventive health care amounted to 2.5 percent of national health care costs. This level of funding has not changed significantly. By rewarding programs that intervene late in a disease while virtually ignoring preventive programs,

we are proceeding from an anti-social ethic. Human health has improved because of improvements in sanitation, refrigeration, and vaccination, not merely from improved hospitalization. While the medical profession receives the recognition and the funding, the public health profession has saved far more lives. Spending for preventive health care rather than solely for surgical intervention constitutes a more effective expenditure of health care resources.

Our overwhelming fascination with technology drives the media and the public to demand the application of new treatments as soon as they are developed, whether or not such treatments are minimally cost-effective. For example, the National Institute of Health has called for expanded federal research efforts to develop a fully-implantable, permanent artificial heart. Such a device "[c]ould provide a significant increase in life span, with an acceptable quality of life, for 17,000 to 35,000 patients below age 70 annually." This group estimated the annual cost for this program to be $5 billion! This is a staggering price tag for a program to benefit relatively few people. Where will the funds come from? What other research projects or public health programs would lose funding to pay for this technology? Such a program would increase medical costs and health insurance premiums and would consume a portion of Medicare and Medicaid funding. But this program would only benefit a select few and do nothing to prevent heart disease.

Recent discussions of the cost of high technology medicine, including my criticism of the artificial heart program, is easily misunderstood. My criticism is not of high technology. On the contrary, high technology medicine can be extremely beneficial. High technology can save far more lives at a lower cost, if the technology is properly applied and managed. My criticism concerns the mindless way in which medical technologies are invented and used, regardless of cost, while many high-benefit procedures that could save both money and lives are ignored. Although we refuse to commit significant resources for preventive health care, once a disease is diagnosed a patient can receive good care, for many times the cost of prevention.

Our society should apply high-technology medicine to the ultimate goal, that of understanding the underlying causes of disease. Fifty years ago, the great menaces to human health were tertiary syphilis of the brain, pulmonary tuberculosis, acute rheumatic fever and, of course, poliomyelitis. Because of classic clinical research, all these diseases

have almost completely been eradicated as public health problems. The cost of eradicating these diseases was negligible compared to what we'd be spending if they were still with us. This exemplifies true high-technology medicine.

Just as polio never would have been cured by investing solely in artificial lungs, we will not understand and cure heart disease by spending our resources on artificial hearts. Our society pays dearly for the treatment of disease while we overlook its prevention. We spend far too much money on dying patients and not enough on research.

Some medical "progress" does deserve skepticism. Nearly half of all medical expenditures are used to treat less than 5 percent of the patients. While this may appear to be heresy, the question should be asked. Given our need to retool the economy, repair and rejuvenate the infrastructure, improve the education system, and balance the budget are these medical expenditures fully justified? Medical miracles may make some doctors and hospitals wealthy, yet these dramatic, high-cost treatments benefit only a tiny minority of patients. Why is it wrong to suggest that rational, more compassionate decisions about treatment are needed? Decisions could be made by weighing the limited benefits of heroic treatment against its costs and the need to fund other programs. Our society provides medical miracles for the few extraordinary patients — the elderly person who cannot walk without an artificial hip, the premature baby whose survival depends on a life support system, or the middle-aged smoker who needs a lung transplant or coronary bypass or artificial heart. We treat patients with dramatic ailments but fail to provide prenatal care to many mothers. A few are given heroic care while many ordinary people receive no care at all.

A Concluding Parable

Let me close with a contemporary parable that reflects our health care priorities.

Many years have passed since the first of many bodies was spotted in the river flowing past the town of Downstream. The elderly folk from Downstream like to recall the spartan methods first used to rescue people from the river. Back then it would take hours to pull ten people from the waters, and only a few would survive.

Although the number of victims in the river has grown recently, the people of Downstream have responded admirably to this need. Their river-rescue system is clearly second to

none: most victims discovered in the swirling waters are rescued within one minute, and many are saved in less than thirty seconds. Only a few people discovered in the river drown before help arrives. The townspeople of Downstream speak with pride about the rescue facilities and hospital built beside the river, the flotilla of rescue boats, and the highly trained rescue personnel and doctors. The residents admit these services are expensive, but they are willing to provide whatever is necessary when lives are at stake.

A few people of Downstream occasionally protest that these services are unneeded and cost too much. Most residents, however, simply ignore such arguments. The people of Downstream are so intent on rescuing those in the river that no one ever wondered how so many victims fall into the river or how this could be prevented. Sometimes that's just the way things are and the way things always will be.