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No convincing relationship exists between the level of health care expenditures and the health of populations, as Dr. Lamarche, clearly demonstrates (see Our Health Paradigm in Peril, p. 558). *Marginal expenditures,* which describe the incremental health benefit per dollar spent, highlight the difficulties of choosing between spending an additional dollar for health care rather than for education, infrastructure, safety, preventive services, and so on.

And we do choose. Industrialized world health care costs continue to rise faster than inflation. In the United States, aggregate health care costs approach one-seventh of the Gross Domestic Product. Dr. Lamarche appropriately argues that the maintenance of health is likely, on balance, to be far more cost effective than response to existing disease. He notes that housing, minimum decent income, food, education, good social and physical environment, and other "prerequisites" are far more important determinants of health than health care expenditures. He is undoubtedly correct, yet there is little will or commitment in the United States to achieve these outcomes for all vulnerable populations. Indeed, the last 10 to 15 years has seen the dichotomy between the wealthiest and the poorest of our citizens grow.

Informed Joint Decision Making

We have been successful in altering some behaviors. Widespread use of seatbelts and the decrease in cigarette smoking among the population as a whole have been important accomplishments. Over the last 35 years, the age-adjusted mortality for cardiovascular disease in the United States has diminished approximately 50 percent, at least one-half of that decline attributable to decreased cigarette smoking, improved diet, and other preventive measures, including control of hypertension. But for sexually transmitted disease, eating disorders, and early detection of cancer, our record is less salutory.

All health care systems must identify incentives to prevent illness. Few direct procedures in prevention are reimbursed in the fee-for-service sector. In Great Britain, the National Health Service achieved dramatic increases in vaccination rates by offering economic incentives to those general practitioners who vaccinated more than 90 percent of the children in their practice. But other aspects of prevention that involve counseling, education, and behavior modification are not encouraged by payment systems in the United States, although they should be.

Preliminary data suggest that managed care organizations, providing services primarily to employees of large firms, have begun to slow the rate of rise in health care costs. To the extent that managed care organizations can control their own expenditures through prevention programs for their enrolled populations, they have an incentive to act. Unfortunately, turnover—the movement of patients between managed care organizations—can eliminate the incentive, as the fiscal benefits of prevention accrue to another plan or employer. Employers could be important allies since they benefit if their employees remain healthy, regardless of health plan. However, increased employee turnover makes long-range prevention strategies problematic for employers. And who will be motivated to carry out these activities for the uninsured, the poor, and other vulnerable populations?

Well-informed joint physician-patient decision making will be critical in any effort to control expenditures regardless of how and by whom. By *patient,* I mean everyone who uses the medical system, individuals and organized groups. By *physician,* I mean more than medical doctors—all parts of the medical system that organize and deliver care. If these participants can understand the advantage of certain behaviors, they can find ways to reward them. Close to half of the mortality in the United States arises from behavior or environmental factors, as documented by McGinnis and Foege *(1).* Education that conveys what we know and better research to learn more about how to motivate people to seek healthier behaviors may be our most valuable leverage points.

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References

1. McGinnis, J. M., and Foege, W. H.: Actual causes of death in the United States. JAMA 270: 2207–2212, Nov. 10, 1993.