

Patient Rights: Is there a Covenant Without Responsibilities?¹

Historically, governments that provide rich legal rights to their citizens have been endangered, not when the community demanded that those who have rights also live up to their social responsibilities, but when this was not done.²

—Amitai Etzioni

Early Roots of Rights and Responsibilities

Even in the earliest days of recorded civilization, the relationship between healers and patients was structured and provided patients with rights. The Code of Hammurabi is the oldest known example, and it is not unlike today's quality-controlled, cost-managed, and patient-rights environment. It established the relationship between the healers and the patients of the day. It held physicians accountable for bad clinical outcomes. It regulated access to care. It also set compensation.³

It is believed to be based on even older—3000 BCE—practices. If that is true, managing the relationships—including the business relationships—between healers and patients has been a long-standing practice in human history. American insurance systems and health policy didn't invent it through employee benefits, union negotiations, rules, regulations, or appropriations. It seems, though, that even after 5,000 years of practice, we still can't seem to get it right. Perhaps that will bring some comfort to those in healing systems and managed care today. Perhaps it will be both humbling and enlightening to those of us in health policy circles. Apparently, we have not been as creative as we believed about structuring health care. It is not as easy as we might have hoped. Our thoughtful health care management plans and proposals are nothing more than the clinical and business relationship patterns established millennia ago, and we are still working to achieve the most palatable refinements. Our health care enterprise today is much more complex, but it does not operate much differently when it comes to the fundamentals.

The Healer's Accountability for Quality

Like their earlier counterparts, healers today are accountable. Physicians, nurses, and pharmacists are monitored and measured and have been since the earliest days of regulation in this country. They take exams, disclose personal information, and are subject to state licensing board reviews and Inspector General investigations. They have also been tracked in a National Provider Data Bank (NPDB) and monitored for criminal and malpractice experience. Hospitals and other institutions are assessed as well. The Joint Commission for the Accreditation of Health Care Organizations (JCAHO) assesses the quality of the care they deliver, and the stakes are

high—slip in the ratings, and the care will not be reimbursed by third parties. In ancient times, governments sometimes took over production of herbals to assure their purity. Today, the quality of pharmaceutical and medical device products is monitored by government agencies.

These methods to measure healer performance and hold them accountable have improved over the years. We have become better at defining what we want in quality care and better at making the measures of it. The number of organizations doing the measuring has grown as well. The National Committee for Quality Assurance (NCQA) drives quality improvement for employers paying for care using its Health Plan Employer Data and Information Set (HEDIS). The Leapfrog Group has likewise created new standards and issued calls for improvements on behalf of leading employers. The Foundation for Accountability (FACCT) is developing more “outcome-based” quality measures to track patients’ experiences across an entire episode of care. The Agency for Health Care Research and Quality (AHRQ) is the federal government agency that is taking the lead in quality assurance. It has developed a comprehensive consumer satisfaction survey (known as “CAHPS”) that complements HEDIS and other clinical assessment tools and enables consumers to compare the performance of health plans and providers. Peer Review Organizations (PROs) are physician-owned quality review organizations that assess quality, and each hospital and health insurance plan has its own method to track healers as well. Public and private sector purchaser coalitions measure quality to incorporate it into contracting and buying decisions. Esteemed private groups such as the Institute of Medicine⁴ and respected individuals like George Lundberg⁵ of the *Journal of the American Medical Association* examined medical error, quality, and trust problems and articulated them for the public and professionals alike to review. Unlike those days of old, we don’t remove a surgeon’s hand when an operation is unsuccessful, but we do remove operating privileges when we judge that too many surgeries result in bad outcomes. Physicians, other clinicians, and institutions are vilified in the press, held accountable in the courts and by Congress, and lose their licenses to practice as healers. Unlike those days of old, we don’t make a physician pay for the life of a slave who dies under his care, but we do sue physicians for lost wages and damages if patients die and the healer is judged to be at fault.

The Healer’s Accountability for Access and Cost

Historically, healers also played a role in assuring access. In ancient societies care was sometimes subsidized by the ruler, or by employers (as in the case of slaves), but healers were required to cooperate to assure access by yielding to a fee schedule. This fee schedule was not only based on the nature of the healer—surgeons were paid more than physicians and pharmacists—but also on the nature of the procedure and on a sliding scale to fit the status of the patient. Yesterday’s gentlemen of rank paid more for the same services than did tradesmen or slaves. Tradesmen paid fees equivalent to half of what a gentleman would pay; owners of slaves paid half again as much for care of their slaves. Physicians were expected to treat patients without regard to payment status and, in fact, to provide charity care as required.

Similar fee arrangements are true today. Today’s “gentlemen” and “persons of rank” are the insured or the wealthy that can afford care. This coverage is provided largely because the “gentleman” receives a health care benefit from an employer. In addition, as an employed person, some of these “persons of rank” can afford to pay out-of-pocket for care because of their

individual wealth. These payment systems allowed a certain amount of cost shifting within the healing enterprises that developed in this country, and, with some subsidies from governments for the care of the very poor or the elderly, health care systems were able to sustain the infrastructures needed to survive and grow. This did not absolve healers of the responsibility to provide free care, however.

Recent years have brought changes to this delicate balance. Increasingly, new payment relationships are common. In some cases these are out-of-pocket arrangements. Some people seek complimentary and alternative treatments or care from alternative healers whose services are not reimbursed by third parties. In other cases, however, traditional healers have opted out of health payment systems and are offering—and individuals are accepting—arrangements in which traditional health care services are paid for directly by the patients themselves. Some physicians, for example, are opting out of third-party systems altogether and structuring practices based on exclusive, cash-only arrangements with limited numbers of people. This situation changes the “balance of payments” that has been the foundation of the cost-shifting methods of financing care. “Persons of rank” and charity care from healers have subsidized care for others. This was so common and so embedded in our tradition of healing that we came to expect that the poor and the uninsured would receive care and that the health care safety net would be woven by our healers. We have come to expect that some care will be delivered at low—or no—fee because some patients are not economically privileged. Since the earliest days of practice—and in particular, since church councils ruled that healers, at least those associated with the religious healing traditions, should not practice medicine for profit—we have come to expect that some care would naturally be uncompensated.

There is no evidence from early times that society as a whole neglected to pay for its care. Even the religious healers of the Middle-Ages Christian tradition were paid. They were restricted only from profiting from their healing over and above the other tributes that were paid them by the local flock in their care. How unlike health care in contemporary America, where there is increasing resistance to paying for the cost of medical care. Furthermore, there does not appear to have been any collective effort on the part of buyers, even when the buyer was as powerful as the emperor, to leverage buying power, or to unite to purchase jointly at better rates. Not so, today. Concern for the cost of care has led governments and employers to take steps to reduce the financial liabilities associated with health care commitments. In turn, healers have counteracted these moves by changing age-old commitments to provide care to all, even at no charge.

Increasingly, powerful buyers and buying consortia are forming to get such low rates that the health care infrastructure is weakening. It is harder to get appointments with doctors and dentists. Hospitals are no longer staffed adequately for the intensity of care required by patients. Institutions are strapped for cash and unable to make improvements in the data and information systems that would support more effective care. Added costs of patient care, training, and research in teaching facilities are not covered adequately. Training programs for medical residents, long supported by private and public sector payers are underfunded. Pediatrics, in particular, has been hard hit. The best and the brightest centers of academic excellence are suffering and in danger of closing. Costs shifted from one payment center to another years ago or were covered by wealthier and more willing payers are in jeopardy today because buyers are

prudent to the point of being stingy purchasers. Costs cannot be distributed across patients and payers refusing to pay for anything other than what they, alone, receive. As a result, research, teaching, and indigent care are falling by the wayside. Investor capital is drifting away from health care, envisioning a future where returns do not justify the risks of investment. Purchasers are getting the best bargain today, but scant assurance about the infrastructure for tomorrow. Healers of old had few tools for addressing disease problems, but apparently could be well paid for it. Today's healers have the tools, but greater difficulty in applying them in such adverse payment climates.

Lack of Reciprocity in the Covenant Relationship

Today's health care climate is adverse not only in terms of payment but in terms of responsibility as well. This, too, originates in the relationships of old. The Code of Hammurabi is consistent with other covenants of grant. Like the Oath of Hippocrates, it does not mention the responsibility of individuals, patients, and family members to care for themselves and each other, nor does it include directions to the community to do likewise in providing for healthy environments. There are no directions or requirements for healthy living. Hippocrates may have felt no reason to mention it because prevention, wellness, self-care, and love of the body were already embodied in ancient Greek lifestyle. At any rate, the ancient codes which are the foundation of our practices today not only insulated patients from bad outcomes at the hands of physicians, they insulated people from the bad outcomes of their own unhealthy behavior and poor lifestyle choices. The codes also ignored the responsibilities of communities. Responsibility was shifted from the person (or patient) and community to the healer. Individuals and communities reaped all the benefits and bore none of the risks.

In a society in which prevention was the norm, the healer was respected, and his nostrums taken as directed, this imbalance between benefits and risks might not be so problematic. In today's climate of inadequately practiced prevention and eroded confidence in the practice of healing, this imbalance creates immense challenges. It traps today's insurance-financed, HMO-managed healers in a maddening descent into hell, defined by customer and community expectations, but not balanced by reciprocal obligations of any sort. There is plenty of evidence to detail what the public believes is wrong and how it now holds healers, and managed care in particular, responsible for the problems. Polling, focus group, marketing study, editorial, litigation, and talk show data abound. Complaints—and there are plenty of them—produce the easiest insights. Americans today are quick to comment on the length of office-visit waits, the cost of prescriptions, the conditions in nursing homes, and the surliness of hospital staff. We are ready with wish lists for quick fixes, cures, and easy answers to tough disease problems. Oh, and another thing: we'd rather not pay for it. Someone else should—either employers or the government—and, barring that, the providers themselves should be capable of footing the bill, especially for new developments in technology. At the same time, though, we neglect good personal health practices that could reduce the cost of care. As individuals, we eat too much, smoke too much, exercise too little, and take risks too often. We carry guns in the streets and in our schools. Then, as our behaviors make us sick, we want the providers of the care to patch the traumas and cure the sickness, at little or no extra cost. Or, so it seems.

But if patients are discontented, healers are even more so. Patients deal with the frustrations of today's health care episodically. The fact is most of us are healthy for the vast majority of our days. It is a minority of us who are ill at any given time, or have chronic or terminal illnesses that require constant care. We confront waits in outer offices on rare occasions. Healers, on the other hand, deal with their frustrations continually, so it is no surprise that healers want changes in health care as well. Many are as dissatisfied as their patients. Their work is no longer satisfying. They wonder if their clinical education has been wasted on filling out reimbursement forms, attending committee meetings, and dealing with bureaucratic dictates. Managed care pioneers who believed they were on the verge of finding the solutions to health care dilemmas have been excoriated in the press, blistered in Congress, and bankrupted out of business.

Communities are also concerned. Health care costs, unemployment, teen pregnancy, violence, and guns have taken a toll on community life and drained resources from the coffers that would otherwise support education, the arts, and business development. Not only are some people unhealthy, some communities are unhealthy as well. At a time when the armamentarium for clinical care and public health is at its best and is positioned to add value to life and years, it isn't clear who should make the first move to create the necessary changes that will re-inspire confidence and rebuild relationships.

Limitations of the Current Covenants of Grant

We're stuck in these doldrums because our health care system today has not progressed beyond ancient times in an important way—our health care system is still a covenant of grant in which patients and communities receive from, but do not reciprocate with, their healers. It is a covenant of grant in which health care payment systems further insulate patients and communities from the financial consequences of unhealthy behaviors. It is a covenant of grant that reinforces a dependency on healers that is frightening in its implications as the population ages. Making changes will be difficult because the covenant of grant has been further entrenched within the contracts of managed care.

Today's patients and communities are dependent on healers not only for health care services, but also, with the dawn of managed care and capitation, for the financing mechanisms to cover cost of the care. The patients of Hammurabi's era would have considered the economic costs of a clinical visit. Today's patients with third-party coverage—especially in managed care—have few such worries. What we as patients have gained in access, we have lost in incentive for personal responsibility. It is not just ancient societies that were guided by myths; ours is as well. A new mythology has arisen in our modern culture that is dangerous for healers, patients, and communities alike. We have come to believe that it is more in the interest of payers, including employers and managed care—or the newly merged healer-payer of managed care—to care for patients, than it is in the patient's interest to care for themselves. This mythology ignores that individual people, themselves, reap benefits that merit some contribution of their own in time, effort, or financing. It ignores the fact that some of the best health care a person can get is not the clinical care in the in the healer's office or hospital, but the preventive measures and lifestyle choices made in their own homes, workplaces, and communities. Whatever our healers do for us in choosing diagnostic measures and available therapies, the most important choices

people make are those between visits to healers. It is not the clinical decisions healers make that create the best value in health, but the lifestyle choices patients make and communities support day to day.

The benefits of prevention are too often stated in ways that promote this mythology, holding the managed care healer-payer responsible for assuring that patients take even the most clear and simple preventive measures. For example, one HEDIS measure assesses quality according to the number of patients who receive influenza vaccines. Why should managed care be responsible for assuring that its patients are protected from flu? How far do those responsibilities reach? With information? With patient tracking and recall systems? With free vaccine? How could any adult today not know that flu is seasonal, that a vaccine can prevent or ease the disease, and that it is cost-effective for the individual—not just for the managed care healer-payer or the nation—to receive it? What additional information and shot clinics should managed care possibly provide? What should it need to provide when a multibillion dollar cough and cold products industry advertises extensively each year about the symptoms of flu, and visiting nurses, WalMart, and neighborhood pharmacies offer easy and inexpensive access to the vaccine, at a cost equivalent to a few soft drinks? Local news broadcasts track the arrival of the offending viruses. Families suffer as parents and children alike lose work and school days to the illness. Yet, how often have patients resisted and avoided even painless, low-cost, affordable items like the influenza vaccine? It is an indication of our covenant of grant in health care today that administration of flu vaccine is a measure of managed care healer quality and not patient responsibility.

Like other preventive measures, vaccines are too often viewed as benefiting the employer or the payer more than the patient. As people, in our dependency on our healers we too frequently say, “The payer (government, HMO, or employer) should pay for my vaccine, my check-ups, my health club, my obesity medications, because it will save them money in the long run.” Legislatures too frequently agree. An entire industry has developed to make cost-effectiveness calculations, and it has flourished on the notion that health care benefits accrue to employer payers and managed care of a population’s health care costs. This notion can reach extremes. One state legislative proposal is aimed at requiring HMOs to cover weight loss surgery for Medicaid patients at about \$15,000 per patient, with the rationale that it will save money in the future by avoiding the costs of the ancillary diseases associated with obesity, such as diabetes and hypertension. Surely there are other less costly strategies for reducing obesity short of radical surgery. Is it that patients will not comply with lifestyle changes? Why should it be so much in the payers’ best interests that even extreme solutions and doubtful procedures are mandated? Why aren’t changes in behavior and lifestyle demanded of patients? These are important questions for this new era.

The dependency of patients and communities on their healers, which was established in the Oath of Hippocrates, reinforced in tradition, embedded in the culture of medicine, and facilitated by today’s health financing systems, has exacerbated the health care financing problems today. This dependency has transferred too much of the responsibility in health care from the patient and the community to the healer. Healers are too often assigned responsibility for all aspects of care, cure, and cost. For the capitated health care provider today—and for the managed care systems that contract with employers and governments to provide care—

attempting to provide care within a paradigm that expresses patient rights but not patient responsibilities is “mission impossible.” By covenant and by contract, the healer is bound to care for the patient. The patient, on the other hand, is in no way obligated to reciprocate by practicing healthy behaviors or following orders.

Hypertension provides another example. In the care of the patient with high blood pressure, healers are obliged to use epidemiology and population studies to identify individuals who may be at risk of the disease, screen them for hypertension to diagnosis the condition, counsel them about diet, smoking cessation, and exercise, prescribe antihypertensive medicines, and subsidize the cost of the drug. They are also expected to monitor compliance, remind patients to take the medicine along the way, and assess the outcome of the therapy, making changes as needed. The patient, on the other hand, need do nothing. The patient, living within the current covenant of grant with the healer and under financing plans with his employer (or government), is not required to show up for appointments, follow the dietary or exercise advice, stop smoking, or take the medicines. If the patient continues to come for care, the healer will be expected to repeat all the care-giving steps. If he does not come for care, the healer will be expected to find out why and encourage him to show up. If the patient has a heart attack or stroke—both likely outcomes of unmanaged hypertension—the healer will be expected to provide the access and quality of care for the emergency services, intensive care, surgery, and rehabilitation required to ensure survival and good quality of life afterwards. And the healer, particularly within the current managed care paradigm, will be expected to provide all of this within the negotiated, preferred, capitated rate.

What is the patient’s responsibility? Few oaths address the reciprocity in the relationship between healers and patients. No oath addresses how to deal with the conflict in health care today over the increasing cost of care and any responsibility of the individual to help control those costs. Yet those opportunities to control costs are myriad, and the implications of not embracing these opportunities are frightening for providers of care. In today’s capitated world of health care, it is the healer who bears the fiscal consequences of the failure of people and communities to practice good health behaviors. It is also the healers who have the best insights into how to reduce those costs through responsible behavior. As such, it will fall to the healers to address this issue in the individual contacts they have with patients, in the contracts they sign with managed care or health payers, and in the public policy settings within communities. There are a number of targets ripe for discussion—compliance, self-care, health behaviors, and public health.

In 1998, HBO aired a documentary entitled “Six Months to Live,” which portrayed a patient’s heroic efforts to comply with a healer’s prescription. This documentary traced the experience of people facing terminal illness and seeking alternative paths to healing in addition to the traditional medical approaches of their clinicians. The story of one woman was compelling. In addition to dietary, attitudinal, and other therapeutic approaches, she visited a Native American healer. His prescription for her, in part, was that she spend a night, underground, naked, and alone, with Mother Earth. Her family spent that night praying for her above ground as she, wrapped in a quilt, descended into an underground, dugout space much like a small sweat lodge. The intention of the healer was that she contemplate her mortality and

eventual return to the earth. It was, no doubt, an attempt to require her to deal with the fears about her eventual death, if not from this terminal condition, then from some other in the future.

The nature of the prescription is clearly unusual in the context of today's healing practices in mainstream American medicine, and so is the response of the patient. She did it. She really did it! She spent the night, naked and alone, underground. How different from many patients in this country today, who will fail to take even one antibiotic tablet per day for ten days. Studies have shown that between 20% and 30% of patients do not fill their prescriptions, and of those who do, many take incorrect doses, take medicines at the wrong time, forget to take doses, and stop medicines too soon. Logic would say that this is because the cost is too great. But surveys indicate otherwise. It is more often because they doubt the effectiveness of the medicine, fear side-effects, and decide they do not need it.⁶ They do this independently, by the way, without consultation and benefit of their healer's guidance.

Self-care and the practice of prevention are other ways to reduce costs. We have the ability to control the most common contributors to death and health care costs: immunizations, tobacco, diet and exercise, and alcohol use. These behaviors drive infectious diseases, heart disease, cancer, accidents, chronic obstructive pulmonary disease, diabetes mellitus, and chronic liver disease.^{7,8} They make their marks quickly on health care costs. In as short a time as 18 months, those who fail to practice prevention and engage in high-risk behaviors will use more health care resources.⁹ Frequently, these factors combine, so it is difficult to sort out the individual contributions of each risky behavior to the cost of care. It is clear, however, that the costs to society are high.

Because we, as individuals, have failed to manage our own health practices, our behaviors are driving up costs. Although we suffer some of the consequences in life lost or quality of life reduced, we have not suffered financially as much as should perhaps, because we have been largely insulated from the health care costs and the community consequences, including those in the workplace. In some ways, our healers have failed us in this respect—they have not been vocal enough about the cost implications of these lifestyle choices. In some ways, our payers have also failed us—they have paid for lifestyle-induced disease, further removing the responsibility we have to practice prevention and encouraging our dependencies on them to take care of us in any case. In some cases, our communities and employers have also fallen prey to accepting the parental role of providing coverage and care, without consequences.

Smoking-related medical expenses for the 48 million Americans who smoke, for example, hit an estimated \$50 billion in 1993, or about \$2.04 for every pack of cigarettes sold. These estimates are believed to be twice as high when they include workdays lost due to smoking-related illnesses. Smoking is linked to heart disease, respiratory infections, chronic bronchitis, stroke, emphysema, miscarriages, low-birthweight infants, and ulcers. Secondhand smoke is related to asthma and respiratory problems and to deaths from lung cancer and heart disease. Smoking by women has caused the lung cancer death rate among women to rise more than 400% from 1960 to 1990, making it the number one cause of cancer deaths among women, surpassing breast cancer. Overall, more than 400,000 people die each year due to tobacco-related diseases. Sixteen percent of high school students are frequent smokers, and that number has been on the rise.¹⁰

Add to that the costs from sedentary lifestyles and poor nutrition. In 1999, the total health cost of treating adult obesity in the United States was \$238 billion—or roughly 25% of total health care costs.¹¹ People who are overweight are at increased risk for heart disease, stroke, cancer, diabetes, and osteoporosis. Obesity is considered the cause of more than 300,000 deaths per year. Estimates indicate that from 15% to 20% of children and 20% to 50% of adult Americans are overweight,¹² and the matter is of such great importance that the Journal of the American Medical Association devoted an entire issue to obesity in October 1999.¹³ Pharmaceutical companies believe that obesity drugs are possibly the world's biggest market. Analysts predict that sales of obesity drugs could exceed \$26 billion in the United States alone. Treating only 25% of the patients at a cost of \$3 per day would generate sales at that level.¹⁴

Limitations of Covenant of Grant with Communities

This same covenant of grant has been extended to communities, and with similar outcomes. Communities that fail to maintain a strong public health infrastructure and address social problems are insulated from the direct and immediate health care costs associated with those decisions. Over time they suffer from lost productivity and economic growth, but the immediate consequences are largely hidden. A Harris Poll conducted in September 1999 indicated widespread support for public health measures, such as infectious disease control, immunization, safe water, air and waste disposal, and education for healthy lifestyles, particularly among the best educated and most politically influential.¹⁵ Yet even those in favor of public health programs admitted that public health measures lacked the excitement of modern medical miracles, leaving political support for funding weak. Since it's modern miracles they expect, it's modern miracles they get; and, like patients, communities pass the bill on to "others." Too frequently, communities expect that local employers who pay for care and managed care organizations that provide it will continue to do so, absorbing the costs of innovations as they spill from research pipelines.

New medicines, devices, and surgery compete for other financial resources; in particular, the public health programs that care for communities. If adequate public health resources are unavailable, problems will become greater in the coming years and disease outbreaks will result. Food-related diseases, for example, have become increasingly common, with 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths each year. The odds are one in four people will become ill from a food-borne illness each year.¹⁶ One in 25 children is at risk of lead poisoning in the wake of inadequately funded screening programs.¹⁷ A number of Healthy People 2000 goals were unmet, and some measures actually got worse. West Nile Virus (WNV) Encephalitis affected the Northeast in 1999. Once the crisis of new cases subsided, regional health commissioners worried aloud about how they would pay for local mosquito control programs to prevent outbreaks in future years.¹⁸ Rabies is once again a problem. Three thousand children were exposed to a rabid goat at a travelling fair and required treatment at \$1,500 each. Rabid raccoons released by hunters at a club in West Virginia have transmitted the disease to wild and domestic animals through the east, causing public health officials to advise that any contact with an unknown animal on the eastern seaboard must be viewed as a potential rabies contact and, tragically, causing severe injuries to at least one baby, who was attacked at his home in suburban Washington, D.C.¹⁹ Air pollution continues to cause an estimated 50,000 to 120,000 premature deaths and \$40-50 million in health costs annually from exposure to outdoor

pollutants.²⁰ An outbreak of avian H5N1 influenza in Hong Kong recently alarmed the world medical community and demonstrated our vulnerability to a major outbreak. For influenza experts, this drove home the need to prepare for an expected pandemic. Since they are fully aware that there will not be adequate supplies of vaccine, some communities, particularly in areas of poverty, will be disproportionately adversely affected. The implications for physician and hospital costs are clear.

Besides shoring up the public health infrastructure, there are other notable social health targets. As a result of the failure to address the social issues of teenage sexuality, the U.S. has the highest teen pregnancy rate among developed countries. About one million teens become pregnant each year. Ninety-five percent of these pregnancies are unintentional, and one-third end in abortion. The cost of teenage pregnancy was \$120 billion from 1985 to 1990. Forty-eight billion dollars could have been saved if the mother had waited until she was 20 to bear a child.²¹ Other infants—more than 2,000 each year—are born with fetal alcohol syndrome (FAS), which causes growth retardation, facial abnormalities, and central nervous system dysfunction. Children often suffer lifelong consequences from in utero alcohol exposure as a result of their mother's drinking, which rose four-fold between 1991 and 1995. In 1992, the National Institutes of Health (NIH) estimated the annual cost of FAS from mental retardation to be \$1.9 billion.²²

Despite public health programs and a new endeavor to apply epidemiology to the problems of injuries, they are one of the most frequent causes of death and among the most costly to the economy. Including homicide and suicide, injuries are the leading cause of years of potential life lost before age 75. The cost of injuries from automobile accidents, firearms, falls, fires, poisonings, and drownings is \$260 billion. Of that amount, \$69 billion (in 1993 dollars) was spent on health care costs for injury victims. That is 12% of all medical spending.²³ Injuries account for 46% of all emergency department costs, 10% of all hospital costs, and 16% of all outpatient costs.²⁴ Traffic crashes continue to be a leading public health problem and are still the leading cause of death for people aged 6 to 27, with total economic costs of \$150 billion a year.²⁵ Despite widespread education and the availability of free car seats, 40% of children ages 1 to 4 years are still unrestrained and nearly 80% of safety seats are improperly secured.²⁶ The rate of death from firearms in the United States is more than eight times that of other economically developed nations, and the costs are also high. In 1990, firearm injuries cost over \$20.4 billion in direct and indirect costs of health care, long-term disability, and premature death. At least 80% of those costs are paid by taxpayers.²⁷ Finally, in 1991, the costs associated with head injury or death from head injury due to bicycle accidents was \$3 billion. It is believed that 75% of bicycle-related fatalities among children could be prevented if all children wore helmets. Every helmet worn saves this country \$395 in direct health care costs and other costs to society. If 85% of children wore helmets for one year, the medical savings are estimated to be between \$109 million and \$142 million. One person who survives a head injury may cost \$4 million in health care services over a lifetime.²⁸

As individuals and communities, when we fail to address these drivers of health costs, the burden is shifted to employers, payers—including taxpayers—and healers. Payers are increasingly resistant to covering these costs and require that the healers bear the fiscal consequences of our illnesses and injuries. Too many of us prefer not to care for elderly parents and turn to healers to do it for us. We choose to allow guns on the street, keep guns at home and

at school, repeal or fail to enforce helmet and traffic laws, and turn to healers to provide us with emergency care to tend our critical injuries. When we survive the accidents our risky behaviors have caused, we turn to healers at rehabilitation centers to restore lost function to damaged limbs and brains. When we fail to address the social issues driving teen pregnancy, we want healers to provide the neonatal intensive care that will keep our low birth-weight grandbabies alive—and they will. Healers are fast running out of strategies that control costs by tinkering with their own systems, however. In the future, patients and communities will need to take responsibilities for health approaches that will yield the desired cost-management results. Accepting personal responsibility, understanding risk in the population, developing targeted group interventions, case management, and multidisciplinary teams that will deal with social, juvenile justice, and education problems will be required. These programs will be invasive in the life of the individual and the community, but they will be necessary if we are to address the real needs of health and health care in the future.

Unfortunately, nowhere in the discussion of the modern miracles of medicine have healers confronted their individual patients, communities, or the nation as a whole with the true cost of the behaviors contributing to health care inflation. Likewise, nowhere do we systematically address the questions of conflicts the public must resolve as we confront the difficult issues of changing personal health and social behaviors. Even worse, nowhere have we systematically confronted the fact that some of the changes—like gun control—will challenge values and liberties.

Rationale for Covenants of Obligation with Patients and Communities

Much of today's disease is preventable, yet all indications are that we cannot assume that even the most advantaged of the citizens in this nation will practice good preventive health or adhere to a healer's advice. Our rates of medication compliance are low, we gain weight and lead sedentary lives, shun immunizations, drive fast on the highways and drive up costs that employers, taxpayers, and health care providers are expected to absorb. Over the decades of modern medical progress, healers have provided and people have come to expect medical solutions to all manner of physical, emotional, and social disease. Live a lifestyle that results in obesity, and healers have solutions for us. If they can't make us slim again, they can at least medicate or surgically correct the arthritis, diabetes, and heart disease that will result. If we choose to delay childbearing, healers will help us conceive with fertility medicines and in vitro fertilization.

This perspective is frightening, as too often the patterns of disease associated with the aging population have been taken as uncontrollable givens. In fact, they are not. Patterns of disease can change as patients and communities modify behaviors and improve public health systems. Patterns of disease had better change if we are going to retain employer-based systems of financing and solvency in federal programs like Medicare. As long as the nation avoids confronting the responsibilities of the individual and the community, health care today will be on the verge of a crisis that cannot be resolved with mere tinkering of per-member-per-month financing formulas, tighter Diagnosis-Related Group (DRG) payment rates, patient rights legislation, or HMO litigation.

How is this about covenants? In much the same way that the divine edicts to Moses in Leviticus defined interrelationships in the life of the tribes of Israel, these questions present similar issues to us today. Our living together, sharing common water, shelter, storage, and sewage enables our sharing of common plagues and bad habits. Those who choose to practice bad public health habits place the health of their neighbors at risk. Unvaccinated individuals transmit preventable diseases to others, which is a consequence for the community, not just for the unvaccinated individual. Food service workers with lax hygiene transmit Hepatitis A to their customers. Areas with contaminated ground water transmit E. coli 057H:17 to children at state fairs. Towns without animal control operations leave their babies vulnerable to attacks by rabid raccoons. Polluted air keeps asthmatic children and adults from work and school. Drunk drivers and gun-toting teens kill others in their path.

In addition, we not only live together, we pay our health care bills together. Payers, and in particular managed care, might feel the first pinch, but ultimately, the buck stops with every worker and every taxpayer. As a result, we are jointly financially responsible for the costs of each other's healthy or unhealthy behaviors. Whether we pay taxes, buy insurance, or pay for care out of our pockets, the costs of irresponsible personal and health behaviors that increase the costs of care are borne by everyone. Risk in health care financing is never "assumed," it is "spread." As a result, few patients pay the true cost of their health insurance or their own care. Those who do pay—whether through insurance payments, lower wage rates, out-of-pocket payments, or taxes—bear the costs, to some degree, for all the care that is delivered—for other taxpayers and insured persons, but disproportionately for those whose high-risk behaviors result in high-cost care. The young person, insured or not, who rides a motorcycle without a helmet and suffers an accident most likely incurs high costs for the health care he will require for the rest of his life—up to \$4 million is the likely expense. Even if the costs initially are borne by insurance, it is unlikely that insurance payments will be sufficient to cover them all. If, as is the case in so many high-risk/high-cost behaviors, this young person requires extensive care over some long term, he would most certainly require tax-supported Medicaid or other indigent charity patient support. Costs, when they exceed the billings, must be passed somewhere. There may be "free care" for an individual in a particular health care encounter, but there is no "free care" for an individual over a lifetime, for a community or for the nation.

Our personal and high-risk behaviors increasingly impinge on the quality of other people's lives. Likewise, our collective decision to fund or not fund community health programs increasingly impinges on us. The most stunning advances in health have been made at the community level in the past 100 years. Increasing life span and improvements in the day-to-day quality of life were supported not by medical care, but by community public health programs and personal lifestyles. Communities must create relationships that lead to reciprocity among their members to ensure health and conquer disease. This is perhaps one of the most pressing needs in health care today.

The community covenant of healing creates reciprocal relationships between healers, patients, and communities. It recognizes a reality of health care today: Not only do we relate to one another as individual patients and healers, but we do so within a context created for us with communities. What we do to protect and maintain our own good health benefits not just ourselves, but others as well. Conversely, steps taken by communities to protect the health of the

public at large also have an impact on each of us as individuals. That impact might be directly related to the quality of life and health we enjoy, or it may be related to the overall cost of care that we all support. We have needs and depend on others to meet them. Others have needs and depend on us. This is precisely the reciprocity of relationship of a covenant of obligation.

Some of our most contentious public policy issues are embedded in community covenants. Resolving them will require that the nature of the other covenants be acknowledged, in place, and practiced. There is no other way to address the critical challenges that the advances in medical technology and patient demand place upon us. Some of these public policy issues are simmering on Main Street. Others are boiling in the halls of Congress. Still others have spilled over to Wall Street. They are most ready for change on matters regarding patients' rights.

The Patients' Bill of Rights

We are not facing these issues as much as we are backing into them. The health care world of the future is one in which costs will increase because of technology, demand, and demographics. It is one in which patients and communities are likely to remain dependent on healers. It is one in which, along with the mythologies of health care financing, we will add the fallacy that much of the new demand for services will be absorbed into previously negotiated capitation rates. Health policy "wonks," managed care executives, and some employers know we're at the breaking point. Consumers and communities, however, believe that an endless supply of health services and resources will be available—with little demand on their wallets and even less constraint on their lifestyles.

It is into this covenant-bound and contract-driven world of health care that patient expectation, frustration, and fear associated with managed care cost controls and large medical bureaucracies has finally spilled over into legislative debates. The most contentious of those are about the rights patients should have as they deal with today's healers, particularly those in managed care. Specific state and federal legislation has been debated for the past several years, proposing one sort of protection or another as patients and, occasionally, clinicians feared, they were increasingly vulnerable to the large forces of corporate medicine.

Federal patient rights debates address two principal concerns: access to care and slippage in quality, as corporate forces govern the healer-patient relationship. The list of patient rights is extensive and goes well beyond the contracts negotiated for patients by the employers and governments that arranged to pay for the care. Patients want guaranteed access to care in times of emergencies, access to specialists, and access to healers from outside the plan's negotiated network. They also want access to all pharmaceuticals and clinical trials for experimental treatments. They want continuity of care when switching plans. Patients want assurances that disadvantaged groups are not discriminated against, that medical records are kept confidential, that they can get help in a confusing medical marketplace, and that health plans will produce comparable information so that consumers can make better choices. They want quality. They want quality improvement processes within managed care, data collected to measure and monitor quality, and utilization review programs that are rational and based on good criteria. When there are disputes about care, patients want a timely review process to settle the dispute, if necessary, by outside, disinterested parties. They want the relationship with their own physician to be

protected from business intrusions. They want doctors shielded from “gag orders” that prevent candid discussions of treatments and from medical necessity guidelines that are imposed by the HMO instead of accepted by the profession. When all else fails, they want to be able to sue the administrators of the plan providing the care. These demands reached the floor of Congress because there were problems in the halls of medicine.

States have also been an active ground for clarifying patient rights, and one in which protections have not only been debated, but enacted. In early 1994 the American Medical Association developed a model law, The Patient Protection Act, which was used the following year as a guide for states’ legislation. It provided the template through 1996 and was later expanded to address Managed Care Consumer Bill of Rights initiatives, which were more consumer-oriented. More than half the states have adopted some type of “Patient Bill of Rights.” Included in the new state laws are provisions that address continuity of care, emergency care, direct access, freedom of choice, mandated benefits, consumer grievance procedures, bans on gag clauses, bans on financial incentives, provider protections, and provider profiling. Freedom of choice was a legislative proposal in 22 states, and mandated benefits were enacted in 26 states, requiring coverage of particular treatments and prescriptions. Financial incentives to compensate providers for ordering minimal care for patients are now banned in 25 states. Continuity of care legislation in 22 states addresses the problem of continuity when the individual’s provider is terminated or dis-enrolls, or if the enrollee changes HMOs. In 42 states, emergency care legislation ensures that managed care organizations provide some type of reimbursement for the cost of emergency care services. In 37 states an individual may select an OB/GYN as their primary care provider, in three states individuals are permitted to use their chiropractor as their primary care provider, and in two states dermatologists can be considered as a primary care provider.

Harnessing the Voices of Patient Rights

The most articulate voices for patient rights are among the most advantaged in our society. Although these voices represent the poor, they more often represent the interests of the employed, who, unlike the growing number of Americans without health insurance, have some form of assistance to pay for most of their care. These vocal patients don’t rely on charity care or government-funded programs. Unlike the poorest and unemployed Americans, they have the income to pay for those services that are not covered at all or require copayments. In today’s economy they are in stable relationships with employers, and their employers are providing a non-cash benefit that, for some with personal or family illnesses, will exceed the value of their salary earnings. For those who will not experience catastrophic events, the benefit brings a certain peace of mind from knowing that the protection against potentially devastating health care costs will not bankrupt family finances.

These vocal patients are precisely the people we would anticipate might be able to accept responsibility for the condition of their health. If they are currently healthy, we would anticipate that they would stay healthy. They would use fitness facilities, watch their diets, get flu shots, and take over-the-counter remedies well and in compliance with the label. If they are not in good health, we would anticipate they might be most able to make the behavior changes required to improve it. If they need medicines, we would anticipate that they would be most capable of

following the prescription regimens or guiding their own self-care with advice from the local pharmacist. If they need more services than their insurance plan subsidizes, we would anticipate that they would be willing and able to spend some of their discretionary income on care for themselves. If they feel compassion for those less fortunate, we would anticipate that they would contribute to financing for others who cannot otherwise afford it.

We would expect those who are vocal to be the leaders in their communities. They would most probably be politically active. They would be among those we call the “elites,” as we poll for public opinions. They are the people we would expect to have the best knowledge and understanding of the health care financing systems that are so stressed today. They would be capable of engaging in a dialogue to retrace how these dependencies were created and how relationships can be better structured to preserve the benefits that twenty-first century miracles can bring us.

Amidst their dissatisfaction is an opportunity to engage them, and other Americans—patients, healers, and their communities—in a discussion of how to better achieve what is most desired by everyone in promoting and assuring good health and access to health care. There is an opportunity to grow past the dependencies that are so widespread in our system today and move into the interdependencies on which everyone can thrive and realize their potential. Creating covenants that address both the rights and the responsibilities of the parties involved is one way to do that.

Creating Covenants of Obligation

Even after years of debate, no federal or state patient rights proposal encourages a covenant of obligation in healing among healers, patients, and communities. National patients’ rights debates took a backseat to national security issues and provided health care players with a “cooling off” period for crafting new relationships in the post-terrorism era. Would it be possible to do so? I believe the answer is “yes.”

The evidence is compelling. Increasingly, employers and health plans are responding with programs that assure many of the rights that patients have sought. More now have direct access to specialists and obstetric-gynecologic care, experience fewer referral barriers, and obtain quick external reviews when there are disputes with plans.

Would it be possible now to gain the reciprocal involvement of patients within the covenant? I believe this answer is “yes,” too. Individuals can come to recognize that good health is its own reward and a worthwhile investment. They can come to understand that they themselves benefit much more from good health than their employers, payers, HMOs, and governments ever will. They can continue to struggle for more patient rights, care, and financing, but they can also recognize that with those rights must come the reciprocity of responsibility.

And what of communities? Can they be engaged? Again, I believe “yes.” Communities, likewise, can continue to demand more miracles in medicine, but they can also recognize the value of public health systems and fund them. Communities can work to improve public safety, prevent disease, and not shift the burden of illness to the healers in clinical practice. The nation

can continue to expect efficiency and effectiveness from its healers, but it should balance any demands with expectations that people will accept their responsibilities as well. This will be possible if individuals, communities, and the nation will reconsider their covenants in health care, moving from the current covenant of grant and into covenants of obligation in healing.

Immunization for influenza provides one example of how a covenant of obligation among the three parties might work. Healers have a number of responsibilities. Public health officials are the healers who monitor the nature of the influenza strains, predict their occurrence in the country, define the vaccine cocktail, and encourage widespread immunization. Vaccine company healers are the ones who produce the vaccines, seek regulatory approval to market them, and ship them to immunization sites. Clinicians and other healers (including employers in some cases) provide immunizations to those who need them. Individuals have a number of responsibilities as well. They should seek the vaccines and, I believe, pay for them if they are employed. The vaccine is reasonably priced, and even with administration fees is rarely more costly than a few soft drinks. It is a worthwhile investment in personal and family health, and it is one way to prevent not only suffering from the disease, but transmission to others—including those we encounter in our work lives. Preventing disease in the workplace is a personal responsibility that translates into health expenditure savings for the employer, and this benefits all employees and shareholders of the company. The community should be responsible for making the vaccine available through public health clinics for those too poor to afford to pay through public health funding.

Those who fail to uphold their responsibilities should be accountable, and in recent years, it has been the individual who has been most subject to that criticism. Too many people have chosen not to receive influenza immunizations. One employer in Kentucky has developed a method for encouraging immunization. The company provides influenza vaccine at no charge to employees. Those who receive the vaccine and become ill with influenza during that year's season are given paid sick leave. Those who refuse immunizations are not given paid sick leave if they become ill. A managed care organization might consider something similar—offering reimbursement for antiviral products for influenza disease only for those enrollees who have been immunized.

Covenants of obligation should build on the existing covenants of grant and call for change in a number of areas. As in the case of any covenant, only the parties to it can adequately define its terms; only healers, patients, and their communities will be able to specify what they expect from each other and how they will agree to abide within the covenant relationships they will establish. It would be presumptuous to offer more than a directional paradigm here, but some items are clear and are called for implicitly within the dissatisfactions expressed by patients, healers, and communities today.

A covenant of obligation, with its rights and responsibilities, would address each of the players—the healer, the individual patient, and the community—and their mutual, interlocking relationships. A covenant would recognize that the health of the individual is dependent on the behavior of the individual patient, the healer, and the community. Likewise, the success of a healer's practice depends on the individual patient, the healer, and the community. The health of the community depends on behaviors of the individual patient, the healer, and the community.

For example, a person will remain healthy to the degree that he practices prevention, has access to quality care, takes the advice of the healer, and lives in a community that provides safe water and streets. A healer's practice will yield successful results to the degree that the healer maintains a level of skill, has patients who follow medical advice, and practices within a community that provides financing for patient care—whether through employers or with public funds for those who cannot otherwise afford to pay. A community's health will be assured to the degree that patients follow good health practices, healers use peer review to monitor the quality of the care rendered, and the community invests in prevention and public health measures.

Other aspects of these interdependent relationships will lead to the health that the patient, the healers, and the community strive for, but those can only be determined if all the parties work collaboratively to make the choices about their mutual responsibilities to the others.

- ***Patient responsibilities.*** Each individual might assess their personal health practices and determine where they can make changes to improve the quality of their own health and life. Each of us, no doubt, can list any number of dietary, exercise, and risk-reducing practices that would prevent disease, reduce health care costs, and add years of enjoyment to our lives. Increasingly, there are health care, employer, Internet, and community resources available to help us make those changes. Patients can take personal steps to get the information they need—it is widely available today—and they can take the steps to change their behavior. In addition, each individual should assess the personal, family, and social problems they face in today's world. They cannot unilaterally resolve the problems that may contribute to their diseases and drive their need for health care resources, but each individual and family can make inroads toward improving the quality of their lives and their health. They can become politically active in creating community change to address the social problems that threaten their health and safety and drive health care costs. Patients can reconsider how to balance their expectations of healers with their own responsibilities for health. Patients might thoughtfully examine whether they expect the skill of their healers to compensate for the lifestyle risks that cause disease and disability. Patients might actively seek healers who will encourage interdependence in the healing encounter.
- ***Healer responsibilities.*** For their part, healers might now draw on the vast public health literature, with its information on how to prevent illness and improve health, and engage patients, employers, and community policymakers in a discussion of how to better address the patients' responsibilities. Healers might challenge why, wittingly or not, national policy has played into the current dependency dynamics, creating cost-quality access tensions that are impossible to resolve. Healers might question why patient rights bills are silent on the matter of patient responsibilities. Healers negotiating contracts with health payers might assure that the plans are written to make patients more responsible for the lifestyle that creates illness and drives medical expenditures.
- ***Community responsibilities.*** Communities must reconsider the nature of the public health and social infrastructure that supports the health of individual citizens and the

community at large. There is some evidence that many communities are beginning to do just that. More should. Communities might find the way to support public health programs, educate legislators and public administrators and improve funding, even in the absence of “crises.” Communities might assure that public health programs are not de-funded when they are successful. Communities might resolve the social issues that drive health care costs, exploring the role of schools, families, businesses, law enforcement, and churches in working to reduce the factors that drive healing costs.

- ***Policy maker responsibilities.*** Policymakers and legislators might consider the dynamics of addressing issues this complex in political settings. The national and state governments that shepherd decisions on questions like these—if they are posed at all, and they rarely are—are geared to giving constituent voters the most for the least tax dollars. As a result, when the questions are posed, the answers yield not a balance among tradeoffs, but new benefits. Policymakers might search for other settings, off the “Hill” of politics that can more successfully resolve the tensions in health care today. If there are none, if politics is too intractable a venue, they might explore how politicians can avoid further entrenching the dysfunctional policies that promote today’s dependencies and remove responsibility from patients and communities. Legislators might call a moratorium on mandated benefits until those mandates are coupled with patient and community responsibilities. Legislators might balance the responsibilities of managed care with rights for those organizations. They might, for example, allow managed care organizations to hold communities responsible for a portion of costs incurred for care when a public health failure results in widespread disease.

Can we bring a set of rights and responsibilities back into balance? Can we shift our expectations from one of total dependency on our healers to interdependency with them to assure the best in access, quality, and cost for everyone? The answer to these questions is yes, but only if we succeed in creating something new in society’s healing enterprise—a true covenant of obligation in which the relationships offer rights, but require responsibilities. This will require a level of reciprocity among patients, healers, and communities. For patients this will mean embracing a new way of living and accepting responsibility for their health. For healers, it will mean shedding the parental role, and some of the power and prestige that goes with it. For communities it will mean entering into new ventures of health and healing. For everyone it will mean creating, for the first time in American health care, a truly new covenant in healing.

¹ This appeared originally in 2001 in *Covenants: Inspiring the Soul of Healing*. Readers interested in exploring covenants in greater depth can find background in *The Origins of Healing as Divine Gift* and *History and Modern Applications of Covenant Healing Traditions* which appear in this series.

In summary, healing traditions are based on ancient views that healing skill came from the divine. Healers were aligned with divine forces against the terrible, unknowable and sometimes evil forces of illness. As a result, healer-patient relationships were structured as covenants. Covenants differ from contracts. Contracts have a defined beginning and end and specify the duties of the parties in detail. Covenants do not end and do not detail the duties of the parties.

There are two types of covenants, both are relevant in health care and are expressed in oaths taken by clinicians and others in health care. The first type – a covenant of *grant* – defines what one party does for another, without conditions or expectations. Parents have covenants of this type with their children, providing them food, shelter, clothing and protection. The second type – a covenant of *obligation* – involves mutual promises between the parties. Spouses enter into this type of covenant ‘...for better or for worse.’

The *Oath of Hippocrates*, a classic covenant statement, contains both types. It creates a covenant of *obligation* with other healers, calling for the oath-taker to “...study, learn and teach my fellows...and to treat his sons as my sons.” Then, the oath “...grants health...” to the patient. The *Prayer of Maimonides*, an oath created later, contains the same covenant of *obligation* among healers and calls patients into a covenant of *obligation* as well, asking that patients follow medical advice, take prescriptions and avoid the advice of meddling friends and relatives uninformed about health and disease.

The book suggests that everyone in health care – not just clinical experts but those in any role in research, management, insurance, health reporting and even policy – are the sophisticated extension of ancient tribal healers. Our societies are more complex, as is our knowledge, our data and information, our technology and our systems of providing care. As a result, as healers we have entered healing streams of an ancient origin. Our patients and communities expect us to ascribe to these covenant values.

In my view – and I am not alone in this – health required the integral relationship among healers, patients and communities. I therefore proposed three steps to transform health: first, a covenant of obligation among all healers, as I broadly defined them; second, a covenant of obligation with patients; and third, a covenant of obligation with communities, as well.

This is an application of those ideas to the policy issues addressed here.

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³ A.D. Speigel, “Hammurabi’s managed health care: Circa 1700 BC,” *Managed Care*, May, 1997. Available at <http://www.manageD.C.aremag.com/archiveMC/9705/9705.hammurabi.shtml>. Accessed November 29, 1998.

⁴ Institute of Medicine, Committee on Quality of Health in America, *To Err Is Human: Building a Safer Health System*, National Academy Press, Washington, D.C., 2000.

⁵ George Lundberg, *Severed Trust: Why American Medicine Hasn’t Been Fixed*, New York: Basic Books, 2000.

⁶ Rates of noncompliance for epilepsy range from 30%-50% [I.E. Leppik, “How to get patients with epilepsy to take their medication: The problem of noncompliance,” *Postgrad Med*, 1990, 88:253-256]; for arthritis from 55%-71% [W. van Elmeren and B. Horisberger, eds., *Socioeconomic Evaluation of Drug Therapy*, New York: Springer-Verlag, 1998]; for hypertension to 40% [L.T. Clark, “Improving compliance and increasing control of hypertension: Needs of special hypertensive population,” *Amer Heart J*, 1991:664-669]; and for diabetes from 40%-50% [M. Nagasawa, M.C. Smith and J.H. Barnes, “Meta-analysis of correlates of diabetes patients’ compliance with prescribed medications,” *The Diabetes Educator*, 1989, 16(3):192-200]. Even organ transplant patients, for whom medications prevent organ rejection and death, have noncompliance rates of near 20% [M. Rovelli, D. Palmeri, F. Vossler, S. Bartus, D. Hull and R. Schweitzer, “Noncompliance in organ transplant recipients,” *Transplantation Proceedings*, 1989; 21:833-834]. The cost in terms of additional doctor visits is high. Excess hospital admissions are placed at \$25 billion per year, nursing home admissions at \$5 billion and lost productivity in the workplace at \$50 billion [Task Force for Compliance, “Noncompliance with Medications: An Economic Tragedy with Important Implications for Health Care Reform,” November, 1993, revised April, 1994. For further information, contact John Hawks, Task Force Executive Director, 2300 N. Charles Street, Suite 200, Baltimore, MD 21218, phone: 410-467-1100]. Even in an aggressive intervention program using pharmacists to improve compliance for lipid-lowering agents, the compliance rates rose only to 84%. That increase is better than most programs, but it is still not good enough if we are to achieve the cost-management goals that the public and payers have set for health care [B.M. Blum, J.M. McKenney, M.J. Cziraky and R.K. Elswick “Interim report for Project ImPACT: Hyperlipidemia,” *J Amer Pharm Assoc*, 38(5):529-534].

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