

Healing Pathways Foundation, inc

A Non-Profit Corporation

Clarifying Concepts and Considerations for Health Care Reform

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CLARIFYING CONCEPTS AND CONSIDERATIONS FOR HEALTH CARE REFORM

A. Understanding The Problem

It is no secret that the number of uninsured individuals as well as the cost of medical services has reached crisis levels. The issue is not limited to any one segment of the population, whether attorneys, doctors, HMO's, hospitals, or insurance companies. This crisis cannot be solved by pointing a finger.

Health care has become a societal issue entailing the balancing of various interests. There are not enough dollars to meet everyone's expectations. The focus of health care reform cannot be on only one segment. The country has provided an environment where the focus can be on improving the affordability and availability of the health care delivery systems and on the quality of health care. The public is demanding a social standard.

We need to identify problems as well as possible solutions relating to the continuing health care crisis. However, to do so, we must weigh and balance the interests of all involved against the overall needs of our society and the needs of its injured citizens.

B. Interests And Conflicts

One caveat must be noted at the beginning. Statistics quoted in this article are merely to show the diversity in argument and to not support a particular position. As with any statistics, there are always others to contradict them.

1. The Attorneys

Many blame trial attorneys for the health care crisis. There have been a large number of lawsuits with high compensatory and punitive damages. Many contend that a material part of the medical coverage cost escalation is due to the cost of defending claims. In Florida, 32 cents of every premium dollar paid was spent on defense cost and containment before major tort reform.⁽¹⁾ After tort reform, this figure dropped to 19.3 cents.⁽²⁾

Others suggest that the major factor driving up malpractice premiums is the impact of a few cases resulting in gigantic jury awards. Median jury awards more than doubled from \$475,000 in 1996 to \$1 million in 2000.⁽³⁾ and to \$1.2 million in 2003.⁽⁴⁾ According to a 2002 article, the average paid medical malpractice claim in 1999 was approximately \$30,000.⁽⁵⁾ However, this does not take into consideration the average cost of defending a claim which could be another \$40,000.⁽⁶⁾

Medical malpractice is expensive litigation. Attorneys usually spend a great deal of time and substantial up front out-of-pocket costs in bringing matters to trial. Attorneys take the chance of no recovery. Lawsuits may force defensive medicine, but they also encourage health care practitioners to be more careful.⁽⁷⁾ Some argue the problem is being overstated and is not really an attorney problem. For example, a 2003 report by the Public Citizen, a nonpartisan, nonprofit watchdog organization, concluded: (i) malpractice insurance costs amount to only 3.2 percent of the average physician's revenues⁽⁸⁾; (ii) plaintiffs drop ten times more claims than they pursue⁽⁹⁾ . . . (and) the small number of claims pursued to a defense verdict are not 'frivolous'⁽¹⁰⁾; (iii) studies conducted in California, Florida, North Carolina, New York, and Ohio have found that jury verdicts bear a reasonable relationship to the severity of the harm suffered.⁽¹¹⁾ In Florida in 2004, death was the leading category for settled malpractice claims which accounted for nearly one third of all claims.⁽¹²⁾

The public's perception that doctors, hospitals, or their insurance companies are the mother lode is not helping either. This pervasive attitude serves the overall public poorly. According to a 2003 Texas Public Policy Foundation report, before tort reform almost 50 percent of all doctors in Texas had a malpractice claim filed against them.⁽¹³⁾ Does that really translate into 50 percent of Texas doctors being guilty of malpractice? According to the report, nine out of ten of those claims were dismissed as unfounded, but the cost of defending those claims still remained.

Another study reported that 57 percent to 70 percent of malpractice claims resulted in no payment to the patient.⁽¹⁴⁾ This clearly indicates that many lawsuits

are frivolous or unfounded. While the cost of defending these suits may increase health care costs, the high payments for the damages may be less relevant. There must be a rational basis for a lawsuit.

It has been claimed that Texas tort reforms resulted in substantial improvements including a decrease in the number of claims which reached a historic low.⁽¹⁵⁾ Additionally, medical liability insurance companies have made 15 rate cuts for an accumulative 20 percent decrease in rates. The number of carriers in the marketplace has increased materially along with the number of physician license requests.⁽¹⁶⁾ There is also evidence that the overall supply of physicians increases when malpractice reforms are introduced which reduces the size of awards (e.g., caps on damages).⁽¹⁷⁾

2. The Doctors

It takes years to become a doctor. Medical professionals spend many years in both education and training. Doctors are entitled to receive a reasonable return on their investment. If professionals are not paid according to their knowledge and education, then very few have the desire to enter the field. Professionals should be encouraged to dedicate themselves to the higher purpose for which they were trained. However, doctors are often forced to err either on the side of cost effectiveness to placate insurance companies or to the side of legal standards to prevent lawsuits.

When we asked a doctor for his assessment of the future, he was very optimistic. He said, "Things are so bad in the health care industry they couldn't get any worse. They have no place to go but up."

Underlying the health care crisis is the fact that malpractice does exist. *The Journal of the American Medical Association* reported that an Institute of Medicine study in 1999 which indicated that as many as 98,000 people died annually as the result of medical errors may have been materially understated.⁽¹⁸⁾ A more recent study cited in a 2004 article reflects 191,000 deaths to be preventable.⁽¹⁹⁾ Yet, another article quoting a survey by the Harvard School of Public Health reported "35 percent of physicians said that a member of their family had experienced a medical error which had created a serious medical complication."⁽²⁰⁾ A 1990 Harvard Study, only one in 7.6 medical errors in hospitals turn up as a malpractice claim.⁽²¹⁾ A more current Florida statistic would support this finding, albeit at one out of six.⁽²²⁾ Commentators have long lamented the phenomenon of 'lawsuit lottery' which results in windfalls for some patients but no compensation for the vast majority of patients injured by medical care.⁽²³⁾

Even with the new tort reforms, doctors are still practicing to a legal standard versus a medical one. A doctor must think of potential malpractice exposure in determining the tests to be conducted and the treatment protocols to be followed. If the doctor does not cover himself by doing so, the doctor may be subject to a lawsuit. This legal standard increases the cost of health care insurance which then becomes responsible for paying for unnecessary tests and procedures.

Another study found malpractice reforms reducing provider liability can lead to reductions of 5 percent to 9 percent in medical expenditures without affecting the quality of care. The study concluded that liability reforms can reduce defensive medical practices.⁽²⁴⁾

There is also a problem in defining medical standards which are moving targets and changing constantly. Although, the new standard may be a good idea in that it assists in early detection, it may also create a quandary for doctors on how to meet the new medical standard which may entail putting patients on several additional medications even if the side effects from the additional medications may not be in the patient's best interest. If the doctor does not prescribe the additional medication, the doctor may be open to a lawsuit. The bottom line is that doctors still must practice to a legal standard.

Florida's Three Strikes and You Are Out Constitutional Amendment⁽²⁵⁾ for doctors reflects concern over the inability of the medical profession to police itself. Although the medical profession is capable of policing itself, there is a major deterrent in doing so due to litigation exposure. Risk management dictates it is not worth the time of hospitals, medical facilities, or doctors in becoming involved with these matters. Almost always, they find themselves embroiled in litigation; and, although they may ultimately prevail, the cost of making the disclosure or becoming involved is detrimental to business.

3. The Hospitals

In 2004, close to 50 percent of Florida malpractice claims came from hospital inpatient facilities which, together with physician's offices and emergency rooms, comprised nearly two-thirds of all malpractice claims.⁽²⁶⁾ Doctors and hospitals have a responsibility to implement systems to tighten internal controls which will minimize negligence. Proper hospital staffing has a direct correlation to medical errors. In 2002, a survey by the Florida Hospital Association noted a position vacancy rate of 12.5 percent or one out of eight nursing positions not filled.⁽²⁷⁾ In February of 2004, 8.2 percent of registered nursing positions in Florida hospitals were vacant.⁽²⁸⁾ Although a meaningful reduction, it is still inadequate to address the needs of many hospitals.

Nurses are concerned about being brought into malpractice suits themselves.⁽²⁹⁾ Due to the shortage, nurses are being asked to cover areas not within their routine department. Minimizing doctor and nurse fatigue along with computerized medical records and prescriptions are areas which can assist in decreasing medical errors. It is well established that certain hospitals have better results for certain types of surgeries.

In certain areas, the cost of medical insurance is forcing doctors and medical facilities to cut back on services. Some doctors (and even hospitals) are closing their doors or leaving the state to find more physician friendly forums. This is especially the case in many rural areas.

If states could identify these areas along with medical facilities where medical services are in dire need, a solution to this problem may be found. Some type of immunity could be granted to doctors or facilities providing services in these areas. Counties (and even municipalities) could petition for immunity which could be granted for a specific period of time. Likewise, specialty areas where availability is diminishing due to the cost of malpractice insurance could be given safe harbor. The alternative is not enough doctors to provide meaningful coverage of these areas.⁽³⁰⁾

According to the Institute of Medicine, it is system failures that result in most injuries rather than bad doctors.⁽³¹⁾ Improving sanitizing systems to prevent infection, surgical procedure identification, or medication disbursement are systems capable of improvement. Health practitioners at the ground level are driving these changes not so much in response to mandates, but to their own underlying desire to improve the quality of care for their patients.⁽³²⁾

Hospitals are in a constant battle to negotiate with the HMO's and PPO's for a cap on the fees for their services. Hospitals are also in crisis. They may not be compensated for services rendered to those who cannot afford their services. When they are compensated, the amounts are not sufficient to cover operating costs. Uninsured individuals cause hospitals to absorb additional costs of health care. This is not a correct allocation of dollars or responsibility. This segment of the population is more likely to sue for malpractice; although they may not have followed instructions, did not understand the treatment protocol, or could not afford the next step of medical care due to the lack of insurance.

4. HMO'S and PPO'S

Certainly, HMO's and PPO's have played a critical role in endeavoring to make health care insurance affordable, and they should be applauded for their efforts.

However, the model is not working effectively because of spiraling medical costs.

Under the current system, an arbitraging is taking place with medical insurance providers such as HMO's and PPO's rationing medical services. Although these systems are major recipients of the monetary return, they are switching the financial and legal burden to doctors and hospitals. Since they are managing the care by rationing medical treatment, should they not have the direct responsibility when these treatments do not pick up potential illnesses which early detection could have cured or minimized?

Many PPO's and HMO's do not cover preventive expenses. The result is a tremendous cost later on as well as a negative impact in treating illnesses. Due to this form of health care, doctors as well as nurses are working harder, making less money, and incurring more liability. Since these provider organizations are rationing care, they dictate to physicians which tests can or cannot be performed. The ultimate effect is that the patient is short changed in terms of how health care dollars are being spent along with addressing the overall health issues.

The volume approach created by HMO's and PPO's has also negatively impacted the quality of care. Doctors are placed under stress to evaluate more patients in less time in order to meet salary draw requirements. Less attention to the patient correlates to a greater possibility that something will be missed. Often, these programs result in the utilization of a multitude of doctors who are sometimes uncoordinated. This is especially the case when a patient's physician does not have privileges at the treating hospital. This only precipitates mistakes as well as increasing costs whether in treatment, misdiagnosis, conflicting prescriptions, or inappropriate drug therapies.

5. Insurance Companies

We need to look at the bigger picture. A 1994 study by the Council of Economic Advisors estimated that malpractice premiums constituted one percent of total health care expenditures. Given current spending levels, this amounts to \$14 billion annually.⁽³³⁾

In a 2002 report, the government stated that high levels of investment income kept malpractice premium rates lower in the 1990's.⁽³⁴⁾ In a 2003 report, the government noted that bad investments by insurance companies did not cause the current crisis.⁽³⁵⁾ The government does not say the problem is due to insurance cycles.⁽³⁶⁾ All of these statements have a degree of truth; however, maybe not enough weight was placed on these problems. High rates of investment do play an integral part of pricing risk. In many situations during the 1990's when investment income was high, it did not matter that some lines were experiencing

combined loss ratios of over 100 percent. In other words, it did not matter that claims (and acquisition costs) exceeded the premium charged for such lines. The shortfall was made up by investment income. After 9/11 when reinsurers left the market coupled with low investment returns, insurance programs had to stand on their own merits.

We are all beneficiaries of favorable investment returns to insurance companies. These cycles materially impact pricing and availability of coverages.⁽³⁷⁾ Insurance is only intended to take some of the risk out of a given exposure and is actuarially determined. Actual experience dictates rate adjustment. When rates are inadequate and cannot be raised to cover the risk, insurers leave the market. Insurers are not going to decrease their rates until actuarial experience and/or a declining market share indicates it is prudent and/or necessary to do so.

Even with tort reform, insurance companies will endeavor to recover prior year losses by maintaining (or even increasing) rates. However, this is the nature of the insurance industry and is not necessarily unreasonable. One analysis of the annual statements filed by the largest medical malpractice insurers in the United States would support this industry characteristic. Over a five year period ending December 31, 2004, a report noted regarding malpractice carriers: (i) premiums doubled while claim payouts remained essentially flat⁽³⁸⁾; (ii) some insurers increased their premiums even though their actual and projected claim payments were decreasing⁽³⁹⁾; (iii) twelve insurers who only wrote medical practice insurance actually increased their surplus by an average of more than 34 percent between 2002 and 2004.⁽⁴⁰⁾

Insurance and federal government reimbursement structures also need to be revisited. Practices should encourage safety improvement and not reward less safe practices. This anomaly was noted in a 2005 article in the *Journal of American Medical Association*: "In health care, perversely, under most forms of payment, health care professionals receive a premium for a defective product; physicians and hospitals can bill for additional services that are needed when patients are injured through their mistakes."⁽⁴¹⁾ One study by HealthGrades, a research firm, noted that 1.12 million Medicare patients were affected by errors in 41 million hospitalizations between 2004 and 2005.⁽⁴²⁾ These incidents cost taxpayers close to \$9 billion.⁽⁴³⁾ Attempts have been made to rectify this situation. Beginning on October 1, 2008, Medicare and Medicaid will not pay for mistakes that should not have happened (i.e., wrong procedure on wrong patient, wrong body part, performing the wrong procedure, or leaving items inside a patient's body.⁽⁴⁴⁾ Medical insurers such as WellPoint and Cigna said they will follow this same policy.⁽⁴⁵⁾ However, insurance companies also must share in the responsibility for medical errors. Hospital stays have been shortened based upon the reimbursement rates of HMO's and PPO's. When a problem arises due to the early discharge of a patient, who should be responsible: the doctor who wanted the patient to remain longer under supervised care or the insurance company who dictated an accelerated discharge? This is an interesting concept in that it now

makes hospitals and insurance companies more proactive to disclose better hospitals. The question is whether they will make the information readily available to the public. But, if Medicare, Medicaid, or the health insurer won't pay, it is up to the patient to negotiate with the hospital. This can cause delay, and, in many scenarios, can have serious, if not fatal consequences.

6. The Drug Companies

Drug companies are encouraged to use a palliative form versus a curative form for drugs. It is more profitable to have a patient take drugs for years rather than curing an ailment. Incentives need to be included in the process so drug companies will look for cures versus palliative products.

Major research is done at the university level. If the government funds this type of research, the findings and results should not be sold to corporations for profit or licensed by a university. If public funding is used, the results should be tied to a requirement that the product will not be overpriced or that the patent should be made available to the general public. Restrictions could be placed on the duration of unused patents. Many large companies purchase competitive patents with their product encouraging monopolies which are anticompetitive.

Pharmaceutical companies also drive medical standards which need to be reviewed and weighed against a community standard. A medical procedure must be available to the public for cure and not only for chronic care. If caught early, there are a number of illnesses that could be treated effectively with medication. These medications need to be made readily available to the American public.

7. Where to Start

The United States public is demanding that health care be addressed. The AARP has played a continuing and critical role in creating public awareness of how all citizens can favorably impact the government's decisions. We, as citizens, need to decide what type of health care is appropriate. As a society, we need to set the norms as to what is acceptable in light of where we derive the most benefit. All stakeholders need to be involved in this discussion.

C. A New Model

What is the proper role of government in this health care arena? Some say government involvement is the problem, and their role should be minimized in order to let the market adjust itself.⁽⁴⁶⁾ Government may not be the most efficient vehicle to supervise health care services; however, it is key to putting together a comprehensive health care package. Government plays a major role in allocating funds for health care which impacts the availability of health care services as well as controlling the cost of health care. In 2008, the United States spent approximately \$2.4 trillion dollars on healthcare. There are sufficient dollars for health care; however, the problem is how the funds are being allocated. How can the dollars be allocated more effectively? There are obvious answers that can have a material impact upon reducing the necessity and cost of treatment.

The distribution of funds could be based upon outcomes and priorities. Allocation of dollars is not a new concept. Oregon once developed a model on this premise which combined state and federal participation. Valuable information is contained in this model which could assist in developing future models. Local community standards regarding abortion and contraception spelled the death of Oregon's plan. However, its initial premise was sound. By eliminating the controversial elements of the plan, perhaps, it could be reconstituted.

Government and insurance companies could be effective in supplying data to serve as a basis for allocating tax dollars which is very different from managing health care. Government needs to take the lead in unifying health care which could be done in a number of ways. Perhaps, there is another standard to be developed (i.e., social or community standards). The focus would be in allocating dollars on the basis of what is most effective in maintaining the overall health of the public.

A balance must be met when enacting new regulations. Policies serving society must be weighed with the interest of other stakeholders. Unless a benefit is given to a material stakeholder, it will not produce new or competitive measures. For every restriction placed, an incentive needs to be offered to those having a stake besides the public.

A productive use of funds needs to be established. Red tape needs to be decreased. A level playing field with our international partners needs to be agreed upon. If markets are restrictive, the United States needs to withdraw its market. Industry standards need to be developed for a sound financial base for the middle class.

1. Tort Reforms

Government estimates with the adoption of certain tort limitations, it would save from \$70 billion to \$126 billion in actual health care costs annually.⁽⁴⁷⁾ This is not an insignificant number. This seems to be supported by the results in those states who implemented extensive tort reforms which favorably impacted the health care market.

In 1992, Minnesota passed legislation providing doctors an absolute defense against medical malpractice when they adhered to practice parameters. In addition, the legislation provided that "non-compliance to practice parameters may not be used as a basis for a cause of action."⁽⁴⁸⁾ This type of legislation attempts to change the focus from a legal standard to a medical one and should be further refined with experience.

Better communication within the medical community itself is critical to pinpoint areas needing correction. However, the medical community is fearful of lawsuits as a result of this disclosure. Fla. Stat. Sect. 766.101 encourages this type of review by hospital medical committees and grants immunity for such reviews as well as precluding discovery and attendance at civil actions.

Taking this a step further, open discussion between doctors, nurses, hospitals, and other health care professionals would assist in developing a better health care system. There could be some type of forum which would have immunity so problem areas and possible answers could be shared without concern that such activities would be subject to discovery or serve as proof of malpractice. In 2003, a government report cited this as one of two reforms which would have a major impact on improving the health care system.⁽⁴⁹⁾

New litigation practices could be implemented to streamline the overall process. Before filing a lawsuit, mediation could be required. After suit is instituted, Florida once had a panel comprised of an attorney, a judge, and a doctor to hear a short form version of the case. The panel would rule. It was not binding upon either party; however, the ruling was admissible in court. This procedure was held unconstitutional but was effective in eliminating frivolous lawsuits. This format could be reviewed and an attempt made to eliminate the parts violating the constitution. Many other states have instituted some format for such pretrial screening panels. Alaska, Delaware, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, and Virginia are a few states upholding the constitutionality of pretrial screening and/or admissibility of the result at trial.⁽⁵⁰⁾

Another option would be to have specific standards for malpractice actions. A special court structure for all negligence cases might be considered. If there was a

special court section with specific criteria needing to be met for these types of cases, this may discourage frivolous or fraudulent lawsuits from being filed. Alternatively, since medical malpractice cases have become so technical in many cases, perhaps, they could be decided only by a judge and not by a jury. Naturally, there would be some constitutional hurdles to do so.

The pivotal planning issue is to bring back the practice of medicine to a medical standard and not to a legal one while still protecting the patient from mistakes.

2. Vaccinations

The government needs to implement strong programs for the prevention of diseases. Vaccines are among our most important and cost-effective medical interventions, preventing disease in those who receive them and reducing the spread and risk of infections through communities.⁽⁵¹⁾ The first area for a community standard is to make certain everyone is given the appropriate vaccinations. The World Health Organization estimates that two million child deaths were prevented by vaccinations in 2003.⁽⁵²⁾ The cost of not being vaccinated and dealing with the treatment of diseases far exceeds the cost of preventing them. This could be shown statistically with data.

Insurance companies can assist in providing actuarial data. A vaccination surcharge could be included in every medical policy. The federal government could negotiate a discounted price for such vaccines.

Vaccine manufacturers need to be motivated by prizes, tax credits, or advanced market commitments to develop new vaccines.⁽⁵³⁾ They also may need immunity or partial immunity to minimize lawsuits regarding governmental recommended vaccinations.

3. Screenings

Another area falling under a community standard is in doing certain screenings. Preventive services often compete with one another and with diagnostic and treatment oriented care for increasingly constrained resources. While preventive services are often believed to save costs, delivery of most preventive services, with few exceptions (e.g., some immunizations) incurs net costs.⁽⁵⁴⁾ Many health care providers will not pay for certain types of screenings since they are preventive in nature. Health care companies are often nervous if they do screenings because they may need to spend additional dollars in addressing problems discovered as a result of the screenings. If they do not provide the

screenings, the problem may not appear for many years, and, perhaps, they will not be providing health care coverage when the problem arises. It has been shown that if patients are forced to pay even a small amount of out-of-pocket costs, it deters them from having the recommended screening done.⁽⁵⁵⁾

Early detection should not wait until later years but should be addressed as young adults. Autopsies during the Korean War found that there was a great deal of coronary disease in twenty year olds. Accordingly, we cannot wait for problems to compound. Again, there is a need for education to be supported by the government. The answer to coronary disease should not be bypass but should be prevention. This applies to any disease to a major organ which is preventable by changes in nutrition, early screening, or treatment as determined by a community standard.

Again, data needs to be reviewed and analyzed to determine this relationship. When you compare the cost of screening for these diseases compared to the impact on the patient, the cost of dealing with these diseases in the future is significant.

Statistically, it can be shown that screenings are effective ways of minimizing treatment costs and are more effective in treating the potential illnesses. There is not only a cost benefit but there is also a real health benefit. The community standard may warrant allocating dollars to screenings to prevent diseases. A prime example of this is colorectal cancer (“CRC”), the second leading cause of cancer deaths in the United States. Most of the deaths because of this cancer are preventable because if CRC is detected early and treated appropriately, it is curable nine times out of ten. Yet, many health insurance plans don't cover CRC screening. Screening for CRC would not only save lives, it would save money. The cost for treating CRC is huge, maybe as high as \$11 billion per year for the 150,000 patients diagnosed with this type of cancer every year.⁽⁵⁶⁾ Similar benefits can be derived by screenings for breast and uterine cancers.

How do we encourage insurance companies to take the lead? Once again, perhaps, a surcharge should be included on each medical policy for such screenings. Government could negotiate with the screening vendors for these services.

However, this does not deal with the problem of what screenings may uncover. One alternative could be setting up an insurance bank where a certain portion of the premium from all medical policies could be paid into a fund. For example, a certain percentage of premiums could be paid into a fund to address treatment often necessary after screening. Treatment identified early can have favorable results. In this way, the health insurance company is not being penalized for doing screenings. This is a type of reinsurance. If the screening indicates a problem, the insurance fund would pay. Another variation is to simply keep the exposure to a set amount, and then have the government pay the balance.

With such a format, the health insurance company would be encouraging screenings; however, their exposure would be capped. This may be a more effective way of promoting detection procedures which could have a material impact on an individual's health. By detecting diseases early, the cost of treating them would be decreased substantially and could be the incentive for insurance companies to do screenings. The cap on reinsurance would be determined statistically. Eventually actuarially, the amount of claims made against the trust will be diminished because the illness will be detected at an early stage so the cost of treating it will be less than treating the illness once it has progressed to a serious stage.

If the risk is taken out for the health care company, we would encourage a scenario where the patient is being screened for the most probable illnesses which can create critical care needs but are preventable by early detection. Society needs to deem the areas in which the dollars are spent for such screenings and preventative practices.

Barriers other than financial and availability to screening also need to be identified and addressed. These include, but are not limited to, lack of patient education and motivation, physician forgetfulness, acute care visits, lack of time, lack of reminder systems, or test tracking systems.⁽⁵⁷⁾

4. Tobacco and Alcohol

The relationship between tobacco and various diseases has been proven. We do not believe in legislating against cigarettes. However, the marketing of cigarettes to new generations, especially to young teenagers, needs to be addressed very carefully. The amount of money being spent on treating lung cancer attributable to smoking should raise a flag. A substantial health tax should be imposed upon alcohol and cigarettes. The tax would be levied on gross sales of the manufacturer whether or not the company is profitable. One commentator noted that the Congressional Budget Office reported that raising the tax by \$1 per pack could generate over \$95 billion from 2009 to 2018.⁽⁵⁸⁾ The tax on tobacco and alcohol products should be increased materially not only as a disincentive but to also place the majority of the health care burden resulting on the smoking population.

Again, it is a question of priority in allocating dollars where they will be most effectively used. More dollars could be directed towards programs to quit smoking. According to a 2005 report by the CDC, a total of 38 (75%) state Medicaid programs reported offering coverage for at least one form of tobacco-dependence treatment (i.e., medication or counseling) for all Medicaid beneficiaries.⁽⁵⁹⁾ According to an article in one professional addiction magazine, "...98 percent of the 152 (health insurance) plans surveyed provide full coverage

for at least one type of smoking cessation intervention."⁽⁶⁰⁾ However, in a survey published in *The American Journal of Preventive Medicine* it was reported that smoking cessation aids are under-used across insurance categories.⁽⁶¹⁾ Other ways to step up the level of awareness of the dangers of smoking as well as available treatment programs should also be considered.

5. Weight Control, The Poisoning Of America

Another area which will have a meaningful impact is weight control. We are a society out of control from a weight point of view. Carrying additional weight impacts the overall health of our nation. According to a report by the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, approximately 66 percent of adults are overweight or obese; 16 percent of children and adolescents are overweight, and 34 percent are at risk of becoming overweight. By 2015, 75 percent of adults will be overweight or obese.⁽⁶²⁾ The overweight problem is increasingly developing at younger ages. Appropriate education and a change in diets at the school level could have a meaningful impact on the future expense of dealing with health care costs.

Obesity is tied into many serious illnesses such as heart conditions, cancer, and diabetes.⁽⁶³⁾ These can be prevented or minimized with the proper nutritional approaches. These approaches need to start with society recognizing that these are contributing factors. Habits can be changed by instituting more nutritious formats in schools as well as educational programs for children and parents.

A health tax for early testing of diabetes or other screenings could be funded by companies who place excessive amounts of sugar, fructose, refined flour, etc., in their products. Reinsurance out the health tax for the screening or treatment of type two diabetes could be established.

The nutritional value of processed foods is negligible.⁽⁶⁴⁾ Soda as well as most cereals are no more than processed sugar. A commentator reported that if the Congressional Budget Office placed a three cent tax on each 12 ounce sugar sweetened beverage, it would bring in \$50 billion.⁽⁶⁵⁾ A health tax could be imposed upon the manufacturers regarding the production and sales of these products. Corporations should be allowed to distribute their products, and the population should be allowed to purchase them; however, since these products negatively impact society's overall health, a fund needs to be established to address the medical problems created by certain products. A percentage could be charged against the company's gross profit and placed into a fund to address diseases caused by processed foods. For example, the sugar industry could be assessed a percentage of their gross for the illnesses resulting from the intake of too much sugar. Bread companies who use bleached flour could be penalized. Corporations producing sugary treats along with candy manufacturers could also

be surcharged. The same format needs to apply to environmental products impacting our overall health.

The use of insecticides and antibiotics may increase food production; however, the impact on society is damaging. Farmers and companies producing these products need to be assessed a health tax. Their products should be boldly labeled when insecticides or other chemicals are used that can create health problems in the future. Current labeling standards are inadequate to protect the public.

A meaningful dialogue about good nutrition must also address the importance of exercise. We, as a nation, do not get enough exercise. When coupled with poor eating habits with an emphasis on sugar and fat, physical inactivity is a serious problem. According to a report by the Surgeon General, regular physical activity performed on most days reduces the risk of developing or dying from some of the leading causes of illness and death in the United States.⁽⁶⁶⁾ However, due to budgetary constraints many schools have eliminated after school activities. It is easy to say these programs should be reinstated and enhanced but finding a funding source becomes more difficult, especially in light of other societal standards struggling to be funded. Many large corporations have taken the lead and provide time for their workers to exercise. More cost effective avenues for exercise need to be encouraged.

6. Untested Drugs and Complementary Therapies

Drug companies should be given more latitude in bringing products to market sooner. Although appropriate disclaimers are needed, if a person has a terminal medical situation, they should be allowed to use a medicine not approved by the FDA with the understanding that the medicine has not been tested and there are no assurances as to the repercussions. However, drug manufacturers should not be allowed to advertise or solicit purchases of the medicine versus having it available to the medical community. It appears the drug companies are controlling the practice of medicine. It also appears that the AMA is controlling complimentary therapies which are as important as medical treatment.

There are many effective treatments found around the world. Why aren't they being utilized in the United States? For example, hyperthermia treatments (which are non-invasive with minimal side effects) have been proven to reduce the size of tumors and is more effective than different treatment modalities being used. It has been approved by the FPA, and, yet, it is just becoming available on a limited basis in the United States. It is also important to note that these modalities as well as traditional western ones are much cheaper to have done abroad. Many insurance companies will not cover procedures done out of the United States even though they are more cost and medically effective.

7. Education

Who can trigger this new approach? When Katie Couric⁽⁶⁷⁾ did her segment on colon cancer, one doctor noted the "Couric Effect" which was a material increase in colon cancer screenings. The Florida Medical Association does television ads to encourage screenings. Some insurance companies negotiate discounted prices for various screenings and actively promote screenings. Insurance companies could be the communicators in letting the public know the community standard. They could highlight to the public that these are critical areas of care and should be investigated. These early detection and treatment messages should be highly promoted by the government, as well as doctor groups, hospitals, or insurance companies. The American public needs to be educated. These groups and programs are an effective way of reaching the public to let them know there are options for prevention, early detection, or the treatment of disease.

For example in nutrition, education can focus on smaller servings (i.e., not super sizing drinks) and on how products are packaged and labeled. We could force the inclusion of warnings on certain food products. It is amazing the amount of sugar and fat in many products labeled "low fat" or "low sugar". The problem is that labeling is often misleading and most people do not take the time to read the labels nor have they been educated on what to look for.

8. New Testing Standards

On October 28, 2008, The Progressive Policy Institute contended that "\$700 billion is wasted each year on unnecessary tests and procedures that do not improve patient outcome. That wasted money is enough to give over \$15,000 towards care for every one of America's 45.7 million uninsured."⁽⁶⁸⁾

What are the odds of a test showing anything? What are the odds that there will be an effective treatment based upon test findings? A two-tiered standard should be developed as the most efficient means of determining necessary tests. The first would be what the community can afford. If someone wants additional testing over the community standard, they would have to pay for it. It would not be the responsibility of the insurance company.

Secondly, the industry must acknowledge that conducting extensive tests to eliminate certain diseases is not a cost effective way to approach health care. Society needs to set the norm. How should society set the social standards for health care in order to allocate dollars? We know this is not an easy decision. However, this is where statistics supplied by hospitals, insurance companies, and other stakeholders are critical in setting the social standards for healthcare.

This ties into liability not only for the physician but also for the hospital and the insurance company. They will not be required to spend money for unnecessary tests since the percentage of people potentially having a certain problem does not warrant testing. Society cannot afford the cost of ruling out every disease nor is it reasonable to impose that type of liability and responsibility not only on health care companies but also on physicians and hospitals. Naturally, if an individual can afford the tests, there is no need to apply a community standard.

Hospitals are going out of business because a material portion of their budget is being allocated to taking care of the poor. This combined with a discounted price to health care organizations is having a crippling effect on hospitals. This problem is only aggravated when, according to a source, over 50 percent of a hospital's budget is spent on unnecessary treatments.⁽⁶⁹⁾ It is easy to see why hospitals are in crisis. Doctors are given incentives to do unnecessary tests because government programs have put a cap on medical services.⁽⁷⁰⁾ Hospitals should be able to follow a community standard instead of conducting a multitude of tests which are not to a community standard. Multiple tests are also having a crippling effect on the insureds because they are expected to pay the shortfall.

An analysis must be done on how money is being spent in emergency rooms in conducting a myriad of tests which have a small percentage of success in discovering a major problem. Even if a problem is discovered, the prognosis for treating the problem may be poor. What is the point of spending money to find a problem if there is no effective treatment? A patient is subjected to tests where there may be no effective treatment for the problem. It would be better to take the dollars and allocate them to services that can have a meaningful impact on the quality of health care. Once again, the focus needs to be on a social standard and not the legal one.

Emergency rooms are the primary source of care for uninsureds. This increasing reliance of the uninsured on emergency rooms has economic implications as the cost of treating patients is much higher in emergency rooms as compared to other hospital departments or outpatient clinics.⁽⁷¹⁾ We can also give hospitals immunity, or, perhaps, a gross negligence standard for indigent care. Some states have also implemented immunity for doctors and other medical professionals who provide services on a volunteer basis.

9. Physician and Nurse Incentives

A study published in 2002 estimated that there would be shortage of 50,000 physicians by 2010 and 200,000 by 2020.⁽⁷²⁾ However, according to other experts, there is going to be a shortage of 200,000 physicians as early as 2010.⁽⁷³⁾

There are two reasons for the shortage. The first is job satisfaction. Because doctors are being controlled by health care organizations and cannot treat as they would like, job satisfaction is at an all time low. Secondly, the need to see more patients in less time in order to comply with health care contracts and to keep their earnings on a meaningful level is also a contributing factor. Their income is low based upon educational requirements to practice medicine.

One physician explained they offer a commodity which is in high demand. However, they are not being paid well. It cannot be all about money. But, it has to make economic sense. To alleviate the educational burden, some countries, such as Mexico and Brazil, permit high school graduates to go directly into medical school, and there appears to be no loss of quality. Some support a pay for performance physician incentive.⁽⁷⁴⁾ But, these programs, under the current environment, are hard to assess but warrant further study. Another alternative is to permit doctors and/or nurses licensed in another country to practice, subject to passing any examination required for doctors trained in the United States.

There should be an expansion of the use of nurses and nurse practitioners. In Florida, nurses used to handle the administration of intravenous sedation by themselves. Now, this routine procedure is required to be monitored by an anesthesiologist practitioner and supervised by an anesthesiologist who usually stops in briefly to say hello. This double billing scenario is not warranted.

10. Response Rate Versus Outcome

The public needs to be educated that there is a difference between treatments with a favorable response rate versus a favorable outcome. It may be possible to reduce the size of a tumor; however, the outcome may still be that the patient will die. Notwithstanding the eventual outcome, treatment may still be warranted if it extends the patient's life with a degree of quality acceptable to the patient. When talking about allocating dollars, an analysis must be done not only on the response rate but how it correlates to the outcome.

The problem is that many treatments are becoming acceptable standards even though the outcome is questionable. When a treatment becomes standard, any patient not receiving the treatment has a basis for a malpractice claim. Currently, 90 percent of Medicare is spent on the chronic treatment of the elderly.⁽⁷⁵⁾ One solution advocated by many is "evidence based medicine."

Our challenge is to take the right statistics and put them to use for improving health care in the United States. One researcher suggested that by referring ten types of surgical procedures to hospitals with higher success ratios for those types of surgery, 4,000 deaths would be prevented annually.⁽⁷⁶⁾

In an editorial in *The New York Times* in October 2008, Billy Bean, Newt Gingrich and John Kerry observed how crunching numbers has revolutionized American baseball where statistics help put better teams on field for less money. They advocated a similar approach for reforming the overpriced, underperforming health care system of United States.⁽⁷⁷⁾ They call this evidence based medicine and it has already been shown effective in a number of areas.⁽⁷⁸⁾

We are not suggesting that treatment be limited, but that hospitals or doctors can be given incentives based upon the favorable outcome of a procedure. Insurance companies can be an exceptional source of data to help reform the health care system both from a legal and medical perspective. Insurance actuarial data can help pinpoint areas that have a material impact on both malpractice and health care insurance. We need to take advantage of the available data. Insurance companies can also help in providing actuarial data to the public and to the government in identifying effective tests for early diagnosis as well as effective treatment protocols.

11. Right To Die With Dignity

Response versus outcome discussions goes hand-in-hand with the right to die with dignity. Does one have a right to die with dignity? Does one have a right to a quality of life? These are not easy questions especially when interwoven with religious ones. Religious implications and controversies relevant to this issue are beyond the scope of this article and will not be addressed. Suffice it to say that every person is entitled to their personal religious beliefs. However, one does not have the right to impose their personal religious belief on another.

The right to die with dignity is becoming more and more accepted throughout the world. In the United States, an increasing majority of the public supports the right to die.⁽⁷⁹⁾ There seems to be a general consensus that putting an animal to sleep is humane when the animal is in pain; however, this does not apply to humans who are able to make the request themselves. Why is it any less humane to put a human to sleep (at their request), when the person is in pain and terminal? Of course, there is always room for abuse, but appropriate safe guards could be built into the process. Currently, Oregon, Montana, and Washington (although the decision may be appealed by the state) have laws giving a person a legal right to die under certain circumstances.⁽⁸⁰⁾

As previously noted, a large part of the Medicare budget is devoted to chronic care. By 2004, the elderly accounted for 12 percent of the total population and 34 percent (\$531.5 billion) of all personal health care spending. The largest payer for seniors was Medicare at 49 percent, followed by private health insurance, out-

of-pocket, and Medicaid, each representing 14 percent to 16 percent of elderly spending.⁽⁸¹⁾

The implications of granting a person a right to die with dignity not only impacts the quality of life for that person but also precludes imposing a mandatory burden on the system as well as those individuals paying to stay alive solely at the choice of others versus making an informed decision personally. In this situation, who gave these other people, who don't know the person or the indignities they are suffering, the right to make so personal a decision that a person would be forced to live no matter how painful, the indignities, or personal desires of the individual.

The government has a vested interest in supporting these people from a constitutional and monetary perspective. About one-quarter of lifetime medical costs for the elderly occur in the last year of life.⁽⁸²⁾ About 30 percent of Medicare spending each year is for people who will die within a year.⁽⁸³⁾

Again, appropriate safeguards need to be put in place. However, it is an area that should be a constitutional right and not fettered by emotional or religious conflicts. Doctors and nurses should be given immunity for physician-assisted peaceful passing.

D. Conclusion

These are major problems. Certainly, in many areas, there is a consensus of what needs to be done to improve the overall health of the country. There is also no shortage of data on how the problems can be cured. The problem is no longer in identifying the solution. The problem is in allocating the dollars needed to implement the solution. Some solutions will take time to implement, but others can be implemented very quickly.

When looking at healthcare from an allocation of dollars orientation, there are basically two paths to be followed. One is to reduce expenditures and the other is to increase income. Both need to be pursued vigorously.

All stakeholders have valid interests; however, government can mould solutions that can mitigate the impact of changes and help these stakeholders refocus their businesses which can be supportive of a new health care agenda. What is evident is that a new model is needed. By working together, it is possible to make a material difference on how health care is delivered to everyone.

February 25, 2009

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E. ABOUT HEALING PATHWAYS FOUNDATION, INC.

Healing Pathways Foundation, Inc., a non-profit corporation, is developing resources for the public and governmental sectors to bring about change in healthcare, diminish hunger, and to provide medical treatment for all. Its first project was an extensive online web site (www.healingpathwaysfoundation.org) which is intended as a free resource for cancer patients and their caregivers. The information contained on the website is for distribution to anyone who is or is involved with a cancer patient. E-mail address: director@healingpathwaysfoundation.org.

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