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Interview With Dr. C. Everett Koop, U.S. Surgeon General

Why You're Healthier—And Paying More for It

What's behind the decline in death rates? How can hospitals control rising costs? Are too many operations being performed? The nation's top public-health officer discusses these and other questions.

Q. Dr. Koop, are Americans getting healthier?

A The American public is getting healthier both in terms of lower death rates and in terms of a lower incidence of disability due to illness. Life expectancy for an American born today is 73.3 years, compared to 68.2 in 1950 and 47.3 in 1900.

Q. What's behind the trend?

A One reason is our marvelous system of health-care delivery. In a curative way, medical advances have cut down the death rate from two major causes of death—heart disease and stroke. In a preventive way, many Americans are changing their lifestyles to achieve better health. This means avoidance of smoking, moderate use of alcohol, some kind of sensible exercise and adequate nutrition.

Q. Is the current decline in the death rate from heart disease likely to continue?

A In the last 20 years, the decline in deaths from heart disease has been very remarkable, but the mortality rate obviously can't go down to zero. There is still room for improvement in treating and preventing heart disease, but after a certain point the death rate is going to level off. I don't think we're there yet, but we haven't got much further to go.

Q. What about cancer? Why are some forms of cancer on the rise while others are declining?

A The problem with cancer is that it's not one disease. Cancer of the bladder is not cancer of the brain. Certain forms of cancer, such as lung cancer, are going up while the incidence of stomach cancer has declined. We also find that we are getting the best treatment results in people under 50.

The death rate, for example, from cancers of the breast and cervix is significantly declining in younger women. For people over 50, the cancer mortality rate is higher. This may be due to the fact that older people usually develop cancer in combination with other degenerative diseases associated with aging.

Q. What are the major hazards to health today?

A After heart disease, stroke and cancer, the leading cause of death is accidental injury. High on that list are automobile accidents—and a major factor in automobile accidents is alcohol. One of the most serious problems in the country is drinking in combination with driving.

The use of drugs, while nowhere near a leading cause of death, is also a major health hazard, especially for young people in high school. Drug use is often associated with low levels of education and sets the stage for an unproductive life. It is a medical hazard to the individual as well as a social and economic hazard to society.

Q. We've been hearing a lot about the crisis in health care. How severe is it?

A The crisis in health care is a crisis in the cost of health care, and there's no doubt that the cost crisis is very serious. In March, the cost of living dropped 0.3 percent, whereas the cost of medical care went up 1 percent. In April of this year, medical-care prices were up 12.1 percent over April, 1981, compared to a 6.6 percent increase for all consumer items over the same period. In this same period, hospital-room charges—the most expensive item within the total cost of medical care—rose 16.6 percentage points, which figures out to an alarming 10 percentage points above the overall rate of inflation.

The crisis in medical costs is easy to understand: When you and I are sick, we don't want second-rate treatment and we don't care what treatment costs as long as it can make us well. But from the point of view of what health care costs the nation—what it costs the government and ultimately the taxpayer—then this attitude of not caring about individual costs is a significant problem.

Q. Why are health costs rising faster than the overall rate of inflation?

A First of all, we are the most technologically advanced country in the world. There is very little time between a discovery in research and widespread use of that advance by the public. The CAT scanner that can make noninvasive diagnoses in the head and other body cavities is an example of one of the greatest medical advances in this century.

The most recent generation of young physicians and paramedic people has grown up in the midst of this technological explosion. As a result, there is a tendency in medicine to overutilize diagnostic procedures. In part, this is a defense against potential lawsuits, but it also stems from the physicians' training to do everything possible to arrive at the best diagnosis for the patient in the least amount of time.

C. Everett Koop, 65, a pediatric surgeon, is the government's chief health adviser on smoking, diet and nutrition, environmental hazards and prevention of disease.

WARREN K. LEFFLER—USN&WR

Q. What new approaches are being tried to hold down costs?

A Anybody who can find the answer to rising medical costs deserves a Nobel Prize in economics. The key is to find a way to give the medical profession a backward incentive. Our society is built on expansion, on being competitive and doing a better job than the next guy. How do you reward a physician or a hospital for doing less? It's very difficult.

Regulations are not the answer. The medical scene changes too rapidly for tight cost controls. There has to be flexibility. Under discussion are various plans to encourage competition between pri-

vate health-insurance programs and to make patients pay a larger share of their medical bills. If a hospital administrator would say to you, "Look, you've been in the hospital only three days, but your bill is already $6,270 and you have to pay one third!" you'd say: "Cut down the bill some way. I can't afford it."

Q. Do you think home care can be a less costly alternative to hospitalization?

A. A number of young and elderly people are in hospitals and nursing homes because there just aren't the facilities at home to care for them. If we could get the patient out of the institution and back home, with the necessary supports to make independent living possible, it would be cost effective—provided we didn't fill the hospital or nursing-home bed with another person.

But what happens is that the bed is filled with someone else. As a taxpayer, you're then paying for the patient at home as well as the patient in the hospital or nursing bed, and the costs just keep going up.

Q. Many Americans are losing health insurance when they lose their jobs in this recession. Is the government planning any emergency measures for this population?

A. Unemployed Americans are eligible for a number of programs, such as unemployment benefits and welfare, and entry into the medicaid system, designed to provide medical care for the needy. I also think that there is going to be some additional free care provided by physicians and hospitals.

Q. Won't this lead to a two-class health-care system—one for the rich and one for the poor?

A. It's going to produce a two-cost system, but I'm not sure that means it's necessarily a two-class system. The second-cost type of care is not necessarily second class in terms of quality. Some of the great hospitals started out as charity hospitals—Bellevue in New York City, Philadelphia General and Boston City hospitals.

Once medicaid, medicare and private health insurance became prevalent, there was no real need for charity hospitals. Today the financing of public institutions is not very different from the financing of private and university teaching hospitals. That's why there are few of the big urban public hospitals left.

Q. Might private hospitals turn away poverty cases?

A. I can't answer for all hospitals. I know from my own experience that hospitals try their level best to make their hospitals swim financially, and they try to cover the costs of patient care by the best means possible.

Everybody knows that surgery is very expensive. In cases of elective surgery, where an operation is not aimed at saving the patient's life immediately, hospitals have to know that the patient has a certain amount of money or is covered by an insurance plan before they go ahead with the operation. But if that patient turned up tomorrow night in need of an emergency operation, there would not be any rigmarole about how the bill was going to be paid. The patient would be treated.

Q. How many Americans are without any form of private or government health insurance?

A. With rising unemployment, the numbers are shifting rapidly. We estimate that from 18 to 25 million Americans—8 to 11 percent of the population—have no health-insurance coverage at all.

According to 1980 statistics, the most recent figures available, 26.6 percent of the total health-care bill was paid by private insurance, 1.3 percent by philanthropy and industry, 28.7 percent by the federal government, 32.4 percent by individuals as an out-of-pocket expense and 11 percent by state and local governments.

Q. Is there a danger that medicare and medicaid will go bankrupt?

A. Some of the estimates are pretty scary. But before the day of bankruptcy arrives, I think there has to be some basic change in the way medicaid and medicare are funded. One idea to control hospital costs in medicaid is to specify payment in advance for the medicaid population—the needy—instead of the present system where hospitals spend what they feel is necessary to treat each patient and then send the government the bill.

With a limit on the total amount of money to be spent on a medicaid patient, hospitals would have the incentive to find the most-efficient and cost-effective ways to take care of this population. This approach is supported by the American Hospital Association.

Controlling costs in medicare for the elderly is more difficult because hospitals receive 66 percent of medicare funds, with the rest going to doctors and outpatient facilities. One approach to protect the financial base of medicare is to make individual patients pay a greater percentage of the total bill. The drawback is that a portion of our disadvantaged population—the elderly—is being asked to shoulder the burden.

Q. Just what is the administration's proposal to protect medicare and medicaid?

A. I'm not in a position to say. We're still in the talking stage. There is no rapid, easy solution. Whatever is eventually decided, it will be a big compromise.

The President has suggested that the federal government take over the cost and operation of the medicaid program in return for the states running certain federal services. Two programs under discussion are food stamps and Aid to Families With Dependent Children. But some states don't want to take over these services because of abuses in the past and the difficulty in monitoring such programs.

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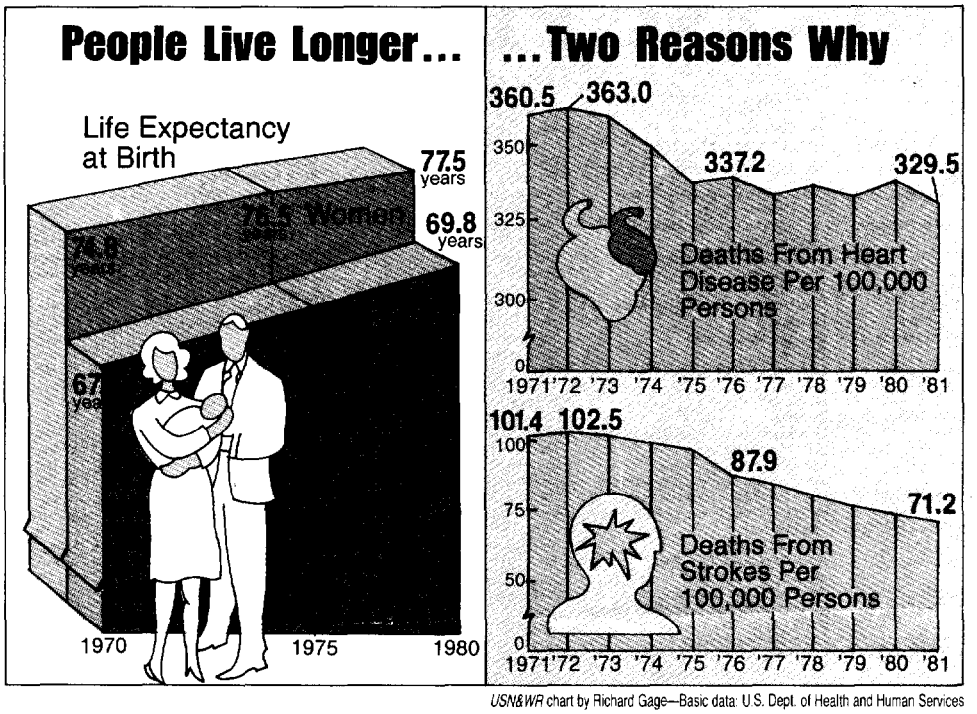
Q. Will there be lower medical bills as the number of doctors increases?

A. Absolutely not, and I'm not sure it should be expected. One of the concerns is this: If there are too many of a certain kind of specialist in a city and individually they are not making what they consider is an adequate income because of a low patient load, then the tendency is for doctors to raise their prices so that they can get an adequate economic return on the investment they have made in their medical education.

Q. Why are there growing numbers of strikes by nurses against hospitals?

A. Hospitals have been asking the same questions for years: What is it that brings women into nursing? What keeps them there? And why do they leave earlier than expected?

The answer, I think, is not economics but job satisfaction. Many nurses thought they would have more autonomy and authority. They



USN&WR chart by Richard Gage—Basic data: U.S. Dept. of Health and Human Services

have been taught enough so that they can be decision makers. But a hospital can't have two people making decisions about patients. Doctors have to establish the concept of the captain of the ship. That's the problem.

No nurse has ever said to me: "I can't stay here because I'm only making x dollars and the doctors are making three times that amount." What they do say is: "I am highly trained and experienced, but when I try to exercise my knowledge, there's a doctor who tells me it's not my role."

Q How serious a problem is unnecessary surgery?

A In my view, it's not nearly as big a problem as people think. To begin with, what is meant by unnecessary surgery? I think there is very little surgery performed on a healthy organ solely out of greed.

Hysterectomies are a good example of this dilemma in surgery. Doctors know that the uterus is a source of two common forms of cancer. When a woman has a uterus that bleeds 13 days a month instead of five, which interferes with her life as a wife and a mother, many gynecologists would say: "This organ is not doing her any good; it could be dangerous. Why not take it out?" The doctors' motives can be purely compassionate and good. Was the hysterectomy needed to save the patient's life? The answer is no.

Q Are hospices, which take care of terminally ill patients, an effective way to provide more-humane treatment at lower cost?

A Yes. A hospice is designed to make the dying patient as comfortable physically and emotionally as possible. Little things like allowing a woman to have her pet canary or her cat in her room seems like a tremendous breach of hospital etiquette, but it makes all the difference to that person and her family.

Over all, the greatest comfort for people in hospices is that they know they will not be allowed to suffer unbearable pain. They are given adequate doses of morphine and other pain killers. What is interesting is that once the fear of pain is relieved, patients report they feel less pain. I think the hospice concept is a tremendous boon to a person who faces old age and a terminal illness.

Q What about "living wills," intended to give patients some control over treatment so that life would not be prolonged when there is no chance of recovery?

A Every physician who deals with people who die comes to his own understanding of how he will deal with death scientifically, emotionally and ethically. It's essential to give the patient all the life to which a person is entitled but not prolong the act of dying.

I am sure those who make living wills do so with all good intentions. However, I feel that they make decisions for the physician and the family more difficult, rather than easier.

Q How prevalent is the practice of letting babies with major birth defects die?

A I know it happens in hospitals throughout the country. The frequency is difficult to assess, but I call it infanticide. I have spent my whole life taking care of children with congenital defects, and the majority of them have become very worthwhile citizens. In a new policy of the Department of Health and Human Services, federal funds will be cut off from any hospitals that deny food or treatment to newborns because of a handicap.

Q President Reagan promised to reduce the role of the federal government, yet the administration has intervened in the doctor-patient relationship regarding newborn care, abortion and contraceptive methods for teenagers. How do you explain this apparent contradiction?

A I can't answer your question for several reasons. First of all, when I came to Washington, I said I wasn't going to discuss the issue of abortion with anybody. I'm also not going to comment on the President's promises.

As for children applying for birth-control information, I think something has to be done about the tremendous epidemic of teenage pregnancies in this country. As a parent, I would want to know that my 15-year-old daughter was seeking birth-control information. If she were getting help behind my back, I would feel that somehow I had missed my role as a father. What's more, a Kennedy Foundation study found that when parents were notified that their children were seeking birth-control information, the pregnancy rate in those teenagers declined over the next four years.

Q How serious a problem is the viral disease herpes?

A Herpes is a major public-health problem and very difficult to control. There is no evidence of any effective therapy for this venereal disease. Not only is it unpleasant, but in pregnant women herpes is a potential cause of death of the child if the baby is born during an acute attack of herpes in the mother.

Q Over all, what impact will Reagan's policy of New Federalism have on health care?

A It's hard to say, because two things are happening at once: New Federalism and budget reductions. If we had New Federalism without any cuts in the health budget, I think everybody would say this policy is the greatest. For as long as I've been alive, I've heard the same story: Why doesn't the government get off our backs? The medical profession was one that screamed the loudest. Well, now it's up to the private sector. When the country recovers from its economic slump, then I think New Federalism will be the wave of the future. □