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The Non-Medicated Life: Helping to Pay for Universal Coverage, Part 2

by Paul E. Lemanski, MD, MS, FACP

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Editor's Note: This is the 32nd in a series on optimal diet and lifestyle to help prevent and treat heart disease. Any planned change in diet, exercise or treatment should be discussed with and approved by your personal physician before implementation. The help of a registered dietitian in the implementation of dietary changes is strongly recommended.

Medicines are a mainstay of American life and our healthcare system because they are perceived to work by the individual taking them and because their benefits may be shown by the objective assessment of scientific study. Clinical research trials have proven that some of the medicines of Western science reduce the risk of heart attacks, strokes and cardiovascular death.

In the first 31 installments of The Non-Medicated Life, informed diet and lifestyle have been shown, for the majority of individuals, to achieve naturally most of the benefits of medications. What has not been adequately emphasized is that such an approach can significantly reduce the cost of care by decreasing or eliminating the need for those medications. The non-medicated life also offers the possibility of reducing the severity of certain illnesses, and the total the number of ill individuals, thereby lowering the cost of care and making the population healthier. In so doing it may also suggest a new strategy to help pay for universal coverage.

The majority of the illnesses physicians currently treat are the result of lifestyle choices. Two such choices, smoking and obesity, account for the bulk of the cost of care. Smoking causes heart attacks, strokes, emphysema, lung cancer, cancers of the head and neck, pancreatic cancer, as well as bladder and cervical cancer. Obesity causes heart attacks, diabetes, hypertension, gastro-esophageal reflux, and sleep apnea. Since obesity is increasing

dramatically in our population, the diseases caused by obesity will also increase, as will the cost of caring for those afflicted.

Diabetes is a case in point. The prevalence of diabetes will almost triple in the next ten years to 60 million. According to the American Diabetes Association, the annual direct cost of diabetes in the U.S. is estimated to be 92 billion dollars, with another 40 billion from related problems. These costs cover care for the current 20 million individuals with diabetes in the U.S. Their treatment represents about 10-15% of global healthcare costs. If it was ever true that an ounce of prevention is worth a pound of cure, diabetes is proof of it. Preventing new cases of diabetes could save hundreds of billions of dollars over the next 10 years and can be accomplished not by new expensive drugs or the development of an artificial pancreas, but by a proven low tech, low cost means of identifying those at risk and an equally low tech, low cost treatment.

Pre-diabetes or metabolic syndrome is easily identified by two routine blood tests, a measurement of blood pressure and abdominal circumference. Apart from the measurement of abdominal girth, the data to diagnose pre-diabetes already exists in the great majority of patient charts. No additional cost for identifying those who may benefit is required.

More impressive still, for the vast majority of people at risk, preventing diabetes does not require new

drugs or new procedures. It requires nothing more than modest weight loss. Indeed, as shown in a clinical trial, for pre-diabetic, obese patients a reduction in body weight of only 20 pounds may reduce conversion to diabetes by 57%! Moreover, those at risk already possess the tools to lose the weight- a healthy diet, exercise and lifestyle- but only if they chose to use them.

Unfortunately, so far the healthcare debate has ignored the role of personal responsibility and appropriate lifestyle choices in mitigating healthcare costs. The debate incorrectly, in my opinion, assumes individuals will not change current behaviors under any circumstances. Costs are calculated on that assumption.

At the same time, to make the system economically viable, the current proposals suggest that all individuals will be required to pay something for healthcare. If this is accepted, why not incentivize individuals by allowing them to “pay”, in part, with a change in lifestyle that can be proven to reduce costs?

Smoking cessation would be rewarded with a reduction in a smoker’s payments. Random blood tests for nicotine would confirm ongoing compliance. For the obese with metabolic syndrome, a weight loss of twenty pounds would, if maintained for one year, result in a reduction in the following year’s health insurance premiums. A graded system of incentives for behavior changes shown to reduce health care costs could be developed and tested in pilot studies mandated by Congress. Initial savings from decreased medication use or elimination could be realized within 1 to 2 years. Longer term savings would result from the reduction in the rates of heart attack, stroke, and cardiac by-pass surgery.

Naturally, those who have always maintained healthy behaviors, would not benefit from these incentives, so may feel this approach is unfair. One possible way to correct this imbalance would be for those participating in the incentives program to agree that only for the first 5 years would they be entitled to a reduction of yearly health costs for healthy behaviors. In the years thereafter, those who fail to alter unhealthy behaviors would incur

graded premium increases to pay for the additional cost of care. It would be left to each individual to either change behavior or, going forward, pay higher premiums.

Controlling runaway healthcare costs by actually improving the health of the population should be a central tenet of healthcare reform. People can change if they have an incentive. Without an incentive, most individuals will continue behaviors they know to be unhealthy until the result is a costly, life-altering event. The present system, with its emphasis on new drugs and new procedures, deflects attention from the source of the problem: unhealthy behaviors and literally disease generating lifestyles.

Because the healthcare crisis has made it difficult for the average American to get affordable care, the time is ripe for Washington to offer new solutions. Let us build incentives into our healthcare system which are reasonable, equitable and can be shown to reduce disease and lower cost. Only at the end of the 5 year implementation of an incentive program as described would the individual engaged in the lifestyle that increases health costs bear the burden of additional cost. Either we allow individuals to “pay”, in part, for healthcare with appropriate behavior change or we may all end up paying higher premiums without our health becoming appreciably better. For universal coverage to be viable in the long term, unnecessary disease must be prevented and total disease in the population thereby reduced. This is one way, hopefully, to accomplish that goal. We will all be the healthier for it.

Paul E. Lemanski, MD, MS, FACP is a board certified internist with a master’s degree in human nutrition. He is director of the Center for Preventive Medicine, Albany Associates in Cardiology, Prime Care Physicians, PLLC.

Dr. Lemanski is an assistant clinical professor of medicine at Albany Medical College and a fellow of the American College of Physicians.