US Health Care

Entitlement or Privilege?
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We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

—The Declaration of Independence of the Thirteen Colonies, July 4, 1776

These words of our founding fathers succinctly congeal the aspirations of all Americans. Although the reference to freedom is unambiguous, the reference to “life” has both figurative and literal interpretations. Was the intent an entitlement to healthcare services? In a country based on free enterprise driven by market forces with an emphasis on consumer choice, was the intent of our forefathers to define health care as unalienable right? Support for this intent may have been provided by the US Congress in 1965 when “first-dollar coverage” was introduced with the inception of Medicare. And yet, in virtually all other sectors of American life (except health care), financial responsibility enables freedom of choice. In buying a house or car, choosing a hotel, or dining at a restaurant, consumers choose what they are willing to pay, and market forces determine the price. This free-market, consumer-driven process implicitly values the quality of goods and personal services provided. Hence, the common adage, “You get what you pay for.”

Recent advances in medical technology have had a significant salutary effect on the morbidity and mortality rates associated with atherosclerotic cardiovascular disease. Furthermore, primary preventative measures and techniques for early (preclinical) detection have evolved. Public news media have sensationalized medical advances. A better-informed and educated public comes with higher expectations for their care. In parallel, the cost of research and development for new drugs and devices has escalated. Indeed, both the cost and time to market for a new medication have increased over the past decades. The ardor for clinical trials testing and the specter of product liability have grown formidable. For-profit, publicly traded insurance corporations have insinuated themselves between the consumers (patients) and the providers of goods and services (hospitals and physicians). These “corporate proxies” have a fiduciary responsibility to shareholders. They profit by the difference between premiums charged to the consumer and payments made to the providers while adding questionable value to the system. Through double-digit inflation in consumer premiums, these corporate insurers have posted record (32% to 260%) profit gains in 2003, while the number of Americans who remain uninsured continues to climb. Corporate healthcare insurance executives are incentivized by millions of dollars in salaries and bonuses to maximize corporate profitability. The dollars paid for administrative costs and corporate salaries are directed from the actual point of patient care. Furthermore, uninsured individuals have a “right insured by law” to receive healthcare services. This system has become progressively dysfunctional. The misalignment of incentives in the current system has become increasingly evident. Is health care an unalienable right as inferred from the US Constitution? If the answer is yes, a specific and defined subsidy must be provided to all...
US citizens. Does this subsidy need to provide all technologies for care to all covered individuals? We believe the answer to this question should be no. Basic components of health care should be identified and provided for all individuals, with systematic review and revision of included services at regular, predefined intervals. Beyond the subsidy for basic services provided to all citizens, "luxury" services either may be paid for directly by the consumer (which in turn empowers the consumer with choice) or can be insured by the current corporate providers. Two of the most challenging aspects of such an "unalienable right" healthcare system reside in the definition of basic services to be provided and the mechanism for financing these provisions. If basic healthcare services are a societal right or entitlement, budgeting priorities must be defined. American tax dollars must be more focused on the health and welfare of American citizens. Drs Weintraub and Shine have long been students of healthcare economics with a focus on cost-efficiency of specific treatments and therapeutic strategies. As both physicians and medical educators, they advocate developing a payment mechanism that provides care for all, "where incentives are in alignment among providers, patients, and society." They define the Institute of Medicine's goal to forge "a healthcare system that is safe, effective, patient centered, timely, efficient, and equitable."

Unfortunately, the intrinsic incentives for system components (doctors, hospitals, and patients) necessary to accomplish such a protean task are not defined. The concept of reimbursing cost-effectiveness is attractive to enhance the dollar value of care and is in concert with the recent pilot strategy proposed by the Centers for Medicare and Medicaid Services to provide incremental reimbursement for documented guideline-compliant care. This precedent-setting move by Centers for Medicare and Medicaid Services to award guideline-adherent care should be applauded, although the task of implementing and auditing quality measures in a diverse and fragmented system for providing care is daunting. Furthermore, the "devil in the details" for determining cost-efficacy has been acknowledged by Drs Weintraub and Shine as well as Drs Watanabe, Malatestinic, and Browne and Mr Dollens. As such, the measure of cost per life-year gained may not be inclusive of costs incurred for "pain and suffering" or other morbidity for the survivor. Return to work and other measures of personal productivity or function must be considered. Drs Weintraub and Shine are proponents of a government-subsidized single-payer system with supplemental insurance. The basic stipends provided to all Americans would be largely derived from pretax dollars contributed by both workers and employers. Drs Watanabe, Malatestinic, and Browne and Mr Dollens provide a slightly different perspective. They point out that our present system neither promotes nor rewards quality measures of care. Furthermore, incentives for disease prevention or proactive management are virtually nonexistent. Remarkably, "50% of Medicare dollars are spent on 5% of the Medicare population," largely because of costly "episodic, catastrophic care" in the final year of life. Watanabe et al caution that the current emphasis on cost, not value, may stifle the development of innovative therapies. They express concern about the strategy of rewarding cost-effectiveness, as cost-effectiveness analyses may be used as yet another cost-containment mechanism. They warn that by basing reimbursing on cost-effectiveness (a strategy advocated in the Expert Opinion of Drs Weintraub and Shine), we might become "trapped at our current level of efficacy forever." Furthermore, they offer the free-enterprise, corporate perspective that arbitrary price controls may "contribute to a major decline in productivity of research and development and a marked decline in the competitiveness of pharmaceutical industries," as has occurred in Europe. Watanabe et al advocate the use of quality measures to grade health care and thus justify incremental reimbursement that might also be used to defray the cost of information and decision support systems that are necessary to measure and audit performance. In addition, although they advocate patient education and participation in the decision process to utilize innovative drugs and medical devices, they fall short on defining the individual financial responsibility that should be incurred for such participation.

**A Consensus Expert Opinion**

The consensus sentiments derived from the opinions expressed in the present issue of *Circulation* may be summarized as follows. First, no US citizen should be denied access to health care. The intuitive inference is that health care is an entitlement. Second, the current system for healthcare reimbursement is inadequate at multiple levels. More individuals must be provided healthcare coverage. Our experts appear to favor a single-payer system with supplemental private insurance. The proposed system would include mechanisms for monitoring quality measures with incremental reimbursement provided for value documented by outcomes and/or guideline compliance. Finally, and ideally, free-market forces and incentives would be preserved. Hence, the incentive for research and development of innovative therapies would survive. How could all of this be achieved? Obviously, more dollars will be required. One portion of necessary dollars could be provided by a tax applied to pretax dollars for both employees and employers. In essence, most of these dollars are already being paid in the form of Medicare and FICA (Federal Insurance Contribution Act) taxes. Furthermore, patient freedom of choice and participation in the decision process for care must entail additional financial responsibility through either out-of-pocket expense or supplemental insurance. Critics of such a system decry the perceived inequity of a 2-tiered approach to health care. However, is anyone so naive as to expect all care for all people at any cost? In the proposed system, at least all care would be compensated, as compared with the present system, in which an appreciable portion of care is uncompensated, and more than 40 million Americans remain uninsured. Further incentive for providers (particularly doctors) to make technologies and care equitably
available to both tiers in the proposed system could be derived by tax benefits commensurate to bad debt incurred. At present, no tangible benefits accrue for providing uncompensated care or technology. We need a system that is incentivized to provide high-quality, best-practice care and that encourages continued advancement in technology. In the American way of life, choice has always come at a price. In addition to raising the bar and providing a subsidy for all Americans, freedom of consumer choice should be preserved. Similarly, providers of medical care must be measured. The concept of quality at a premium provides incentive for continuous quality improvement. Indeed, as aptly pointed out by Dr Watanabe et al, our current system has no mechanisms for either measuring or rewarding the quality of care provided.

**The Future is Now**

Rapidly evolving technology has provided more innovative and costly drugs and devices that are currently being implemented into practice. What, if any, material benefit will be derived from recent legislative developments is unclear. Despite being hailed as “the most important healthcare legislation passed by Congress since the enactment of Medicare and Medicaid,” the new Prescription Drug Act provides the most generous subsidy to individuals whose annual income is below 135% of the poverty level and those with catastrophic medication expenses of $5100 or more. As such, this legislation represents a safety net for only one, limited aspect of medical expenditures. In fact, many relatively healthy American seniors who have less extreme pharmacy expenses will actually pay more to receive their current medications. The more sweeping changes in healthcare reimbursement that are required to achieve the goals outlined by Weintraub and Shine and Watanabe et al will not come easily. However, it has become increasingly apparent that sweeping changes will soon be required to meet the demands of American society and technology. Ideally, constructive input from thought leaders in both medicine and industry, as expressed in the present issue of *Circulation*, will help in shaping our system for healthcare reimbursement in the future.

**References**
