

EDITORIAL

Health Care for All

In the current issue of this journal, a letter to the editor by Jerry Frankel asserts that this column “blasts government’s role in health care, but offers no real alternatives or solutions.” Here is one solution.

Pay for health care in a manner analogous to the graduated income tax. A graduated payment system of health care could work like this. Basic health care—those things that have stood the test of time and have been found to be necessary and effective—are paid for by the patient on a sliding scale depending on his or her own financial circumstances. Patients with little or no financial resources pay little or nothing; patients at the top of the financial ladder pay a larger share of their own costs.

A very simple premise, but diagnostic and therapeutic services, which are not considered basic ones, complicate things. Very expensive diagnostic and therapeutic technology has burgeoned at a rate that far exceeds our ability to determine whether these things are necessary, useful, or even cost effective. For example, 25 years ago most prostate cancer was discovered on rectal examination long after it had spread beyond the confines of its capsule. There were few treatments—estrogen, orchiectomy, radiation, and anti-androgens. Today most prostate cancer is detected because of an elevated PSA discovered by prostate cancer screening. Much of it is localized to the prostate and a myriad of diagnostic and treatment options confound an already confounding disease. PSA, free PSA, PCR, innumerable ultrasound-guided prostate biopsies, bone scan, CAT scan, MRI—these are all part of our diagnostic armamentarium.

For treatment, radical retropubic prostatectomy, radical perineal prostatectomy, cryosurgery, brachytherapy, external beam radiation, conformal radiation, and a host of expensive anti-androgens taunt physician and patient alike. But how can this all be paid for? We don’t know which (if any) are effective. Is it a basic right of an individual patient to be offered each of these in succession, without any consideration of cost? I think not, but each should have the right to determine the particulars of his own treatment.

For those diagnostic and therapeutic services that are not considered basic ones, the sliding scales steepens and the relative costs borne by the patient increase. Since the utility and outcomes of new therapies are unknown, it is only fair that if a patient wants to try a new health care option, he should be responsible for more of the costs. Further, if there is greater public awareness about what is experimental and what is not, there will be even greater pressure to fund research, and there will be a greater incentive for patients to participate in clinical research. For example, if there is a new treatment for prostate cancer, and it proves too expensive for an individual to pay for, he’d have the option of participating in a prospective clinical trial evaluating its efficacy (at little or no personal cost).

Under the graduated income health care system, patients also have a financial incentive to keep costs down because they are much more involved in financial decision making about their own care, but there is still one thing lacking—coverage for catastrophic illness. The finances of insurance against catastrophic illness were extensively studied in the late 1980s. The legislature of the United States enacted a catastrophic health care plan for all Medicare recipients. That plan, which effectively protected patients and their families against economic disaster due to illness, was ultimately repealed because it reduced Medicare benefits by \$200 per year.

If, as a society, we cannot afford \$200 per year for catastrophic health care insurance, I don't believe that we can afford basic quality health care either!

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