

The Ethical and Economical Dilemmas of Modern American Healthcare:
An Argument for Re-incentivization of the American Healthcare Delivery System

Eric J. Bayer

Alicja Stannard & Brent Little

Honors Capstone HN-300-D

March 21st 2020

The United States of America has a conundrum on its hands; our healthcare system is in trouble. Specifically, our healthcare system is experiencing unprecedented ethical and financial dilemmas. According to the US Centers for Disease Control and Prevention, total national healthcare expenditures in 2017 were nearly 3.5 trillion dollars, which is almost 18 percent of the United States GDP.¹ The economic consequences of this place great strain on every facet of the healthcare industry. Hospitals, insurance companies, and doctors are all feeling the burden of rising healthcare costs. Yet the people who suffer the most are the most important part of healthcare: the patients. Patients are faced with high drug costs, fragmented care, and astronomical insurance premiums... that is if they can afford insurance in the first place. So, how do we fix this? The most obvious answer is to lower costs and lower spending, though, the complexity of healthcare makes it much more complicated than that. The current model of how America does healthcare is flawed both ethically and financially. According to a study cited by the movie *Escape Fire*, 75 percent of American healthcare spending is on preventable diseases.² The current model of American healthcare is a disease management and sick care system. In other words, the current fee-for-service system profits on patients being sick and being treated for those sicknesses rather than keeping them well and preventing them from being sick in the first place. Healthcare providers are paid based upon interventions that they perform. Fancy testing, procedures, and exams are much more profitable than sitting down with a patient and discussing their lifestyle habits that are pre-disposing them to developing a chronic, and often costly, disease down the road. Therefore, doctors are incentivized to do more testing and more poking and prodding, even if it is unnecessary, in order to make a profit. At the end of the day,

American healthcare is a business. And like any business, in order to keep their doors' open and pay their bills and employees, they must make a profit. But the current business model of American healthcare is ethically flawed, which leads to a financial burden that is unsustainable. *The current state of the American Healthcare System is putting extreme stress on our economy and the wallets of the American people. We need to change from a disease management system, which profits on patients being sick, to a wellness-promotion and preventive medicine system, which profits on patients being and staying well.*

The United States is somewhat unique in that its healthcare system is a for profit, revenue-driven business. Other developed countries use single-payer or federally subsidized healthcare systems. Canada, for example, uses government-funded "provincial health insurance plans" which provide universal access to hospitals and physician services for patients.³ The United States does not have a single-payer or government funded system (with the exceptions of Medicare for the elderly and Medicaid for the impoverished). Rather, the US has a system that is mainly dominated by privatized health insurance companies. At its core, the American healthcare model is this: the patient gets sick, the patient goes to the doctor and/or hospital, and the patient is put through a battery of tests and procedures to figure out what is wrong and treat the issue. The treatment is often a prescription drug, which adds to the cost of care. The patient's insurance company is sent a bill that shows all the testing performed, and the doctor or hospital gets paid by the insurance company for the services that the doctor and/or hospital provided. In the healthcare industry, this is known as "fee-for-service."⁴⁻⁶ The insurance company is also paying for the prescription drug(s) that were dispensed from the pharmacy for the patient. The most common argument is that healthcare and business should not be mixed.

Many say the American Healthcare system is in need of an overhaul where everybody is moved to government-funded Medicare and healthcare business as we know it should be abolished. However, healthcare being a “business” is not the problem. In fact, healthcare being a business promotes healthy competition between healthcare companies which results in better, lifesaving treatments to come about. The real problem lies in what is and is not profitable in healthcare. In the United States, there is a unique opportunity that exists in healthcare being a business: the power of incentive. Monetary incentive can be a valuable tool to use in order to change the landscape of healthcare. The current system does not incentivize wellness and prevention. Doctors and hospitals do not turn a profit for preventing patients from getting sick and/or hospitalized, which is of no fault of their own. The system instead incentivizes more tests, more treatments, and more hospitalizations. Therefore, the healthcare system in the US needs a new business model. For years the American healthcare system has been on a “fee-for-service” business model, as discussed previously. From a business perspective, this makes sense. But from the medical perspective, it is ludicrous, and even harmful. The doctor performs a procedure, an exam, or a test, and receives compensation for it. But what if the patient is not sick right now, but they have risk factors for disease? This is where the current American healthcare model fails. Take a common risk factor such as obesity, for example. Obesity is fully preventable with proper diet, exercise, and lifestyle habits. In 2017-2018, 42.4% of the adult American population was obese.^{7,8} That number is increasing at an alarming rate with every year that passes. Obesity in itself is dangerous because it negatively impacts quality of life, but the real consequences come from the co-morbidities associated with obesity.⁹ Then one disease, like obesity, leads to another, like cardiovascular disease or type 2 diabetes mellitus,

the secondary diseases are known as co-morbidities. Obesity has been isolated as a major cause of many different chronic diseases, including cardiovascular disease, type 2 diabetes mellitus, renal disease, hypertension, stroke, heart attack, asthma, and mental illnesses such as depression and eating disorders.^{7,9} These disease patterns are known co-morbidities that can almost always, in some way or form, be traced back to the most common root cause: obesity. Cardiovascular disease and type 2 diabetes mellitus are two of the most common, yet fully preventable, co-morbid disease patterns that are present in obese Americans. This fact presents the medical community with both ethical and financial issues that must be addressed.

For one, these diseases should be prevented in the first place. All of these diseases have associated risk factors. Patients do not just simply gain 200 pounds overnight. Likewise, they do not just develop plaque in their arteries or type 2 diabetic insulin resistance overnight either. These diseases are the result of a poor lifestyle that has often gone on for years. Healthcare providers should be recognizing these symptoms early and addressing them with their patients. Healthcare providers should also be coaching their patient on lifestyle changes and directing them to the available resources that can be provided as preventive measures for a patient to get better, such as dietitians, physical therapists, and lifestyle coaches. When they are initially classified as obese, or have cardiometabolic disease, the patient should have access to preventive services. However, the all too common occurrence is not prevention. Insurance companies do not pay doctors to sit with patients and coach them. Insurance companies often do not pay for lifestyle coaching, dietitian services, or any other service geared toward overall health promotion, wellness, and prevention. The patient is almost always sent home without

these services and will almost always develop co-morbidities. These co-morbidities, such as a stroke or hypertension, will bring the patient back to the hospital. The hospital will then need to do more testing and procedures, which are profitable, to treat the patient for the ailments. They will get paid for treating these co-morbidities. They will get paid for their services. But ultimately, the patient suffers. The patient now has medical issues that were fully preventable, if only they had received the right care in the first place. Instead of preventing these things from happening, the current healthcare model practices damage control after the patient has already suffered. The American healthcare system continues to fail patients like these every single day. One could say, the American healthcare system is doing exactly what it shouldn't be doing: harming patients.

The second conundrum that results from these preventable chronic diseases is the financial strain that they place on both the healthcare system and the patient. Researchers estimate that the yearly cost of cardiovascular disease associated with poor diet is about \$301 per person on average, which translates to a total of \$50.4 billion annually, or 18.2% of total annual insurance payouts.¹⁰ The numbers for type 2 diabetes mellitus, another disease pattern that is often preventable, are even more disturbing. In 2014, 18.26 million patients were estimated to have type 2 diabetes in America.¹¹ That is the equivalent of almost the entire population of the state of New York. Further, the total projected direct care costs for patients with type 2 diabetes mellitus in America in the year 2014 was a whopping \$287 billion.¹¹ The spending on type 2 diabetes and cardiovascular disease alone are enough to take out a sizeable chunk of the previously mentioned total American healthcare expenditures of \$3.5 trillion. If these disease patterns were prevented in the first place, imagine the economic relief that it

would provide to the healthcare system in America. Instead, the American healthcare system continues to hemorrhage money. But economic stress is not the only problem that American healthcare is facing. American healthcare is facing ethical challenges too. In fact, the economic and ethical issues are perpetuating each other.

Every doctor educated in a medical school in the United States knows what the Hippocratic oath is. The oath itself can be traced back in written history to the first century in Rome.¹² The oath, written by the ancient physician Hippocrates, is a 250-word long creed that was established as the code of ethics for medical practitioners. It is still used to this day. Every physician, upon receipt of their medical degree, recites this oath and promises to uphold it. The Hippocratic oath is to doctors as the oath of office is to the President of the United States. It is not taken lightly, and it serves as a creed by which every physician is expected to live by. The one phrase of the oath that almost everybody is familiar with is, in the original Latin, “*primum non nocere*,” which translates to English as “first, do no harm.” Of course, in a literal sense, it is understood that doctors should not be harming their patients. They should not do something that could kill the patient or harm them in any way. But if we take it to the next level, how does contemporary medicine define *harm*? Have we arrived at a time where doing no harm is merely defined as not killing a person?

In their peer-reviewed interpretation of the oath, Askitopoulou and Vgontzas say:

The word “harm” in medicine has two possible meanings. It may either mean an adverse effect on the patient or else abuse or injustice. The first one refers to the harmful side effects caused inadvertently from the right treatment of a specific disease.

The second one refers to the harmful effects of applying the wrong treatment because of a doctor's negligence.¹²

As defined by the Hippocratic oath, harm is one of two things: either the inadvertently wrong treatment provided to the patient, or the wrong treatment provided to the patient due to the doctor's gross negligence. But the way medicine in the US works now, it is doing a lot of harm that is not necessarily explicitly defined in the oath. At the time the oath was written, it did not address the complex problems that are coming about in contemporary medicine. In contemporary medicine there is a new type of harm. The harm comes in the lack of prevention.

Modern medicine has abilities that Hippocrates and other ancient physicians could not even dream of. Modern medicine, in many cases but not all, has the ability to prevent patients from falling ill in the first place. It is also important to remember that the innovation in the clinical practice and science of medicine is not the only thing that has taken place since the times of Hippocrates. There have also been great advances in the administrative structure of healthcare. Insurance, staffing, pharmaceutical companies, device companies, supply companies, etc. are all entities that play key roles in modern healthcare delivery, which is far different than the healthcare delivery that took place way back when. Therefore, the Hippocratic oath needs to be interpreted in a modern context and adapted to the way medicine is now. The interpretation and heed to the moral compass of the Hippocratic oath needs to go far further than just the frontline medical providers (doctors, nurses, etc.). The morals and ethics that are detailed in Hippocrates' sacred oath need to be heeded in all facets of the healthcare industry, because, after all, every part of the massive machine that is modern healthcare are all working together towards the common goal of providing exceptional

healthcare for the patient. So, if they all have the same common goal, why are they not abiding by the same ethical standards? If any of this “preventive medicine and wellness promotion” stuff is going to work, there needs to be a massive ethics overhaul in all parts of the healthcare machine. If the healthcare system was really abiding by the Hippocratic oath, it would shift its focus to preventing the patient from getting sick in the first place. Though, the unfortunate reality is that the current healthcare system has become more concerned with doing what is profitable rather than what is truly right. Medicine has lost sight of what it means to truly do no harm. Modern medicine is fixated on doing good by treating diseases and state-of-the-art surgeries and drugs. They have lost sight of what medicine was always meant to be: keeping the patient well by preventing disease in the first place.

Healthcare cannot begin to change from a disease management system to a wellness promotion and sickness prevention system until its business model is changed. As mentioned previously, American healthcare is on a fee-for-service business model. Many critics argue that healthcare and business should not mix, but that is not necessarily true. Healthcare being a business creates the opportunities to use monetary incentives to better the system. For example, American pharmaceutical companies are constantly motivated by profits to make better and more effective pharmaceutical treatments for patients. Healthcare needs to make money in order to be sustainable. There is no way around this. Doctors and nurses must be paid, and hospitals need money in order to run. The overarching problem in American healthcare can be boiled down to one term: mis-incentivization. Healthcare is being paid to treat patients. They are paid per treatment, per hospitalization, per test, and per drug. What healthcare is not being paid for is prevention; keeping patients well and preventing them from

needing treatments in the first place. These treatments, drugs, hospitalizations, and procedures are expensive! If the patient is prevented from needing these treatments it would solve two problems.

First, it would lower the cost associated with healthcare in general. Less sickness means less care is needed. But how will doctors make money if patients are not getting sick? Doctors would make money from keeping their patients well. Insurance companies are frugal; they want to pay as little money as possible. That is the way insurance works. At its core, insurance is simple. They want clients to pay premiums to maintain health insurance while the insurance company keeps as much of that money as possible. They do not want to pay it out, because then they would be losing the money that they made. But where health insurance differs from other insurances (car, home, etc.) is that its risk management model does not really make much sense. It seems simple, the insurance company does not want to spend money. Well, if the patient gets sick, there is going to be claims that need to be paid. Those claims are often expensive... much more expensive than preventive measures. Yet, insurance companies fail to cover some things. For example, blood pressure medications that can reduce a patient's blood pressure and therefore reduce their risk of having a catastrophic stroke. What is better? Paying a few hundred dollars per month to pay for the patient's blood pressure medication, or paying hundreds of thousands of dollars down the line for the patient's ambulance, neurological care, hospital stay, and rehab after a massive, yet fully preventable, hemorrhagic stroke? Insurance companies should want to keep their clients, the patients, well so they do not have to pay as much for treatments and tests. Instead of insurance companies paying for doctors to fix their patients, they are paying for doctors to keep their patients well. The insurance company makes

an investment in the client by having a doctor prevent them from needing services. These investments often require money upfront to cover the costs of dietitians, personal training, and other wellness services to minimize the patients risk for developing chronic (and costly) diseases down the road.

The second problem prevention would solve is the ethical dilemma that modern medicine is facing with respect to wellness promotion. Modern medicine is fixated on episodic, damage-control type healthcare. The current mentality around patients is “if they are not sick, they do not need care.” This is a grossly false statement. Patients do not want to be sick. It is not the patient’s responsibility to know how to keep themselves healthy. Patients rely on their healthcare providers to educate them on how to be healthy and stay healthy to have the utmost quality of life. If providers are incentivized to spend time coaching their patients and referring them to the correct resources to get the preventive care they need, patient outcomes will ultimately be better. Waiting to act until a patient gets sick is innately harmful. It violates the sacred Hippocratic oath’s quintessential line: “do no harm.” Prevention is the best medicine, and it is also the most ethical. But is it truly financially advantageous?

Up until very recently, the American healthcare system entirely relied on the antiquated, unethical, and costly fee-for-service model. Most care delivery in the US still currently relies on this model. However, in 2010, a landmark act was introduced that is pioneering the “prevention over cure” movement in American healthcare. In March of 2010, under president Barack Obama, the Patient Protection and Affordable Care Act (also known as “Obamacare”) was signed into law.^{13,14} In this act, Medicare, the nation’s government-funded health insurance for the disabled and people over the age of 65, introduced a brand new

concept: Accountable Care Organizations, known as ACO's. ACO's were "first proposed as a theoretical model for improved health care as a way to combat ballooning health care costs—particularly for those with chronic illnesses and those under long-term treatment plans under Medicare."^{13,14} An ACO was the first healthcare model to prioritize prevention of illness; a drastic change to healthcare as we know it. Its two main goals were to improve healthcare quality and bring down costs. How? Re-incentivization of healthcare. Under the ACO model, healthcare providers are provided monetary stipends for managing the care of their patients. Most importantly, providers are tasked with keeping their patients well and out of the hospital. ACOs require doctors to share information on patients and work together as a care team to create the best care plan tailored to the patient... all with the goal of wellness in mind.

ACOs have been around for ten years now, so preliminary long-term benefit data is just now being synthesized. The financial data speaks for itself. In the year 2014, ACOs saved Medicare a total of \$411 million.¹³ ACO patients also benefit from increased healthcare quality. Patients discharged from ACO participating hospitals have lower per-discharge Medicare spending (about \$206 less per patient on average).⁵ Patients who were admitted to ACO programs, when they did need to go to the hospital, had lesser lengths of hospital stay and less chance of being re-admitted to the hospital post-discharge.⁵ Based off of the data currently available, ACOs have been proven to provide better care quality and lowered overall cost, all while preventing disease from occurring in the first place. Under the ACO model, doctors are being paid to keep their patients healthy, not to subject them to more care that they do not need. It is a dream come true for healthcare as a whole, but this transition will take much more

time and effort. The United States of America continues to spend trillions of dollars on healthcare annually, yet our quality of care is nothing to be proud of. Year after year, the financial strain of healthcare negatively impacts the lives of the American people. American healthcare is preoccupied with frivolous and costly testing, treatment, medicating and performing procedures that are very often necessitated by disease patterns that could have been fully prevented in the first place. It is both economically and ethically wrong. Healthcare being a business is not the problem. The problem is the mis-incentivization that exists in the industry. Doctors are paid for the procedures and treatments that they provide, regardless of the resulting outcomes for the patient. There is no incentive to keep the patient well. There is only incentive to test, poke, and prod, because that is what pays the bills of the health industry. In order to be financially sustainable, there must be a considerable cultural shift, a revolution if you will, in the American healthcare system. Episodic, fee-for-service, damage control type medical care must be traded for preventive, wellness-oriented, holistic healthcare. Medicare ACOs have pioneered this revolution in the United States. But most Americans are on private health insurance that is still based upon the old models of care delivery. In order to better healthcare for a bright, financially sustainable, and ethically sound future, these changes need to happen. It is no small feat, and it will most definitely take years of pain-staking hard work. However, as healthcare providers bound by ancient ethical principles to “do no harm,” it is their moral and ethical obligation to change healthcare for the better.

References

1. FastStats. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/fastats/health-expenditures.htm>. Published September 4, 2019. Accessed March 9, 2020.
2. Froemke S, Heineman M. *Escape Fire*. Roadside Attractions, Lionsgate; 2012. <http://www.escapefiremovie.com/>.
3. Iglehart JK. Revisiting the Canadian Health Care System. *N Engl J Med*. 2000;342(26):2007-2012. doi:10.1056/NEJM200006293422624
4. Ware JohnE, Rogers WilliamH, Davies A, et al. COMPARISON OF HEALTH OUTCOMES AT A HEALTH MAINTENANCE ORGANISATION WITH THOSE OF FEE-FOR-SERVICE CARE. *The Lancet*. 1986;327(8488):1017-1022. doi:10.1016/S0140-6736(86)91282-1
5. Agarwal D, Werner RM. Effect of Hospital and Post-Acute Care Provider Participation in Accountable Care Organizations on Patient Outcomes and Medicare Spending. *Health Services Research*. 2018;53(6):5035-5056. doi:10.1111/1475-6773.13023
6. Kavanagh KT. Financial incentives to promote health care quality: the hospital acquired conditions nonpayment policy. *Soc Work Public Health*. 2011;26(5):524-541. doi:10.1080/19371918.2011.533554
7. CDC. Obesity is a Common, Serious, and Costly Disease. Centers for Disease Control and Prevention. <https://www.cdc.gov/obesity/data/adult.html>. Published February 27, 2020. Accessed March 10, 2020.
8. Products - Data Briefs - Number 360 - February 2020. <https://www.cdc.gov/nchs/products/databriefs/db360.htm>. Published February 28, 2020. Accessed March 10, 2020.
9. Overweight/Obesity | Encyclopedia of Adolescence - Credo Reference. https://search-credoreference-com.sacredheart.idm.oclc.org/content/entry/estad/overweight_obesity/0?institutionId=4247. Accessed March 10, 2020.
10. Jardim TV, Mozaffarian D, Abrahams-Gessel S, et al. Cardiometabolic disease costs associated with suboptimal diet in the United States: A cost analysis based on a microsimulation model. *PLoS Medicine*. 2019;(12). doi:10.1371/journal.pmed.1002981
11. Willey VJ, Kong S, Bingcao Wu, et al. Estimating the Real-World Cost of Diabetes Mellitus in the United States During an 8-Year Period Using 2 Cost Methodologies. *American Health & Drug Benefits*. 2018;11(6):310.

12. Askitopoulou H, Vgontzas AN. The relevance of the Hippocratic Oath to the ethical and moral values of contemporary medicine. Part II: interpretation of the Hippocratic Oath-today's perspective. *European Spine Journal*. 2018;27(7):1491.
13. Dewey J PhD. Accountable Care Organizations (ACOs). In: *Salem Press Encyclopedia of Health*. Salem Press; 2018.
14. Auerbach MP. Patient Protection and Affordable Care Act: Overview. In: *Salem Press Encyclopedia*. Great Neck Publishing; 2019.
<https://sacredheart.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ers&AN=89158281&site=eds-live&scope=site>. Accessed March 12, 2020.