Dr Nguyen is a consultant for Edwards LifeSciences, Abbott, and LivaNova. Dr Nissen has nothing to disclose with regard to commercial support.

REPLY: SURGEONS AND HEALTH POLICY— CLAIMING OUR SEAT AT THE TABLE

Reply to the Editor:

In a recent issue of the *Journal*, Mennander and colleagues¹ provide an insightful summary of cardiothoracic (CT) surgical training in the Nordic countries. Although not the focus of their manuscript, the discussion of universal health coverage is certainly unique compared with the current status quo in the United States; a point nicely expounded on in a recent editorial by Vervoort and colleagues.²

Under our current market-based system, it is clear that millions of patients are left without access to health coverage and without the potential financial safety net offered in single-payer systems. While procedural, medication, and follow-up costs continue to rise, the likelihood of patients needing CT surgical care that is financially prohibitive or injurious will continue to grow, while clearly any sentient surgeon or physician understands why such circumstances should not drive health care decision making. As inequities in the social determinants of health are increasingly studied, one point appears increasingly clear—that universal health coverage offers high-quality care without financial hardship for those most in need.

What may be simultaneously frustrating is that our current system for physician reimbursement is sorely inaccurate without apparent systematic rhyme or reason, with CT surgeons being the most underreimbursed specialty, according to a recent examination of the Medicare Fee Schedule by Chan and colleagues.³ Financially, it appears the current system within which we operate is broken from both the perspective of patients and their surgeons. But what can the CT surgical community do about this?

On an individual level, the simplest step is prudence with regard to cost containment, whether that be avoiding unnecessary testing, expensive equipment with little added value intraoperatively, and use of best practices shown to decrease lengths of stay for our patients. More broadly, it is time for surgeons to claim their seat at the table for future deliberations and policy changes. It is clear that previous policymakers have missed the mark, and who better than us to advocate for our patients, communities, and the health care system within which we work every day? Institutional and hospital-system involvement represent critical

grassroots-level leadership opportunities for meaningful change, whereas the Society of Thoracic Surgeons and American Association for Thoracic Surgery Workforce on Health Policy, Reform, and Advocacy as well as the American College of Surgeons Health Policy and Advocacy Group are both national-level groups offering myriad opportunities for involvement to make our collective voices heard. There is no better time than now, and who better to advocate for their patients than their surgeons?

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REPLY FROM THE AUTHOR: CHERRY PICKING OR CHOOSING FOR BETTER AND WORSE

Reply to the Editor:

On behalf of my co-authors and myself, we gratefully acknowledge the insightful comments on universal health coverage by Vervoort and Swain¹ and very much thank them for their interest toward our manuscript.² The *Journal* offered us an exceptional opportunity to discuss cardiothoracic specialization in the Nordic countries, and we sincerely understand that our manuscript is only part of a whole series of educational aspects.

Nordic cardiothoracic surgeons believe in the efficiency of the tax-based, single-payer model characteristic to the Nordic countries. The strong tradition of equity of the citizens is present in medical decision-making. It is impossible to exchange money for a desired treatment, which is decided on medical indication only, eg, an aortic valve stenosis cannot be treated by transcatheter means if the method is considered medically questionable to the individual patient. The Nordic consultants are collectively responsible

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for all the patients at their institution, especially during on-calls. Income is not based on numbers of patients treated, and therefore, the best medical treatment is thought to be selected purely keeping the patient's benefit as a priority.

Complimentary health care is mandatory, as the Nordic community is responsible for the well-being of its citizens. Free health care in the Nordic countries has proven to be essential in controlling epidemics, rehabilitation from drug and alcohol abuse, and assuring proper follow-up treatment, including pharmacy. Social security covers wages during unemployment, pension, and sick leave. Maternity and parent leave are secured by the Nordic states. There is relatively low emergency department crowding in the Nordic countries, as opposed to many other countries.³ The Nordic citizens are tracked by an individual social security number, which serves as an identification code for lifelong follow-up of the patient before and after medical care. The system extends to complimentary education, including elementary schools, high schools, and universities. The Nordic states secure lodging and catering.

There is a high price to be paid for the maintenance of the Nordic welfare society; mainly this means high and incremental taxes. Criticism includes the loosening of independent self-care and increasing guardianship. Social security and equity cannot be taken for granted and need balancing between adjustments and updating. The Nordic system seems to necessitate constant vigilance against threats that try to gnaw social equity. Voluntary private health insurances are carefully inspected to avoid the creation of distorted fast-track treatment lanes only for citizens who are

capable of affording them.^{4,5} Increasing waiting times for elective hospital care have driven interest toward hospital choice reforms to motivate the patient to choose his/her hospital.⁶

Advocacy for a Nordic universal health coverage demands submission to sharing of all social benefits and responsibilities. The system is above all practical and ethical for the Nordic countries, but its world-wide application may require special attention to local traditional and historical values. No holistic system may be changed overnight. The possibility to attain high-quality education, rehabilitation after surgery, least to mention pure water and nourishment, are also interdependent virtues that are requisite for maintaining collective health, satisfaction, and responsibility.

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