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Views on the ethical struggle for universal, high quality, affordable health care and its relevance for gerontology

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ABSTRACT

The US pays about twice as much per capita for health care than any other developed country, yet its health metrics rank among the lowest among peer nations – for example, the US has 12.2 maternal mortality deaths per 100,000 compared to 4.8 in Canada which, like other developed nations, has a single payer health care program. The leading cause of bankruptcies in the US is attributable to medical expenses. Despite recently introduced legislation (the Affordable Care Act) many millions of Americans remain uninsured or underinsured. We shall consider views on the pathogenesis of such a dysfunctional health care system and make suggestions for how it can be improved. We shall also emphasize the importance of an integrated system of universal health care for population-based epidemiological research and preventive medicine, including its implications for the enhancement of the healthspans and lifespans of future generations via trans-generational inheritance. Finally, we suggest that the anticipated major health care savings of such a system, if partially invested in basic and translational research, should accelerate progress towards further gains in healthspans and lifespans.

1. Introduction

We must first ask why a publically funded single payer system of universal health care is of special relevance to medical ethics as it impacts our geriatric patients. Answers to that question are motivated by an extrapolation of a favorite admonition by the late Robert Butler, the founding director of the National Institute on Aging and a Pulitzer Prize author (Butler, 1975). His response to skeptics concerning the need to support research on aging was to remind them that our elderly grandparents are "our future selves". Given the growing evidence from research on epigenetic inheritance (Bohacek and Mansuy, 2015), the substrate for healthy aging can potentially begin at least as far back as grandparental generations and most certainly are functions of the quality of pre-natal and pediatric care. *How well one builds an organism makes a great deal of difference in how long it lives and how well it functions.* Given these views, geroscientists should not only be advocating for more research and healthcare in geriatrics; they should extend their efforts to embrace such disciplines as developmental biology and pediatrics, particularly as regards preventive medicine. The quality, universality and cost-effectiveness of a nation's healthcare system are therefore of central importance to our collective goals to enhance both healthspans and lifespans of our populations, particularly the enhancements of Healthspan/Lifespan ratios. We shall review evidence that, despite the effort of the recent Affordable Care Act, the system of health care in the US continues to fail to meet the needs of many millions of its residents, unlike other peer developed nations. Moreover, the per capita costs of our complex, dysfunctional system are about twice that of any other peer nation http://www.pgpf.org/chart-archive/0006_health-care-oecd.

As a pathologist, the author will frame the discussion in terms of the "pathogenesis" of this national "disease". We shall therefore consider six major relevant issues: 1) the hypothesis that the balance between two broad ethical views on health care (Actuarial Fairness vs. Community Solidarity) (Stone, 1993) is shifted towards the former among Americans; 2) the failure of the United States to recognize healthcare as a human right; 3) the "love affair" of Americans with the magical power of the "Free Market Economy"; 4) the American paranoia of the influence of government; 5) the extraordinary recent growth of the monetary and political power of special corporate interests in American politics; 6) the growing socioeconomic disparities within our American society. As a physician scientist, I am also interested in a "cure" for this "disease" and shall argue that we need a multifactorial approach, certainly including the development of a single payer (i.e., single bargaining agent), publically funded system of *universal* health care. Legislation already exists in the form of HS 676, a bill

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introduced in the US House of Representatives by the Honorable John Conyers (https://www.congress.gov/bill/114th-congress/house-bill/676/cosponsors.

2. Evidence for a dysfunctional US healthcare system

Let us first consider the per capita costs for health care here in the US as compared to the costs of the US health care system up to the implementation of the Affordable Care Act. As shown in Fig. 1 (see http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective), the rapid rate of growth of health care spending in the US, expressed as the percentage of the gross domestic product (GDP) is compared to 12 other high income peer nations. In 2013, our spending was at the level of ~17% of GDP compared to a mean of about 10% for the case of the cluster of these 12 peer nations. Given the slope of the US curve and absent any effective amelioration of these trends, an extrapolation into the mid-21st century could result in costs of ~25% of the GDP. Given the demographic trends of an aging society (Halaweish and Alam, 2015) and the anticipated increased costs associated with the care of the elderly, the costs of medical care could easily approach ~30% of GDP, clearly an unsustainable burden on the economy and upon those who cannot afford the high premiums and co-payments of the currently structured US system of private health insurance. Evidence that the current system is dysfunctional comes from studies of the causes of bankruptcies in the United States. In 2007, Dr. David Himmelstein and colleagues published the first-ever national random survey of bankruptcies in the United States (Himmelstein et al., 2009). Remarkably, they found that 62.1% of all bankruptcies were due to failure to pay medical bills. Moreover, there was evidence that within the six year period between 2001 and 2007, that proportion had risen by approximately 50%. Also of considerable interest were their observations that some ¾ of these medical debtors actually had some form of health insurance and were typically middle class, well-educated individuals. The contrast with what is observed in European countries with some form of a single payer universal health care system is stark: 65.2% to essentially 0%, as I cannot find any credible reports of such bankruptcies.

Now let us see what all this money has done for our health here in America. Alas, for most health metrics, we rank far below our peer nations, including our rates of infant mortality and maternal mortality. These comparative data depend upon the gestational ages of mortality. For all neonatal deaths, however, a study of 2010 data ranked the US last among 26 mostly European Nations (MacDorman et al., 2014). A recent more nuanced study clearly demonstrates, however, that the major variable underlying this statistic is the socioeconomic status of the mother (Fig. 2) (Chen et al., 2014). The US also ranks last among peer nations in the category of maternal mortality (see Fig. 3 for a sub-set of this data). One would predict that, as in the case of infant mortality, socioeconomic status may also be a major contributor to the poor US performance.

In an impressive analysis of a gerontologically relevant, but often neglected parameter – Healthy Life Expectancy (defined as "the number of years that a person at a given age can expect to live in good health, taking into account mortality and disability"), Professor Chris Murray and his colleagues found that, from among the 34 member OECD nations, the US ranked 26, just below Slovenia (Murray et al., 2013). A more nuanced set of data than that shown in these metrics would likely have demonstrated that the burden of these unacceptable results is carried by lower socioeconomic groups (Ezzati et al., 2008), certainly including many African-Americans (Rossen and Schoendorf, 2014).

The superior results of treatments for some forms of cancer in the US are interesting exceptions to the above generalizations. These achievements are associated with much higher costs than what is the case for other peer nations, however. Consider, for example, the monoclonal antibody (blinatumomab) which, when initially approved for the treatment of acute lymphoblastic leukemia by the US Food and Drug Administration, was priced at $178,000 per year (https://en.wikipedia.org/wiki/Blinatumomab).

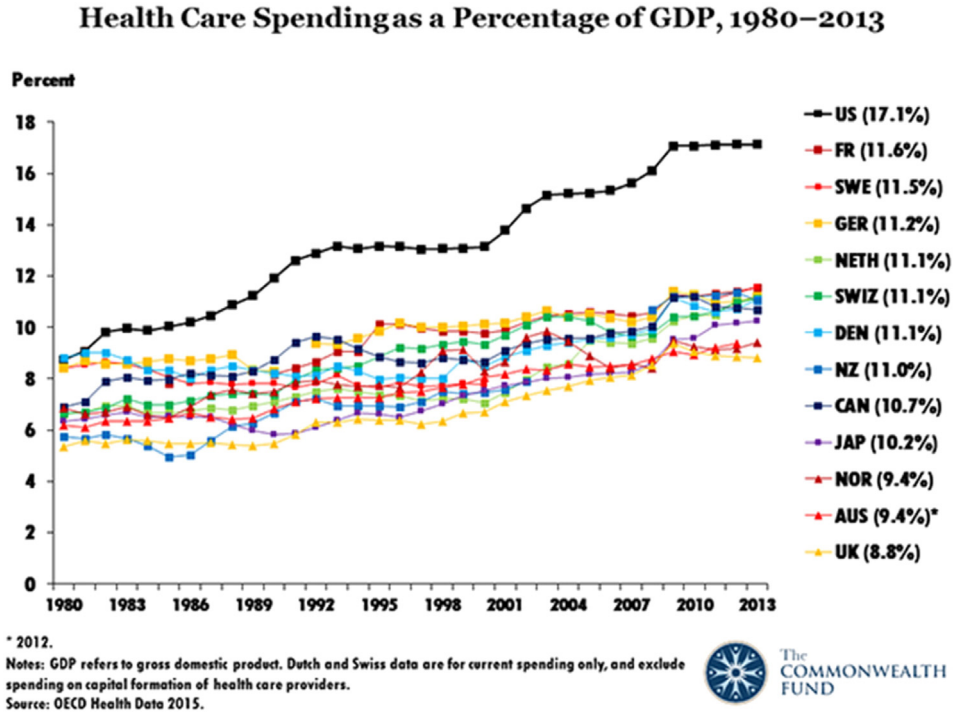

Fig. 1. The rate of increase in health care expenditures in the United States, expressed as percentages of GDP (Gross Domestic Product) greatly surpasses those of 17 other developed countries. Figure is reproduced with the permission of David Squires of the Commonwealth Fund.

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