



Are We Looking at an Overwhelming Crisis in Healthcare, or A Poorly Hidden Opportunity Calling on us to Improve our Systems? Perhaps Both?

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Commentary

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Abstract

We need to face reality; the impact of many recent changes is and will be negative. Arguably adding a profit motive to health insurance systems in the second half of the 20th Century was one complication we didn't need. The result being the change for what in much of the world is a public service to a for-profit business lacks an ethical basis. One of the great ironies of our time is the opportunity to address many of the issues in healthcare, including this one, may well be upon us soon. The basic issues of access and quality, general education and prevention are facing us all at the same time. When we see comparative data showing us that our allies and competitors around the world are experiencing lower morbidity in many chronic conditions and longevity far beyond the US, scream to professionals and policymakers that the time to address these issues is now and our situation is getting rapidly more complicated and expensive.

Keywords: Bioethics; Chronic Disease; Public Policy; Health; Wellbeing; Policy Change

Introduction

Some history to remember, the evolution of healthcare from a private physician (often working out of their home) to sophisticated hospitals and technology brought along significant expense and huge opportunity for income – sometimes with bioethics taking a back seat. Some of you may be saying “oh this is politics!” To a degree you have a point, there are political implications to taking actions to improve the system – or choosing to not improve the system. The reality is that some people will suffer poor health and poor health outcomes but not addressing the issues I'll note

here, and some others will result in huge differences in how many will suffer; and how much. My experience in public health and public service have exposed me to a volume of evidence that we have often undervalued risk reduction, prevention and public health, especially recently, offering us and the next generation of healthcare and public health professionals a tremendous opportunity to see changes that move the numbers in a positive direction [1-3].

Let us review some of the facts (thank you to the team at RWJF regarding one area that gets attention – work requirements for access to Medicaid and SNAP benefits [4].



The research is clear that while this concept dovetails with American folklore about the value of hard work (which I agree with in many instances), with these populations the facts are different due to a myriad of factors including access to support systems, housing, transportation, education, nutrition etcetera – you get the meaning – informal supports make work a practical addition in some instances and an overwhelming exclusionary tactic in many others. First some facts, contrary to popular beliefs among Medicaid participants who are not enrolled in disability or Medicare programs, 64% work full or part-time. Common reasons for not working include caregiving responsibilities, illness, and attending school. In SNAP more than 80% of families report at least one person working in the past 12 months. I offer this as a commonly proposed “system improvement” that has already been shown to not result in the touted improvements.

These politically motivated, but scientifically not supported ideas require a second level of analysis. This would include questions like:

1. How can we integrate those in poverty into life and systems that reduce their dependency and improve their health and opportunities to become self-supporting?
2. Which health services need to be available to the population as a whole to reduce the significant cost of chronic conditions and premature mortality, especially those factors that include human behaviors and modifiable risk factors?
3. What steps are needed to ensure access to basic primary and preventive care from birth to death?
4. What steps are available to reduce healthcare dependency related to behavior (i.e. DPP, Obesity Prevention?)?

I addressed several of these questions in a Commentary in mid-2025 and suffice it to say: “our situation is more complicated and worse” [5].

A recent Commonwealth Fund Report offers additional information [6]. First, we can look at the percentage of GDP spent on health, the US at 17.8% while the international comparison group averages 9.6%, I offered the example that most modern democracies have 100% of the population with health insurance compared to the US with 62% Voluntary Insurance and only 38% with Government Insurance. At the same time the US life expectancy at birth is three years lower than the average and US rate of avoidable death is 336 per 100k population compared to the average of 225 per 100k. Other key factors include the US Obesity rate almost double the average and the US leads the group in adults with multiple chronic conditions. The US is also significantly below the average for practicing physicians per 1,000 population and has among the lowest number of hospital beds by population. So we spend more for worse results and more suffering, what’s wrong with this picture?

Conclusion

This data, and the fact we’re facing another period for policy change offer us an opportunity to catch up to other nations while building a healthier population and health systems that respect the individual and community.

We need to stick with science and facts, we have evidence of what works, and we need to call out misinformation for the danger it is to all of us [7].

We need to realize the value of investment in prevention and public health and education of the future workforce across health and public health.

We need to recognize the value of all the professions focused on health and wellness working together with similar goals and collaborative approaches. This will all be a smoother and more efficient process if we share basic principles to motivate us. All this we need to approach respecting the values of our founders like “All are created Equal” and the principles referenced above including [8]:

- Autonomy (fully informed decision making for ourselves and those we serve);
- Beneficence (always begin with intention for good for all);
- Non-maleficence (avoidance of harm, “first do no harm”);
- Justice (requiring fairness for all).

This involves all the engaged and related professions, many of which already profess to adopt these or similar principles.

I’d like to emphasize two points. First, the issue of misinformation and disinformation has been demonstrated to be an obstacle to progress. It has also operated on an entirely unknown level with the advent of social media and other easily accessible on-line tools (complicated further now by artificial intelligence). It would be a grave error for health professionals or policymakers to underestimate the damage already done and continuing in this arena [7,9].

Secondly, the conventional wisdom regarding Alzheimer’s disease and other dementias is out of date. With many thanks to groups like the Alzheimers Association, Lancet Commission, and countless committed researchers and volunteers, we’re now in a position where the huge and growing body of research leaves us with much hope for the future and wins already in the arenas of early detection and risk reduction [10,11].

As mentioned above, we’re in trying times. Challenges in many areas push many to their limits, we must not overlook the co-occurring possibilities for positive change, improved health and longevity that can be shared by all.

Lastly, as I've highlighted in these pages before [12], we need to relearn the lesson again: "Leave room for hope". The daily news can be discouraging on many levels; our experience tells us that there are also many hard-working people around us with good intentions and belief in values and ethics in health and public policy. We can each offer encouragement and support for progress and be part of the solution.

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