

## Not the Last Word: Medicare for All is Not Enough

Joseph Bernstein MD

Although the United States currently does not guarantee health care to its citizens, that arrangement might change soon. In the current Democratic primary season, many politicians are promoting “Medicare for All.” This so-called single-payer system would expand traditional Medicare (currently limited primarily to people older than 65 years of age) to all Americans.

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Medicare for All likely will require trillions of dollars in additional federal spending, as even its supporters concede. And trillions of additional federal spending, as supporters of Medicare-for-All will soon find out, is much too much.

Yet there is a stronger argument against Medicare for All, beyond the problems of cost: Not that it is excessive, but rather that it is inadequate. That is, Medicare for All will not be able to deliver on its implicit promise of equal opportunity for the best possible health outcomes.

The moral justification for universal health care is that all citizens deserve an equal shot at attaining good health. Although people might accept an economic system in which the wealthy have nicer cars and bigger houses, a healthcare system in which the rich receive the best of everything but the poor are left to languish is repugnant.

Nonetheless, Medicare for All cannot erase the health disparities driven by wealth. Simply put: Even if everybody had the same health insurance, wealthy individuals will have better health outcomes—for health outcomes depend on more than just access to health care.

Consider two patients with minimally displaced tibial plateau fractures,

one patient with a high income, the other patient with low income, both treated with the same operation. In that setting, it is likely that the patient of greater wealth will end up with the better result. Wealthier patients usually have fewer comorbidities. Wealthier patients are less apt to smoke cigarettes, which can affect bone healing, of course. Wealthier patients may have more “social capital”—friends and family to drive them to physical therapy, for example. Wealthier patients might more easily obtain accommodations at work and at home, and therefore, may be more able to follow the surgeon’s suggestion to stay off the leg [6, 7].

The relationship of healthcare outcomes and socioeconomic status, despite similar access to healthcare coverage, was powerfully demonstrated in the Whitehall study. In this landmark report [8], the authors studied 17,530 civil servants working in London, all of whom are covered by the National Health Service (a “British Medicare for All”, one might say). The researchers found a strong relationship between a person’s levels of civil servant employment and life expectancy. Workers with higher civil service rankings had better outcomes, even though all participants in the study had health insurance.

Orthopaedic surgeons might have a special perspective to share on this issue. Orthopaedic surgeons have witnessed a natural experiment testing the premises of Medicare for All. They have cared for a cohort of patients who were given

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complete coverage—coverage that’s actually more extensive than Medicare for All. With this coverage, these patients had no co-pays or deductibles. Durable medical equipment was provided. Time off for therapy—and even in many instances, transportation to therapy—was provided. Nevertheless, these patients’ outcomes were consistently “less favorable” [5] with twice the risk of a negative outcome [4]. These patients’ outcomes have been so much worse, many journals allow outcomes studies to segregate those patients from all others.

Who are these patients? These patients are those with workers compensation insurance.

I sense an objection: “Joe! You are forgetting about confounding! These patients are different!” Well, no doubt injured workers are different, but that’s the point. People who currently lack insurance now also are different. (In the Whitehall study, for example, a lower civil service rank was associated with a higher prevalence of health risk factors such as obesity, smoking, and sedentary lifestyle.)

I am not laying blame, and I am not saying the confounding factors are inherent, but they are present and should not be ignored. Critically, even if the relationship between wealth and risk factors fully explains unfortunate outcomes that some unfortunate patients attain (and in Whitehall, it did not), the larger point holds: Merely giving healthcare coverage to everybody will not give all people the same opportunities for well-being.

The example of workers compensation clearly demonstrates that providing full access to health care does not provide full access to the best chance for health. Medicare for All will come up short. The trillions of dollars needed to implement Medicare for All should be spent elsewhere.

### Joseph A. Bosco III MD

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Each person living in the United States ought to have access to basic affordable health care. Yet despite healthcare spending of more than 3 trillion a year, 28.5 million Americans do not have health insurance. Lack of basic health insurance equates to lack of healthcare access. Certain policymakers have advocated Medicare for All and a government-run single-payer system as a way to solve what philosopher David Hume termed the “is to the ought” problem. The estimated cost of Medicare for All is around USD 32 trillion dollars over 10 years. Medicare for All would also require privately insured individuals to forgo their insurance and join the government program. The price tag and the requirement that all join makes Medicare for All unlikely to come to pass.

More than one-third of all insured Americans are covered under a federally funded healthcare plan (Medicare, Medicaid, or Child Health Plus). This has resulted in a sizable federal healthcare bureaucracy and an unsustainable level of healthcare spending. We must ask ourselves whether it is wise to expand this bureaucracy in order to enact Medicare for All. Dr. Bernstein presents a cogent argument against it. He correctly states that this program would not correct the social determinants of health (smoking, obesity, and poor diet). He rightly argues that the growing socioeconomic healthcare disparity is a societal problem that will not be addressed by simply offering insurance to all. So what are we to do? How can we allow our country to continue to lead the world in per capita healthcare spending while lagging behind our peers in the overall health of our population?

First, we need to determine what reasonably constitutes “basic” health care. This requires us to define and promote high-value procedures and preventative medicine. Most importantly, it would require fiscal discipline and difficult decision making as to which interventions are covered for which patients. Second, we ought to provide this level of insurance to all who desire it based on their ability to pay. This should be done through public-private partnerships who are allowed to compete for patients on a national basis and are not encumbered by bans on interstate insurance. This is already being done with some success in the form of managed Medicare and managed Medicaid. In these programs, private entities are paid Medicare or Medicaid rates and are responsible for managing the health of their covered lives. Patients are free to drop out of these programs if they are not satisfied with the care provided. These managed programs are growing as patients continue to be satisfied with the care they provide.

The American Academy of Orthopedic Surgeons believes that all people living in the United States ought to have access to basic healthcare at an affordable price. Nothing is controversial about this statement. How we get there, without bankrupting our country, is the challenge. There are many possible solutions to this problem, and they all will require some level of governmental involvement. However, I believe that Medicare for All is not a tenable way of getting from the “is to the ought.”

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Dr. Bernstein selected a hot-button political topic to discuss, about which

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most (if not all) of us likely have strong opinions, and my use of “us” is not restricted to the readership of this journal. I’d also venture to guess that many of us are rather uninformed about the proposal commonly referred to as Medicare for All. By way of full disclosure, the opinions that I express here are my own, and do not represent the opinion of the University of Missouri (or any of its affiliates).

Dr. Bernstein believes that Medicare for All seeks to reduce healthcare disparities, and he feels that it will not do so. In that opinion, he is partially correct. Providing healthcare insurance will not magically do away with healthcare disparities that may be related to socioeconomic standing. Healthcare coverage will not change lifestyles, such as smoking, alcoholic beverage consumption, or use of illicit drugs. However, it would provide those who are currently uninsured (or underinsured) with the ability to visit with a physician of their choosing. It may mean that these individuals do not have to seek out the local emergency department for a consultation on a non-emergent problem. It may mean that they will not be triaged only to be moved on to yet another provider for care that could easily be delivered at the point of encounter. Also, it may remove the possibility that an individual with insurance may be cared for by a physician who is less competent than a neighboring physician (because they will be paid); I know of at least one instance where a patient received an “OIF” (Open Internal Fixation—note the absence of the letter “R” from ORIF as no reduction was performed) of a tibial plateau fracture, only for that patient to come to implant revision and intra-articular osteotomy because screws were placed into the joint itself at the time of initial fixation.

Healthcare disparities exist throughout the world. Were one to look at

Sweden, the United Kingdom, or Canada, for example, where health care is thought (at least by Americans) to be delivered in an even manner to all, they would find that there are still pockets of those populations that have comorbid conditions that may be related to their poverty [3, 9, 10, 12]. Population-based research studies have shown that living in socioeconomic deprivation increases the risk that a patient will have heart disease and diabetes compared with those who have more [1, 11]. Provision of healthcare insurance would not erase these problems. However, it might make it easier for those individuals to have ready access to convenient and timely care.

The use of workers compensation insurance as a comparison to Medicare for All is misguided. Secondary gain issues, such as continuing to be paid while out of work despite the possibility that full recovery from the injury has transpired, are relevant here. To my knowledge, Medicare-for-All has no provision of payment for patients who are out of work on account of their maladies. I agree completely with Dr. Bernstein that workers compensation outcomes are poorer than those seen for patients with private insurance for multiple problems [2]. However, the systems are entirely different, and a rejection of Medicare for All cannot be based upon perceived failures (or successes, to be fair) of workers compensation insurance.

Whether Medicare for All is a good idea is debatable, but it will almost certainly not equalize the health and well-being of people in differing socioeconomic strata, and it may not completely eliminate healthcare disparities. That is not a reason to reject the idea of expanding healthcare coverage to those who currently have none. Those are insufficient grounds to

allow so many people to remain without access to care. In a country as wealthy as the United States, all patients should have—at the very least—access to care. The fact that providing access will not eliminate all disparities is no reason not to try to eliminate some of them. Medicare for All should improve health compared to our current system, albeit at substantial cost to society. As such, it will almost certainly require substantial tax increases to fund and sustain it.

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