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ETHICAL CHALLENGES TOWARDS SUSTAINABLE HEALTHCARE WITHIN CHANGING DEMOGRAPHIC AND ECONOMICAL ENVIRONMENT

Abstract. Healthcare services are facing continuously enormous amount of cumulative knowledge, increasing number of new processes, technologies and devices applied, and altogether with growing administrative, processual and legislative entropy within healthcare systems increases number and importance of ethical issues of healthcare. Progressive complexity of situations requires adequate level of education also in non-medical branches, including ethics to support not only medical, but as well ethical dimension of responsibility. All that within environment of raising global social inequality, change in demographic structure, limited economical and raw resources and generally expected fair access to modern healthcare. Antagonism among scientific and technological advances and economical limits and availability need to find balance between freedom of unlimited healthcare services consumption and responsibility for expenses of its overuse to find forthcoming future of healthcare sustainable.

Keywords: healthcare, ethics, demography, economy, sustainability

WYZWANIA ETYCZNE DOTYCZĄCE ZRÓWNOWAŻONEJ OPIEKI ZDROWOTNEJ W ZMIENIAJĄCYM SIĘ ŚRODOWISKU DEMOGRAFICZNYM I GOSPODARCZYM

Streszczenie. Usługi opieki zdrowotnej stają w obliczu ogromnej ilości skumulowanej wiedzy, rosnącej liczby nowych procesów, zastosowanych technologii i urządzeń, a wraz z rosnącym procesem administracyjnym, procesualnym i entropii legislacyjnej w systemach opieki zdrowotnej zwiększa się liczba i znaczenie etycznych kwestii opieki zdrowotnej. Progresywna złożoność sytuacji wymaga odpowiedniego poziomu wykształcenia, również w oddziałach niemedyce, obejmujących etykę, aby wspierać nie tylko medyczny, ale i etyczny wymiar odpowiedzialności. Wszystko to ma miejsce w kontekście podnoszenia globalnych nierówności społecznych, zmiany struktury demograficznej, ograniczonych zasobów ekonomicznych i surowcowych oraz ogólnie przewidywanego sprawiedliwego dostępu do nowoczesnej opieki zdrowotnej. Antagonizm wśród

postępu naukowego i technologicznego oraz ograniczeń ekonomicznych i dostępności musi znaleźć równowagę między swobodą nieograniczonej konsumpcji usług medycznych a odpowiedzialnością za koszty jego nadmiernego wykorzystania, aby znaleźć zrównoważoną przyszłość opieki zdrowotnej.

Słowa kluczowe: opieka zdrowotna, etyka, demografia, gospodarka, zrównoważony rozwój

Healthcare services, according by WHO, are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions. Improving, and let me add sustainable access, coverage and quality of services depends on these key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users¹.

Antagonism between scientific and technological progress on one side, and economical possibilities, access and availability on the other will necessarily have to face in very short time more an more questions regarding possibility to maintain present and presumably future growing quality, range and accessability of healthcare.

Interaction between individual healthcare service provider and its recipient is historically determined by the presence of illness, eventually suspicion of it, or an effort to prevent it. This interaction was always not only clinical transaction, but commercial too, based on the principles of privacy and confidentiality. Ethics of such relationship was, and still is supposed to be, deontological, and in the centre of its interest stands individual patient, and not demands of the whole healthcare system, regional or state economy or politics. But, wider context of interactions become unavoidably and necessarily core utilitarian with inevitability of limited resources utmost utilization. It means – taking care of individual patient is at first place, but within a frame of limited time and sources at the disposition. Availability of highly professional standards offered by highly qualified personel and its inaccessibility due to resources insufficiency creates tension between deontology of individual healthcare service provider interaction with patient, and utilitarian character of the system, allowing to bring healthcare towards patients. This situation describes perpetual dilemma between limitations of general resources and claims of any individual patient for the whole range healthcare. Limits of economical resources are accepted and applied in all healthcare systems, including the richest. Restrictions of modern applications and approaches in diagnostics and therapy in the sense of economical, material and human resources allocations represent compelling ethical, and in its consequences also social and political problem. Hence it seems unavoidable to seek conjunction of ethics and economy and to find model of equitable healthcare distribution in the way of acceptable balance between unlimited healthcare services consumption and responsibility for expenses of its overuse, and fair allocation of economical resources. Although, ethical challenges are hidden it the conjunction of pragmatic, profit oriented economical rules with healthcare services system. One of the

¹ http://www.who.int/topics/health_services/en/.

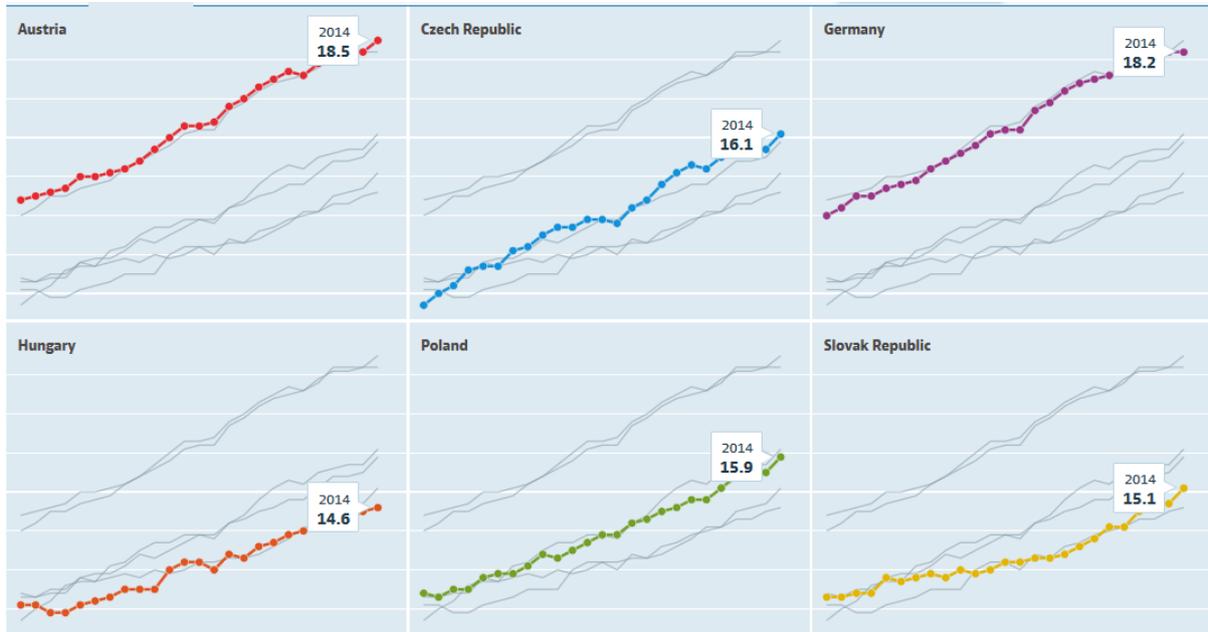
challenges is hidden in the process of privatization followed by redevelopment of the system. Systematic underfunding of public healthcare services creates systematic debt and insolvency, which can be, temporarily, „cured“ only on the highest executive level. Paradoxically, in accordance with legislation and generally in conflict with ethical values, we observe sudden profitable conversion of privatized services by contracts adjustments, and effective monetization of previously permanently loss-making processes. Even more conflicting seems to appear privatisation of healthcare insurance industry and its legal, but questionably ethical entitlements for profit, even if their income is guaranteed by law, and despite the fact that scope of pay-per-service rate is not covering real prices. Buying and selling of such services truly does not represent real marketisation of this process. Making principal beneficiaries private healthcare insurance industry instead of health insurers corrupts altruistic nature of the system. This is, of course, applicable only in situation, when private health insurance companies are component of obligatory insurance system, and do not, or cannot offer significantly distinctive extra added value for their clients. Canadian economist Robert Evans wrote in his article published 20 years ago: *International experience over the last 40 years has demonstrated that greater reliance on the market is associated with inferior system performance – inequity, inefficiency, high cost and public dissatisfaction. The United States is the leading example. So why is this issue back again? Because market mechanisms yield distributional advantages for particular influential groups*².

We can argue that European healthcare markets, including V4 (the Visegrad group) countries have its own distinctions and specifics, and widely contain solidarity items. However, strive for expeditious signature of 1600 pages of CETA (Comprehensive Economic and Trade Agreement) by brusselian globalistic proxy vices as a replacement for broadly refused TTIP (Transatlantic Trade and Investment Partnership) might raise again question asked by Robert Evans two decades ago and slowly change the nature of our healthcare systems as well as our attitude towards it. We can also unrealistically expect that our healthcare system will not meet, at minimum partially, criteria for inequity, inefficiency, high costs and public dissatisfaction holding firmly gear-shaft at first speed EU position.

Divergency among the pace of research, economical resources and accessibility of healthcare will certainly deepen due to unbearable and unsustainable grow of sustainable growth, and demographical structure transformation. Macroeconomic factors, as population ageing, or insufficient health care insurance fees have influential and direct impact on recipients as well as providers of healthcare. People are living longer and better also thanks to advances in diagnostics and therapy, increasing average life time expectancy (Fig.1 and 2), which is directly coupled with prevalence of chronic illnesses. Nevertheless, it still seems to be stunning that even after more than quarter of century of political, economical and life-style westernization is life expectancy at birth and at 65 years of age significantly lower in population of V4 countries, than in the closest neighbouring western countries. We can only presume and guess complexity of the reasons why it is so. Whether it is ecology, economy, different (worse)

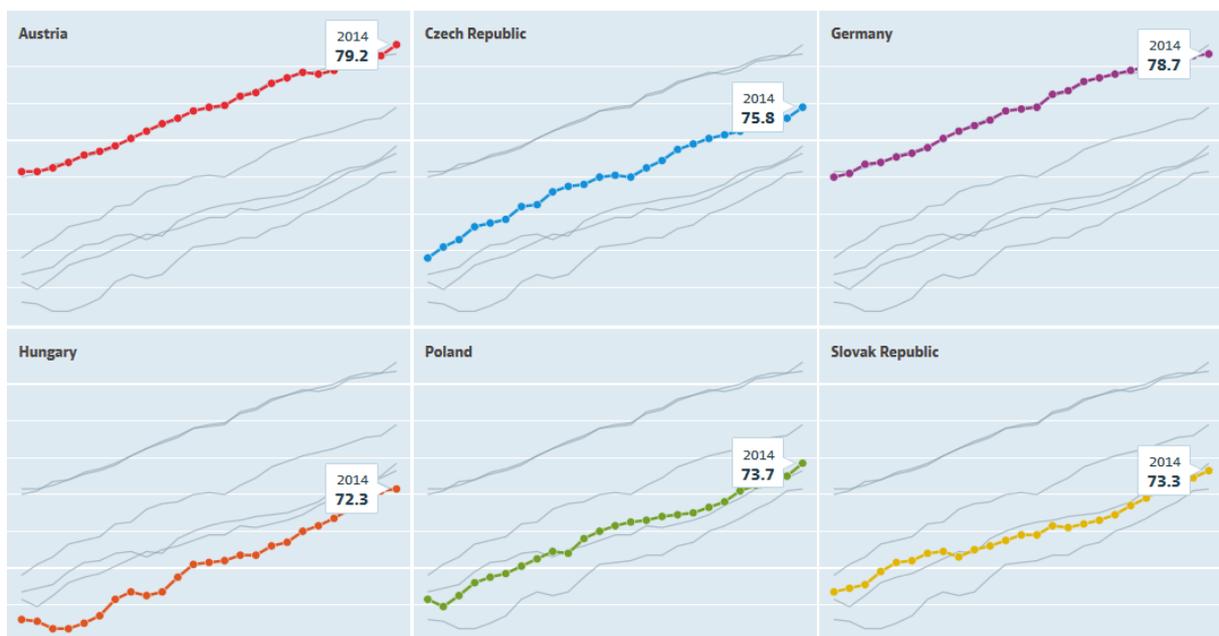
² Evans R.G.: Health Care Reform: Who's Selling the Market, and Why? "Journal of Public Health Medicine", Vol. 19(1), 1997, p. 45-49.

quality of food, tremendous social stresses in legislatively unstable environment, in/accessibility of latest medical advances and technologies, i/legal drug abuse, genetic burden or other unnamed factors mixture. The positive fact is that we can observe growing life expectancy trends also in V4 countries.



Life expectancy at age 65 years old is the average number of years that a person at that age can be expected to live, assuming that age-specific mortality levels remain constant. Life expectancy measures how long on average a person of a given age can expect to live, if current death rates do not change.

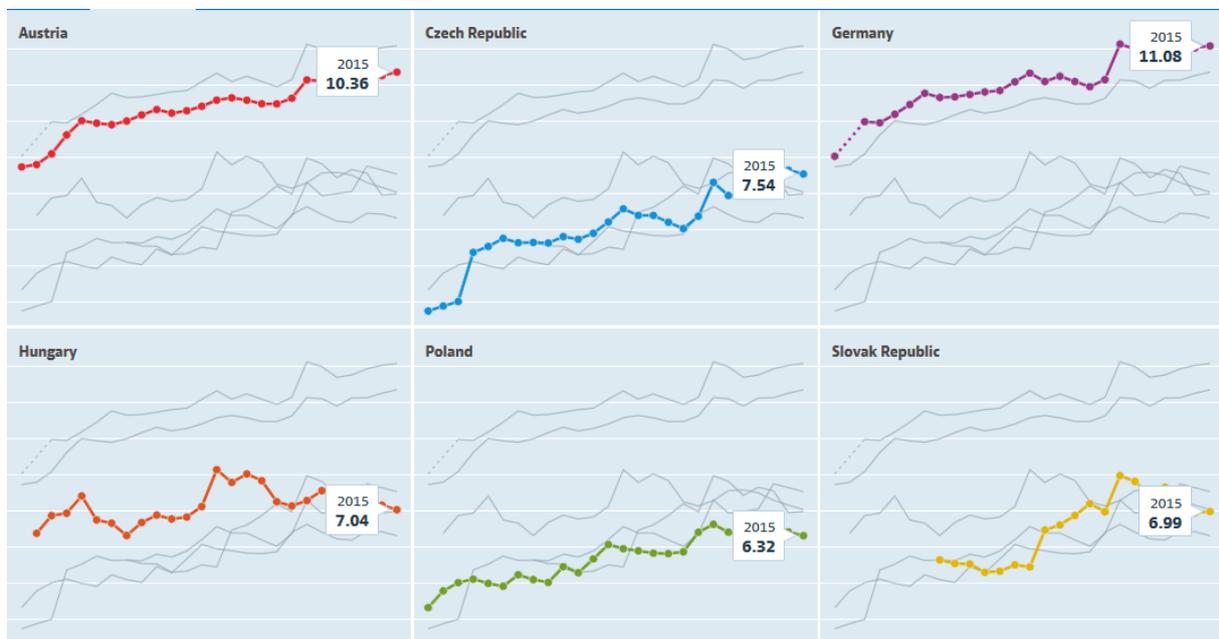
Fig. 1. Life expectancy at 65 years 1990-2014 (www.oecd.org)



Life expectancy at birth is defined as how long, on average, a newborn can expect to live, if current death rates do not change. Life expectancy at birth is one of the most frequently used health status indicators.

Fig. 2. Life expectancy at birth 1990-2014 (www.oecd.org)

Majority of the countries present healthcare, besides economics, as substantial political agenda, and its status is intimately related to state economy condition (Fig. 3). Fact is, that healthcare services expenditures in V4 countries are similarly like life expectancy curves significantly lower than in two neighbouring western countries (Fig. 4).



Health spending measures the final consumption of health care goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments.

Fig. 3. Health spending – % GDP 1990-2014 (www.oecd.org)

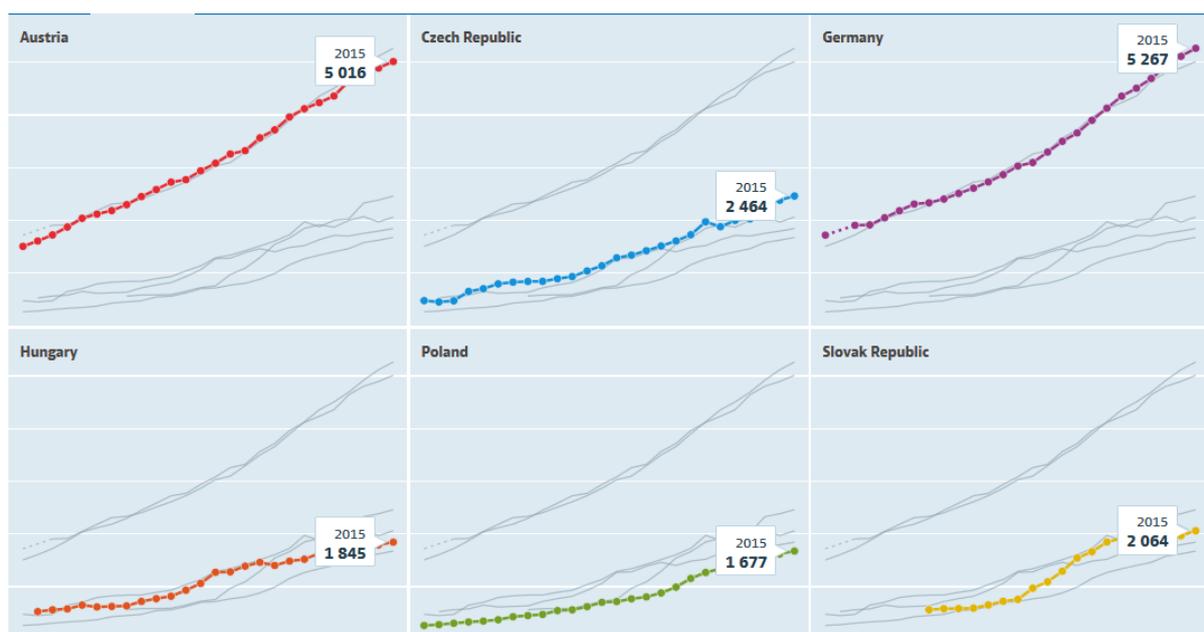


Fig. 4. Health spending – USD/Capita 1990-2014 (www.oecd.org)

Figures and curves show not only close connection between economy and healthcare, but moreover what is obvious in the EU and globally as well – economical inequality on national, and without a question on individual level, too. The economical inequality was identified by World Economic Forum as a major threat to social stability³. That economical inequality which achieved level when richest 1% own more wealth than the rest of the planet⁴. That economical inequality when eight men now own the same amount of wealth as the poorest half of the world⁵. Situation, when incomes of the poorest 10% of people increased by less than \$3 a year between 1988 and 2011, while the incomes of the richest 1% increased 182 times as much⁶. Situation which became unsustainable and unjust, when more and more people are no longer willing to tolerate it. We can only wonder whether global scheme of disproportionate and unjust wealth distribution is mirrored the same way on our national levels. It became less and less difficult to see different levels of poverty, specially in certain region of V4 countries, walking hand in hand with unemployment and bad housing. Poverty accompanied by literacy, poor hygiene and illnesses incompatible with epidemiology of wealthier and more fortunate part of the population. Worsened quality of education, not reduced only on the impecunious, supports theory of planned „global debilitation“ of population in order to achieve its easier manipulation by downgrading level, range, amount, quality and validity of educative informations and processes, and does not preclude potential for systemic inequality relief. Interestingly, these problems were clearly identified in 1942 by William Beveridge and presented in the „Report on Social Insurance and Allied Services“⁷, and came into history as „the five giants of poverty“. These giants create vicious circle of want, disease, squalor, ignorance and idleness. It is still riveting how plenty of his observations and recommendations are still valid and would be beneficial to present society.

Probability of forthcoming development and sustainability would be potentially acceptable under similar political, economical, social and demographic presumable trends and conditions we observed in the last decades. But, recently number, pace and quality of changes is aggravating globally and probability of system re-configuration is rising. And, learning from history, we should not forget about „black swan theory“, which is metaphor describing extremely rare, unthinkable and unpredictable event occurrence generating profound changes, and having enormous impact magnitude on consequences afterwards. The theory was introduced by Nassim Taleb in his book „The Black Swan“ published in 2007, being reviewed

³ World Economic Forum. Global Risk Report 2012, http://reports.weforum.org/global-risks-2012/?doing_wp_cron=1478086016.053333997726440429687.

⁴ Credit Suisse. Global Wealth Databook 2016, <http://publications.credit-suisse.com/tasks/render/file/index.cfm?fileid=AD6F2B43-B17B-345E-E20A1A254A3E24A>.

⁵ Oxfam calculations using wealth of the richest individuals from Forbes Billionaires listing and wealth of the bottom 50% from Credit Suisse Global Wealth Databook 2016.

⁶ Hardoon D., Ayele S., Fuentes-Nieva R.: An Economy for the 1%. Oxfam, Oxford 2016, <http://policy-practice.oxfam.org.uk/publications/an-economy-for-the-1--how-privilege-and-power-in-the-economy-drive-extreme-inequ-592643>.

⁷ sourcebooks.fordham.edu/mod/1942beveridge.html.

by Sunday Times, as one of the twelve most influential books since World War II⁸. The author establishes inability to forecast the unexpected event of large impact, which after the occurrence and retrospective analysis by the overpriced analysts and prognosis-makers is explained, and set as a predictable and expectable. The possibility of such an event to occur lies also in individual and collective blindness ignoring retrospectively obvious facts and chain of decisions, actions and events funneling, often in front of our (blinded) eyes, into „the black swan“ phenomenon. Historical examples of „the black swan event“ are many, with positive or either negative impacts – theory of relativity, internet, mobile phones, vaccination, Chernobyl, Fukushima, 9/11, Lehman Brothers, Hitler, ISIL, black death pandemy, Spanish flu etc. These events usually do not repeat, and occur despite the fact, that we have data and informations necessary to make appropriate conclusions, but they are not linked together or taken into account. Having this in mind we should be cautious to make too much optimistic predictions about future healthcare and economical sustainability. Specially, when not disregarded european political and economical agenda is nowadays question of organized, invasive, uncontrolled, unscreened and unregulated migration, which could be the next „black swan“ or another „giant“ added to Beveridge’s five. Migrating masses of predominantly uneducated and unqualified male population of the different origin inevitably bring into less and poorer vaccinated, but so far sustainable healthy european continent undisputable health risks and presence of the bacterial strains, viruses and parasites defined as an exotic, dangerous and difficult to diagnose and treat. And as an exotic and difficult, understand uncommon and expensive, is diagnosis and treatment of such a diseases caused and related to them.

So what are the main risks? The main risk lies in epidemiological jeopardy of nature of the most widely prevalent diseases in Africa and Middle East. Not unknown for Europe is HIV virus, which is largely prevalent in subsaharian Africa, where became problem not only medical, but political and economical as well. Long-life retroviral therapy is very expensive and potential epidemic spread would lead to healthcare insurance collapse. Tuberculosis (TBC), and specially multiresistant type, which is in subsaharian countries the main cause of death in HIV positive patients, is on the rise in EU countries. Treatment of TBC represents six months of therapy in detention, with screening and eventual treatment of all contacts, which is, in case of unregulated migration „policy“ impossible. Treatment of multiresistant TBC takes two years with very expensive and noble medical drugs. TBC is not entering EU only from traditional middle east and african countries, but also from former USSR republics and Ukraine. Malaria is altogether with HIV and TBC one of the main killers in tropical and subtropical countries of Africa and Asia. However, the probability of plasmodium transfer in V4 countries climate is very low, the cost of treatment is inversely related to its probability. Pertussis, poliomyelitis and other diseases, formerly almost eradicated on European continent, are also seen more frequently, and liberal vaccination policy could lead to severe hit back in the future.

⁸ Appleyard B.: Books that helped to change the world. “The Sunday Times”, 19.07.2009.

Unawareness of such diseases, often in asymptomatic stadium and with long term dynamic, hand in hand with difficulty, complexity and costs of diagnostics and treatment underlines risks we are all exposed to.

The irresponsible action of eurobabylonian elites, massively and uncritically supported by massmedial mainstream newspeak and NGO's, purposely overlook and underestimate these risks and long term impacts not only on prevalence of so far unseen or extremely dangerous and rare diseases among domestic population, but also tremendous extra burdens on national health care and social budgets. So are we, apart of assumed globalistic aims to change european population pattern, ready to accept, without profound expert discussion, these health risks and to carry significant burden of unavoidable expenses, when healthcare and social budgets restrictions are already yearly tight? Is it ethical and right to require, not ask, for false solidarity in the situation of long standing economical genocide, when east european payrolls and pension revenues are still so significantly lower, and slavery wages, loss of economical perspective and chance for dignified life expelled out of our countries thousands of young people? There is no argument about the will to offer help to people running away from the disasters of war, bur frankly, do we know, or better – do we wish to know what percentage of such a people is among the hordes of social travellers? And can we identify margin line between humanitarianism, abusement of weak liberal system still intentionally keeping uncontrolled its geographical borders, and direct threat to political, epidemiological, economical and social stability? Is it ethical and right to give priority and find immediately resources for migration supporting policy, and for quarter of century to refuse resources rise and share to support domestic populations? Why are we being ordered, under the threat of penalties, to accept without discussions presence of health risks, our taxes derived extra expenses, religious and cultural intolerance and incompatibility with european environment, and certainly not possibly to ignore specific types of law violations? Under these circumstances it is legitimate to ask bureaucratic euroelites for quarantine zones, where asylum seekers should be concentrated (australian example could be inspirational), and for use of diplomatic armamentarium to discuss asylum offer in the rich countries of the same cultural and religious values and traditions. Obviously, to accept the arguments of cultural enrichment, fulfillment of labour market in situation of domestic countries youngster unemployment rates and slavery wages, or demographic restructuralization of ageing European continent is attacking level of intelect of the opposing part and offending pure common sense.

This situation undoubtly does not support assumption of possibility to maintain current level of healthcare and sustainability of social system. Demographic restructuralization, strive for federalization of euro-atlantic market, its potential superiority of hypothetical competitiveness, privatization of benefits and socializing of losses, gigantic disproportion of wealth distribution, unregulated invasive migration – all that generate conflicts with possibility of political, social or even brachial rupture and also „the black swan event“ by chance. Selective targeted blindness does not preclude impending consequences. What is already confirmed in

medicine – prevention is the cheapest therapy – could be possibly applied to handle present and forthcoming ethical and economical challenges. Unless it is already too late for prevention, and aggressive systemic therapy should be prescribed. Maybe already with the aim to prevent assisted suicide.

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