Public health expert speaks on the crisis of American healthcare

Cases like Hedda Martin's heart transplant denial "will continue to happen"

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The *World Socialist Web Site* spoke this week with Dr. Laura Siminoff, Dean of the College of Public Health at Temple University in Philadelphia, to discuss the crisis of public healthcare and accessibility of organ transplants. The WSWS asked Dr. Siminoff to comment on the recent case of Hedda Martin, a 60-year-old Grand Rapids, Michigan woman, who was informed by letter on November 10 that she could not be placed on a list for a heart transplant due to "needing [a] more secure financial plan."

The Spectrum Health Richard DeVos Heart and Lung Transplant Clinic instead urged Martin to make "a fundraising effort of $10,000." Martin and her son courageously posted this notification on social media and GoFundMe, tapping into an outpouring of support as workers and young people nationwide decried her callous treatment, donated generously out of their own pockets, and insisted in a myriad of different ways "no person should be denied for reasons like this."

As a result of public outrage and generosity, Martin raised nearly $30,000 on the crowdfunding site and has been subsequently informed by Spectrum Health that she will be placed on the transplant waitlist and can receive a mechanical pump to assist her heart function during her transition. The family thanked her well-wishers saying that Hedda's hope for a good quality life was entirely "because of you."

It is estimated that hundreds of similar denials for lack of money occur each year for heart transplants alone (not to mention other organ transplants or complex procedures) and fail to find such a positive outcome.

Dr. Siminoff is an expert in this area of public health, having conducted research for over 25 years on health disparities, bioethics and issues of organ and tissue donation. Together with a group of colleagues, she authored a paper in 2005 entitled "Health Insurance and Cardiac Transplantation: A Call for Reform."

In fact, the paper, published in the *Journal of the American College of Cardiology*, began with a story similar to Martin's, that of a middle-aged African-American woman with end-stage heart failure whose cardiologist "noted the urgent need for cardiac transplantation." The woman had no private insurance and her income made her ineligible for public insurance despite her long history of steady employment.

"Therefore, she was not evaluated for transplantation, as it was known that she could not be listed for a transplant in the absence of funding for the procedure," explained the authors. "Over several weeks, her condition continued to deteriorate despite maximal medical therapy and she was made 'do not resuscitate' at her request before expiring. The hospital discharge note included the following statement, 'All attempts at transplant were thwarted by lack of funding'."

Dr. Siminoff and her colleagues have drawn the public's attention to the government's failure to even track cases like Hedda Martin's. There are no records being maintained on the number of people excluded from necessary heart transplants because of lack of funds, much less the action necessary to provide this care.

According to their statistical models, a detailed explanation of which is found in the 2005 paper, the authors estimate that an initial one-year cost for funding heart transplants to those who need them and cannot afford them (about 330 people) would be about $130 million, with another $60 million over the next five years. Even with a decade's worth of inflation, this is a drop in the bucket.

By comparison, the 2018 Congress has approved $708 billion for military spending. Even Donald Trump's military parade now planned for 2019 is expected to cost $92 million, nearly half what it would cost to provide heart transplants and make up-to-date surgical procedures available to those who desperately need them.

Dr. Siminoff's body of work strives to raise fundamental questions about fairness and ethics in the current healthcare delivery system. She emphasizes the marked discrepancy between organ donations and organ recipients. The group's study estimates that as many as 25 percent of the poor or uninsured *give* their organs, but fewer *receive* them. "Health Insurance and Cardiac Transplantation: A Call for Reform" concludes, "We believe this situation to be untenable and to violate one of the basic tenets of bioethics, the principle of justice … specifically the general inequity inherent in asking a group of people to contribute to a pool of resources not generally available to them."

This paper was reprised in an ABC News expose with the provocative, but truthful, title, "Need an Organ? It Helps to Be Rich." In that article, Siminoff again emphasized the role of socioeconomic status in securing access to these advanced medical procedures, "[Transplant] Centers have different practices. And if

you're a well-to-do patient, you can shop around to centers. But if you don't have any money, you will go wherever is closest, and their policies are what you are stuck with."

The WSWS spoke to Dr. Siminoff by phone on November 28.

WSWS: Are you aware of the case of Hedda Martin who was recently denied a place on the heart transplant list because of her lack of resources?

Dr. Siminoff: I haven't followed the case of Hedda Martin particularly, but the paper I worked on in 2005 is still relevant today. This is largely because of our unequal health system. It is now more and more for-profit.

We have spotty coverage for our citizens, dependent on whether they have health insurance or access to the range of healthcare needed. Because of that, the sorts of cases like Martin's will continue to happen.

WSWS: Why do you believe these patients continue to be turned away for necessary medical help?

Dr. Siminoff: First of all, the healthcare system we currently have doesn't guarantee that those all who can possibly donate an organ, can also receive one. The one real exception is kidney donation and transplantation. Years ago, when dialysis was first being used to maintain kidney function for individuals who had failing kidneys, there was a shortage of dialysis machines. Local communities would have a committee that would meet and decide who would get access to this treatment and obviously that produced a lot of bias as to who was worthy.

As techniques and facilities became more accessible, Congress decided to include this coverage under Medicare. Now if you have a failing kidney and need dialysis, it comes under Medicare. But that's not true of any other organ—heart, lungs, etc. Generally, one doesn't hear about these cases [denial for inability to pay] for kidney transplantation. It is one of the most equitable pieces of our healthcare now.

But, depending on coverage, your insurance may or may not cover a heart transplant. This treatment may be out of your reach.

WSWS: What is the role of poverty?

Dr. Siminoff: Socioeconomics plays a huge role, for example, as to whether you have insurance at all or insurance that will cover this procedure and also whether you can afford the aftercare.

The actual transplant is just one step in the process. Getting the organ is just the first step; maintaining the graft is equally important. The ability to afford those drugs that will ensure the health of the transplanted organ is critical. If you find you cannot afford the antirejection drugs, you are going to be just as bad off as before the surgery, if not worse. To transplant an organ without the ability to maintain the transplant is not a good use of a scarce resource. The drugs are very expensive and that moves us to the whole issue of the cost of medication in the US.

Under the initial legislation for Medicare coverage of kidney transplantation there was only limited coverage for the medications. It has since been expanded. A symptom of the irrationality of our health system is to cover the cost of a transplant but not the medication needed to prevent rejection of the transplanted organ. There is a complete irrationality here. It's part of the reason we're now seeing a decrease in our statistics for longevity. All [of the inequities] are catching up to us.

WSWS: What are the inequities you are speaking about?

Dr. Siminoff: Issues like the unequal access to primary care, early treatment of hypertension, or the availability of prenatal and maternal care. Then there is the opioid crisis. These issues are far more important from the standpoint of the whole population.

It's hard to know where it's all going. We see an administration trying to take the Affordable Care Act (ACA) apart. These are political and policy decisions. The next few years will be telling. We should be alarmed that the Centers for Disease Control and Prevention (CDC) recent mortality report indicates a continuing increase in mortality, especially among individuals ages 25-44 and 85 and older.

In 1980, the US had some of the best healthcare outcomes in the world. Since then, there has been a gradual decline in our health statistics. Basic primary care is not as accessible as it needs to be. We have unusually high infant and maternal mortality rates in the US. They are worse than our peer countries and worse than even some developing countries.

When I was training there was no Type 2 diabetes in children, only Type 1. Yes, it's poverty, it's not having access to proper nutrition, it's food deserts in cities and more. This is symptomatic of a health system which is not working any more for a lot of people.

WSWS: We agree with much of that, except the implication that the Affordable Care Act was designed to solve these problems. ACA was written by the insurance companies, pharmaceutical corporations and hospital chains and aimed to expand their profits.

Dr. Siminoff: Yes, the ACA certainly wasn't the Medicare Act. Originally it was thought that ACA was one step in the process of obtaining healthcare for everyone, but it never became Medicare for all. The act was very flawed and particularly its implementation was flawed.

The state of public health in this country is poor. It is completely underfunded. Most public health is state and local, and the funding for those systems is highly variable.

We have the CDC losing funding for years. We shouldn't be thinking about it just when we have scares like Ebola, but every day and for everyone. We should be thinking about clean air or the lack of it—populations living near brownfields—I understand the water still isn't safe in Flint. Obviously this can't continue.