Death Panel Podcast

TRANSCRIPT: Adam Gaffney on the Pandemic And a National Health System (Medicare for All Week 2021)

SPEAKERS
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Beatrice Adler-Bolton 00:00
Welcome to Medicare for All Week, for today's episode, Phil and I are sitting down with a returning favorite from last year's series. Dr. Adam Gaffney is a practicing physician writer, public health researcher and advocate for single payer. He is the most recent past president of Physicians for a National Health Program (PNHP). And he practices Pulmonary and Critical Care Medicine at the Cambridge Health Alliance, as well as teaching at Harvard Medical School. Adam, welcome. It's so great to have you back.

Dr. Adam Gaffney 00:28
Thank you for having me back.

Philip Rocco 00:29
This is long, this is long overdue. It's good to talk to you again. And also, thanks for taking the time to catch up with us. I know you've been pretty swamped.

Dr. Adam Gaffney 00:38
It's been a very interesting year to be a critical care doctor, which is never a good thing.

Beatrice Adler-Bolton 00:44
Yeah. For real.

Dr. Adam Gaffney 00:46
You don't want interesting years for ICU medicine, if you can avoid.

Beatrice Adler-Bolton 00:52
Definitely not. In our last discussion. Last year, we talked a lot about the past battles for single payer, the current battle for Medicare for All, we touched on the way that the question of labor and labor power factors into it. But this year, we're hoping to frame the series from a more forward looking perspective, it's all about how would a single payer program like Medicare for All be a valuable tool in building a larger movement for health justice and equity, moving towards something better for everyone? So I

guess my first question, which is an obvious but really important one, how have you been holding up during COVID? You're, as you're saying, your scope of practice is directly relevant to the pandemic...

Dr. Adam Gaffney 01:35
Well, it's a very, I mean, look, I'm very fortunate compared to so many people in this country. Obviously, all the people who've lost their lives, the family members of those individuals and friends, and then all the massive economic dislocation that this has brought and the job loss and insurance loss and all the harmful ramifications. So I mean, I'm very fortunate in every way. What I would say is that it has been very, you know, odd in a way to have my policy interests and political concerns, so directly tied into my practice, which isn't typical, and, obviously I the sort of policy issues that we think about healthcare, justice and reform issues about insurance and underinsurance, I mean, all of these things, we see the the downstream effects of, in the ICU, make no mistake, but it's always a little more removed or not quite as tied in with with the sort of what's in the headlines, that particular moment. So it's been, for me, it's been a moment where I've been, I'm in the intensive care unit, on average, every other week. And then I've been trying to use my other time to understand and address some of the health equity implications, and specifically with the focus on healthcare implications of all this. So yeah, it's been a, it's been a very strange year, for lack of a better word.

Beatrice Adler-Bolton 03:12
Yeah. I mean, I feel like it's really unfortunate that the SARS-CoV-2 pandemic is such a, I guess, blatant demonstration of the urgency of this policy that you've been working for many years on pushing? Do you feel like with the pandemic, this is brought, like increased awareness of how helpful Medicare for All could be, within your peer community or within the medical profession at large?

Dr. Adam Gaffney 03:39
I do. I don't have any sort of hard survey data on that question. But my sense and anecdotes suggest: yes. For one thing, I think, one of the things we focus on the most when we talk about Medicare for All — the need for national health insurance — is sort of more on the access side, which is the critical and the most important. And that's uninsurance. And underinsurance and ability to go to the doctor's you need and all that, and I'm sure we'll come back to that a bit. But I think one of the aspects of the need for a national health program that the pandemic has brought out is something that is connected, but it's sort of related, but it's separate. Right? And that's on the supply side. The fact that we, without a national health program, you tend to have market chaos, right? This was seen in every aspect of the response, and some of it was just willful disregard and incompetence by the Trump administration, but some of it is, in all fairness, not Trump's fault because it predated Trump, right? So the fact that we don't necessarily have healthcare facilities where we need them, but we always have them where they're profitable, that's a sort of downstream consequence of the way we finance healthcare, the fact that some health facilities are very well resourced and others are not and it just so happens that those are not are in poorer places are disproportionately people of color. That's the ramification of the health financing system, the fact that hospitals have no great way of sharing resources, personnel, PPE, ventilators, I mean, these things came together in an ad hoc manner. In fact, that amount of cooperation, I think might actually reinforce the need for a national health program. But I think the pandemic certainly laid bare the need for planning, and planning I think became a four letter word in the neoliberal era. But when it comes to, and it's not good, you know you don't want planning when it

comes to neighborhood restaurants, but when it comes to healthcare, planning is actually needed. And we don't have enough of it in this country.

Philip Rocco 05:47
Well, I was really curious, you wrote this essay in Dissent, I think back in the summer, because you talk a little bit about how, actually what was happening on the ground, and the way that your ICU began to work with other hospitals, it actually kind of illustrated the the value of planning. Can you talk a little bit about that? I thought that was really fascinating.

Dr. Adam Gaffney 06:10
Absolutely. So in addition to some of my clinical work in the ICU itself, I've played a role helping with logistics in terms of moving patients to where they need to be — cooperating with other hospitals to get patients where they need to be. The reality is not every hospital has all the tools that it needs. There's some very advanced technologies, you know, you may have heard of ECMO, extracorporeal membrane oxygenation, which is a sort of artificial lung that's only available in certain hospitals, and only limited numbers. And the reality is, when you have something like a pandemic, hospitals can't function on their own, you need to think of it as a system, a regional system. So we were involved with hospitals in the Massachusetts regional area. And conference frequently, this is actually still ongoing, and, to coordinate where patients are gonna go when beds are tight when technology is tight, and that happens other places. I'm not trying to exaggerate the extent to which it was in any way unique to Massachusetts. The epidemic made clear that you do need systems and you do need planning, and you do need coordination, and that coordination and not competition is really intrinsic to the healthcare mission. I think that this made that clear.

Beatrice Adler-Bolton 07:39
Yeah, I keep thinking about if we had gone into this pandemic, with Medicare for All established, how many things would be so much easier, just both in terms of, for example, portable medical records. I keep thinking about this, I have some doctors who are on the Epic system, and I have some that are on proprietary systems. During normal times, it's a pain in the ass to make sure that everybody is on the same page. But the pandemic has made that so much more difficult. And you're you're also seeing this, I think, well, at least like anecdotally, anecdotally speaking thing where you have patients that are perhaps seeing an Urgent Care physician, getting a positive test for COVID, and being given antibiotics right off the bat and that there's these basic errors and communication errors and charting errors that are also happening, just as a general result of the disorganization. And I feel like there are so many small things like that that would be changed, just through simple coordination, just through the removal of all these different pass throughs that basically exist between the provider and the patient.

Dr. Adam Gaffney 08:51
Mm hmm. Absolutely. And I think another way, another manifestation of this that I think it's going to become increasingly obvious, is in the vaccine rollout. I think there's little question that the fragmented system as it is, regardless of what you think about prioritization schemes, because I'm becoming, I'm sort of coming to think of that as less important than the fact that we don't actually have a health service to bring this to the people where they are. And that whatever the prioritization scheme is, it's going to

result in inequities because of that, and I think that remains to be totally shown, but I think it's highly likely.

Philip Rocco 09:29
So, Adam, one of the things that I remember reading, that you'd written, I can't remember if it was before or after the pandemic started, was you did this little analysis of just how much public health funding as such has cratered in the United States. And it just occurred to me that even the way that we think about that, the way that we define public health, as such in the United States is so limited because we don't have a system like a single payer system. So the way that we think about the resources and facilities for public health is hived off even, conceptually from the way that we think about individual medicine. And so that just introduces all of these contradictions when you begin to face a pandemic.

Dr. Adam Gaffney 10:18
Oh, absolutely. And I think, the underfunding. I mean, it introduces contradiction, as you say, and just on a pure resource level. The proportion of total healthcare spending that goes to public health is massively inadequate. We've been undercutting public health for many years, and I think that has resulted in job losses and inadequate choices. The reality is, most of public health is actually — even though we think of the CDC a lot and Fauci is always in the news and so on — it's really the local and state health departments that are doing this, or the majority of the boots on the ground work that you need, whether it's test and trace and contact tracing, or whether it's some of the vaccine logistics. The fact is that we need to recognize that where we are today is not, and I'm guessing we probably all agree on this, but where we are today with the pandemic is not simply the result of the bungled response to the Trump administration, it stems from a lot longer legacy of defunding of the public sector as a whole and the shift towards a market driven society, that that left us where we are, I think that if a better president had been empowered, it would have ameliorated some of this, but it wouldn't have eliminated it.

Beatrice Adler-Bolton 11:44
Yeah, I think that's a really good point, because I think too easily people just dismiss the situation that we're in now on like, "Oh, Trump = bad, therefore, pandemic response = bad." But it's so much more complicated, because healthcare is just a conversation about the allocation of resources, and we're seeing strains on resources across the board, especially when you think of hospital capacity, and the fact that you have these regional choke points where you have more, let's say, hospitals with a little bit more liquid capital on hand, because maybe they're in a wealthier neighborhood, offering nurses pay like $5,000 to $6,000 a week, if you'll just travel out of your county in into ours, because we're short staffed, because COVID — and the fact of the matter is, rural hospitals can't afford to offer the same. And you have this movement of expertise and labor power away from where it's needed the most. We're seeing constantly the worst case scenario effects of both, the trend of defunding the public sector, but also hospital consolidation, and the shift to a profit model for hospitals, that's very dependent on really lucrative surgeries and it's just laying bare how unsustainable our current system is really, because when you have it stressed at all, which right now, it's under a lot of stress, but even just a little bit of stress, really tips the balance, and it becomes immediately obvious how cruel and unequitable it is.

Dr. Adam Gaffney 13:26
I mean, you put that really well, and I think I have a very similar perspective, I wrote a piece for the Baffler a few months ago, sort of on this issue, in recent years, there's been a lot of discussion about the issue of high sort of hospital prices, meaning like what hospitals are able to charge private insurance, which is a problem, and it's a very real thing. But what that kind of discussion misses is a couple of things. First, it misses the fact that there are these big disparities in resources, as you outlined between hospitals, yes, there are certainly hospitals that have bigger budgets, they need to, to provide care to their communities. But there's a lot of hospitals that don't have enough resources to take care of the people in their communities. Right. And that's absolutely an area where you saw COVID, once again, expose that. There was this one very simple analysis in JAMA that basically just compared total COVID hospitalizations in different boroughs of New York with the number of hospital beds in each borough. And if you follow this New York stage of the pandemic, there was a general sense that some of these hospitals that were less well resourced were much more overwhelmed. I think it's not surprising that will be the case but that happened, and why are there these giant disparities in resourcing behind hospitals? There was another article in Health Affairs more recently, that ties into what I do in terms of care unit medicine, and we don't really usually think of intensive care units as like something that's, you know, we don't usually think of it in terms of disparities for various reasons, mostly good ones, but this article just showed that, like, they look at communities, and the number of ICU beds per capita, and they compare that to the community's median income. And they found that about half of the poor communities had no ICU beds. So that's obviously going to have a big impact when it comes to response. That ties back into the planning issue, which is we don't have healthcare facilities, necessarily, where we need them, we have them where they can turn a profit. Second of all, healthcare facilities are not always financed according to community need, they are often financed according to community means. And so we have what I refer to as supply inequality, which is, what it is, it's pretty obvious. And it's actually, it's connected to, but not totally the same as what we might refer to as demand inequality, which I don't like because it uses demand in the way that economic economists use it, which is to mean that, if I have more money, I can have more demand. But, functionally, what it means is that people don't necessarily aren't able to get the same regard, even if they're living in the same place and have access to the same hospitals, a less well insured, a lower income person is unable to get the healthcare that they need, according to their medical needs. Because of that. So there are these two interrelated, very tightly interrelated, slightly separate concepts.

Philip Rocco 16:36
Yeah, that's helpful, because I feel like at the beginning of the pandemic, a lot of the quite the way that, almost from the beginning, people started framing, the implications of COVID-19, for the Medicare for all kind of debate was like, "Oh, well, what's going to happen when x percentage of people lose their insurance?" But in a way, it goes so much deeper than that, because it's about whether or not people can actually receive care in their normal, place of residence, and how far they have to go? And are there going to be adequate resources there? Just on the basic supply side, even before you get to the question of how they're going to fare in terms of insurance coverage?

Dr. Adam Gaffney 17:18
Exactly, exactly. You know, and those are the two sides of the coin. And in many ways, both sides of the coin are like, I don't know the right word, are degrading to some extent or getting worse, in the

sense that I mean, on the demand side, and again, it's a weird way to I don't like the term demand for this. There have been falls in uninsurance, with the Affordable Care Act, as we all know, about 20 million people gained coverage that's been attributed to the law. But there's been a gradual rise over the last, since the beginning of Trump administration, there has been a rise of about 2.3 million people losing insurance. So that's actually getting worse, at least for the last four years. And then, of course, there's the whole under insurance pandemic, you know, we're up to about 44 million people underinsured, although that number is, like, very specific, it's a specific definition of under insurance. And it actually excludes both children and elderly. So that number, it actually doesn't include the Medicare population or kids, it's only working age adults, it comes from a Commonwealth Fund survey. So that's on the demand side, but the supply side, there's been a lot of studies that have shown again, and again, that the closure of hospitals is disproportionately impacting rural communities, of course, we know that, but also just like, primary health care and if you just look at, even at one study of Philadelphia, and different communities within Philadelphia, where there's no primary care doctors correlates with a higher proportion of minority individuals. Another study looked at, and looking at trends in time, we found that nursing homes are closing disproportionately in poor communities. So there's inequality in our [society], everyone knows that inequality is rising in society, we usually think about inequality in terms of economic inequality, rightfully, because that's the big part of it. Economic income inequality has been growing since the 1970s, late 1970s. But I think the rise of health inequality, although people were sort of familiar with it, doesn't get as much emphasis, life expectancy between rich and poor has been widening, and health care access, in a way, has as well. My colleagues looked at this going back, I wasn't involved in this study, but going back to the 1960s, they found that medical expenditures for high income versus low income, which is a measure of their overall use of health care, there was sort of a gap, and it actually narrowed after Medicare and Medicaid in the civil rights era into the 1970s. But it's been growing again, suggesting that we're moving towards a system where more and more we're allocating services and healthcare generally, on the basis of means not needs.

Philip Rocco 20:04
Well, that's a real, it seems really important because I feel like one of the frustrating things for me about this debate in the way that it plays out both to the extent that you see, a senate Senate Budget Committee hearing, or if it's just sort of discussed briefly on the news is that the debate over Medicare for All almost gets narrowed down on to like, sort of one outcome of interest versus another, either people are just talking about in terms of how much more or less is this going to cost or how many more or less people are going to be insured or insured at an adequate level? Or it's some other kind of very, very narrow kind of thing, but I think what your your work sort of both in the clinic, and also your your research kind of shown this really interesting way, is that it's wrong to be a reductionist in the way that you think about the the value of Medicare for All. Sure, it makes it maybe easier to talk about, because you can recite a single statistic or it's gonna do this one thing, but in a way even just focusing on for example, economic inequality, or even just health inequality has a way of delimiting the way that we talk about the possible benefits of it.

Dr. Adam Gaffney 21:27
No, I think you're right. And I think this is a larger issue about messaging as well. Remember, during the 2016 primary debate, when Clinton and Bernie were debating about health care, one of the things that Clinton said during one of the debates, and I'm sort of paraphrasing roughly here was like, "Well, look,

we already got 91% there," meaning 91 coverage, "why don't we just go the final 9% rather than sort of starting from starting all over again?" Right? And I apologize to Clinton if I've mangled that paraphrase too much. But I think that's basically accurate. And there is a sense in which some people think that that's like, all this is about is like, oh, let's just plug in this one hole, this sort of 9% that has kind of fallen between the cracks, we need to find some sort of solution for them. The more I learn about healthcare, the more I realize it's not just about covering the 9%, who are uninsured, which is absolutely important. And it's not even just about eliminating financial barriers, for everyone else, which is also absolutely important. And it's not even just about getting rid of restrictive networks. It's also about other things, it's also about actual justice, when it comes to the supply side, as we talked about already, it's also about the fact that fragmentation is a fundamental defining feature of our healthcare system. The 9% that we hear uninsured doesn't do justice to the reality of what people in this country go through, which is that far more people will have interruptions to coverage, at some point, far more will have changes in networks, that suddenly they realize they're getting bills they didn't think they would have because their insurance only covers that provider, that hospitalization, or they can't even fill the prescription, because it turns out that drug is not covered, and therefore they have a delay in starting that medication. And who knows, maybe winds up in the intensive care unit, because it was insulin? Right? I think the more you are immersed in the healthcare system, and I don't mean, I'm sure the two of you may both have first and second hand experience in this, you realize that it the fragmentation in of itself is, is such a fundamental pillar of our healthcare system that does so much damage, both psychologically and physically to people and financially.

Beatrice Adler-Bolton 24:02
Oh, for sure. And there's the additional knock on effect of the fact that this fragmentation also prevents us from being able to collect usable data, in order to try and mitigate some of these things. One of the issues that I've experienced a lot in my own advocacy is people have been like, well, we don't collect this data. So we'd have to start collecting it first before we could change anything because without the data, we can't measure success or failure of the program. And I get that, you have to evaluate whether or not policy interventions are successful however, I feel like often, you know, we completely lose out on on tons of useful data just from the simple fact of there being so many insurers, we could use billing data, to get a better idea of general health need in order to try and better allocate resources. It would be even better if we had some sort of comprehensive, like American NHS, but better, obviously. But even if we were just passing Medicare for All and Long Term Care tomorrow, you would all of a sudden have information about how many people in America have autoimmune diseases, which we don't study, how many people are actually filling their prescription for their inhaler every month. And this is the kind of planning that healthcare really demands, especially when so many things make you sick, not just regular viruses. People's homes are making them sick, we can't necessarily realize that someone's water is making them sick. But if we had Medicare for All, and all of a sudden you start to see this data come through for a particular community. What better canary in the coal mine than, "Oh, my god, there might be something going on here." And we need to direct some emergency resources towards I don't know, you know, like making sure people aren't being poisoned by their air, water and house.

Dr. Adam Gaffney 26:00
I think that's a great point, I think that a single payer system does have advantages that go beyond the expansion of coverage, or even the planning of infrastructure that we've talked about. I think you're

right, that it does give you tools to better understand the health of the population. I mean, incredibly so, right? I mean, you can understand not just a sample of the population, but the population itself, which is a rare, you know, it's hard to do that, you know, I think it is another example of a way in which a universal system can be very useful, and that pertains, explicitly to the pandemic. I don't know if you followed this story with some of the clinical trials that have been done for severe COVID. You know, it was found in this trial that steroids are sort of life saving. Have you heard about this at all?

Philip Rocco 26:50
No.

Beatrice Adler-Bolton 26:50
Yeah, we've been covering...oh, well, Phil hasn't. So please, and probably listeners haven't as well, but so please give us a little overview.

Dr. Adam Gaffney 26:57
For sure. Well, when the pandemic hits there's obviously an urgent, sudden need to know what drugs work, what drugs don't work, what treatments work, what treatments don't work, right? And, and those of us on the provider side are unsure, we know a lot about viral pneumonia, acute respiratory distress syndrome, which is what severe COVID basically is ARDS, it's a severe inflammation of the lungs, often causing lung failure entirely, but there wasn't adequate knowledge. And to get good, hard information on what actually works you, of course, need randomized clinical trials, because all the observational data is always sort of just, there's just too many factors. And it's hard to know what to make of it. So you need randomized trials. And so you know, they start in and there are some that are done. But in the UK, they launched something called the recovery trial platform. Basically, it allowed them to very rapidly, very quickly, very efficiently run, basically national level randomized trials, in some cases, enrolling up to a quarter, I think of the total COVID population. And they were able to get big answers to critical questions at a rate that, at a robustness of data that no one else was, so I use the example of steroids dexamethasone is a steroid. I'm trying to remember when they actually published this, I want to say it came out in May, I think it was in, like...

Beatrice Adler-Bolton 28:31
Yeah, I think it was like back in mid-May...

Dr. Adam Gaffney 28:33
Which is incredible!

Beatrice Adler-Bolton 28:34
Which is astonishingly fast.

Dr. Adam Gaffney 28:35
Astonishingly fast!

Beatrice Adler-Bolton 28:36
So fucking fast! Imagine if we had something like that here and in the UK...

Dr. Adam Gaffney 28:40
Yes!

Beatrice Adler-Bolton 28:41
...what if we had an international version?

Dr. Adam Gaffney 28:42
Exactly.

Beatrice Adler-Bolton 28:42
Imagine what we could do with that. It's like... [sighs]

Dr. Adam Gaffney 28:45
Right!

Beatrice Adler-Bolton 28:45
Ah, [sighs, laughs] sorry.

Dr. Adam Gaffney 28:46
And it's such a lot. No, I mean, it makes me upset too, because the reality is the recovery trial found that steroids have a BIG life saving impact. And we weren't using them for the most part before that. That was massively life saving, it's hard to even like, based on their data, many, many, many lives have been saved, because we know that steroids work. And there was concern before that trial came out that steroids may even be harmful! No one knew — we weren't sure. So anyway, you could have done that on the national level in the United States, if you did something similar. You need investment, again, in public health resources and research and then direct investment and research. But I definitely think it would have been very hard to pull this off in the fragmented US system, the UK were able to do it across their whole system within again, I think they launched it in March and had results in April and had thousands and thousands of patients. And the thing is, is the US is so much bigger than the UK, that had we done something similar — because you need to get a certain number of participants in order for the trial to be able to show something — but the US is such a bigger country that we could have actually had the answers to those kinds of questions much quicker than the UK could just by virtue of our size, or we could have asked different questions. And we could have known what would work and what would not work. So that I think is another example of the way, and so our trials have been much more fragmented, smaller, are taking longer, and so on. And a lot of them are just launched at like, you know, one hospital or a few hospitals, and they just don't give the kind of data that that can.

Philip Rocco 28:54
Right. Adam, I'm wondering, one implication, I think of what you're saying is that the — I think the way that we've seen the traditional political constituency for Medicare for All is people who are insured or underinsured. There's the history of labor campaigns for single payer, which is fragmented too in certain ways, as we've seen in the past year. So, but I mean, I think one thing that Bea and I've been talking about in the last few months, especially, is that once you start to begin opening up these

arguments and seeing all of the different potential impacts of Medicare for All, the potential constituencies seem to grow, and there seems like a lot of latent constituencies that maybe haven't been tapped into, because we haven't necessarily talked about it in this way. And I'm wondering what your experience of sort of like looking into this range of benefits, what that tells you about the potential sectors of support that we maybe might not have thought about before, because we're thinking about this in a different way?

Dr. Adam Gaffney 31:26
Yeah, that's a good question. I mean, I think, and we've talked about this, I guess, in the last time I was with you, but I do think the medical community is a sector that, particularly physicians, has been discounted too frequently. I honestly think this pandemic, and contemporaneous trends in the political economy of physician hood is going to alter that, with the consolidation that Beatrice mentioned, the fact that physicians are increasingly employees, the fact that many have seen the impact of lack of coordination and lack of integration, the way it's played out, I think that's going to generate more support, growing support. I do wonder, you know, this is a very narrow constituency [laughs], that is not going to make the difference. But I do think, in regard to what I was saying about this recovery trial and all this, the medical research community to a greater extent too could potentially see the benefits and the possibilities of an integrated system. There's probably many other constituencies that we can think of those two that come to mind, probably just because where I'm situated personally.

Beatrice Adler-Bolton 32:50
Yeah, I feel there's a huge capacity for potentially reducing some of the errors that we've seen in the COVID response as well. I mentioned, people being prescribed antibiotics right away, when they, all of a sudden, they have a positive COVID diagnosis, maybe they have a cough, they're in an outpatient setting. And part of what's been happening, it seems, there's so much misinformation about COVID, there are, especially in the United States, we're kind of like patient zero for a lot of the quackery that's going on, and, what we're seeing is actual harm being done on patients, I have a friend who does critical care in New York, and he was saying that some of the patients that he sees are in the ICU, because they were given the wrong medication in the beginning, and this is gonna, these kinds of errors are gonna happen, right, error happens in medicine. However, I feel this sort of disjointed fractured healthcare system is like actively contributing or actively impeding the transfer of knowledge at a time that it's so important.

Dr. Adam Gaffney 33:57
Yeah, I think what this gets out is a much broader point, which is, this comes up sometimes in discussions about single payer and what it can do that it can't do. And so if you have a big group, and you talk to people about single payer, a lot of times, a variety of issues come up, that are not directly related per se, to healthcare financing. Like for instance, what you're bringing up sort of patient safety or quality, or research or these other things, these things that are tangentially connected, or they're not even tangentially connected to healthcare, they're sort of tangentially connected to healthcare financing. And I think the broader point to be made is that whatever the specific problem is that you're dealing with, whether it is research, whether it is data, whether it is quality and errors as you're referring to Beatrice is not going to suddenly solve them in the sense that there's going to be medical errors under every system, there are medical errors in every healthcare system, but what it does do is it gives

you a framework to address them systematically, not just locally. And I think that's sort of the broader point here.

Beatrice Adler-Bolton 35:10
Totally. I think that's a great point. Designing a healthcare system where the finance model doesn't get in the way, which is our current situation that we have now, where we have all these other issues that are being exacerbated by the fact that we have an inefficient and frankly, cruel, finance model that supersedes everything and gatekeeps access to the various components of the care infrastructure in the United States.

Dr. Adam Gaffney 35:34
Agreed.

Philip Rocco 35:34
Yeah. And I also feel it contributes to its own stability in a way because it does make it harder for people to know who to blame when things go wrong. So it allows errors to persist, potentially for much longer, that there are fewer adequate feedback or accountability mechanisms.

Dr. Adam Gaffney 35:56
Why, and I think that's a very good point, right? I mean, we don't, it's very easy to know, in a country with a reasonably well functioning single payer system, where the problems are, and it generates a constituency that can push to fix them. But you don't even really know where that is in the United States. So, if there was a shortage of MRIs in a region or whatever "country x," that is known. It's a problem. Politicians can be pressured, the problem can be fixed, life can move on. We don't even know where those kinds of, or, you know, maybe someone does, it's buried in the medical literature, but it's certainly no job to actually do anything about it. And even if it was someone's job to do something about it they couldn't do anything about it because we don't actually have the tools that would allow someone to say, all right, well, we need more MRIs in Tucson, I don't, we probably don't need more MRIs in Tucson, I'm guessing. But that's just an example of the problem. And that's also why it's important to have a system that includes people across the class spectrum, the way the world is now, the wealthy have more power, and that's not going to change immediately. And if you have a healthcare system that includes people who are across the income spectrum, that actually helps you to ensure that those quality shortfalls those issues are addressed. Unfortunately, right now, we have a society where poor people's programs often just simply get neglected. And the problems within them don't get addressed.

Beatrice Adler-Bolton 37:36
Yeah, what's the phrase rising tide raises all ships, right? That's it. Except for some people in our current system are just anchored and then drowning. I think it's just, it's absolutely, obviously exhausting day in and day out to be inundated with all of this horrible, scary COVID information. But I think it's such an important time for us to be talking about these things, because I feel more so now, it's much easier to convince people of the urgency, often where I come from with my own advocacy is, I'm a patient myself. So people who are also patients gravitate towards what I'm talking about, because it speaks to their own experience. But, I do get pushback from people who say, well, you're only doing this because you need XYZ medication and all these people need insulin, and you guys should all just

get a job that, you know, pays for it. And if you don't, if you can't get that job, then your shit out of luck, this is the American way. I guess, the silver lining of COVID is that that's really dropped that out of the conversation for me, I'm not hearing that from people as much anymore. It's sort of reframe things away from this idea of the binary between the well insured person and the underinsured person, which I think, as we were talking about, is sort of a limited picture of what's actually going on because looking at just simply how the finance portion is being allocated doesn't give us a full picture of actually what's going on in people's lives. And before the pandemic. I mean, you did research looking into, for example, like how health disparities contribute to chronic respiratory diseases, and we're seeing that be, exacerbated by COVID. Do you feel like this is a moment where we can push for something more than Medicare for All because I really feel like we need to be pushing for an American NHS and we need to be pushing for Medicare for All it includes Long Term Care because as we've seen congregant settings are not compatible with our pandemic situation.

Dr. Adam Gaffney 39:54
I think there's a number of great points tied together there. So first, I do think there's a window of opportunity here to be very ambitious. First of all, I think, and I'll get to your point a little more directly in a second, but I think there is a common crisis that may have been temporarily averted. But that's going to hit us in terms of health coverage. Okay. And what do I mean by that? Well, there's been obviously lots of job losses, and insurance and private coverage losses. Now, we don't know exactly how many people have been left uninsured by that — the data is a little spotty. For a variety of reasons. We don't have a standard survey for 2020 yet, but it seems like at the very least, Medicaid has stepped in, in a major way to prevent many of those people from becoming uninsured. Right. But at the same time, states are seeing pretty death desperate budget shortfalls in the coming months, right, we know this. I think that states are going to be increasingly squeezed, and I am very worried what that's gonna mean for their decisions about the Medicaid population, and the adequacy of funding for Medicaid, I think that the only answer is going to be a federal solution, or at least something on the state level that goes beyond the current system. So it was a long way of saying I mean, this even if the economic skies begin to improve, let's just say best case scenario in the coming months relative, I think there is a huge crisis ahead of us in terms of health coverage, that's going to grow. And so anyway, that's just just a preliminary point, I think, to go beyond that, to your question of is this a moment to start thinking bigger than Medicare for All? And I like, I like the emphasis. And I like the idea. What I would say is a couple of things. I would keep in mind that the Medicare for All proposal that is, you know, let's just say in PNHP's [Medicare for All] proposal — and that, to a large, very large extent, is incorporated in the Medicare for All legislation in Congress, particularly in the House — goes beyond just pure public health insurance, to a greater extent than I think is often realized. And so what do I mean by that? So a couple of things. In both the PNHP proposal and the house legislation, there's a separation of capital and operating expenditures for globally budgeted hospitals and nursing homes. And that's a very big change. Okay, what that would mean would be that the system — and part of the reason why, just as a side note, that Physicians for a National Health Program was called that, instead of Physicians for National Health Insurance, Physicians for National Health Service, it was called PNHP, to try to get a little bit away from this National Health Insurance, National Health Service dichotomy and binary and dispute, and go outside of that. But to go back to what I was saying, a system where the program makes decisions about where new health facilities, new capital investments are going to happen, expansions, new buildings, new beds, new wards, a system that is making those allocation decisions on the basis of

need, and that is then funding hospitals, not according to each patient that comes in the door, service provided fee for service, but on a goal budget model. Okay, that is a step well beyond just a sort of Medicare for All narrowly defined as like a "better Medicare for everyone." Okay? Because what that means functionally is that profit has been taken out of the system entirely. That hospitals no longer actually generate a profit in a global budget system. They are paid, but they are paid a budget for all their operating expenditures. And if they use less than that, they don't get to keep the money as profit. It just goes back to the government, and separately new investments, a new expansion occurs. And furthermore, the PNHP proposal specifically, and to some extent, the House proposal actually as well, explicitly excludes for profit companies from taking part in the system at all. And then the PNHP proposal explicitly involves buying them out. So why am I saying all this? I'm saying, because I think, in some of the ways, there's a little more of a gradient between National Health Insurance and National Health Service systems than is sometimes perceived. And so we can absolutely call for things that go beyond just replicating fee-for-service Medicare for everyone in the country that I think captures some of the most important things of a National Health Service.

Beatrice Adler-Bolton 45:27
I really appreciate you getting into that.

Dr. Adam Gaffney 45:28
You can envision even going beyond that. Yeah.

Philip Rocco 45:31
That's helpful, it hadn't been framed to me in quite that way. Or I hadn't thought about those dimensions of it. But it's I, yeah, when you look at the entire legislative package it's more, I think, than just financing.

Beatrice Adler-Bolton 45:44
Well, it's so important, because what we're really lacking more than anything else is a cohesive, comprehensive system of care. It's a fiction to try and break it up into like healthcare payer or healthcare finance versus healthcare administration or planning, right, these are all components of one big, gigantic process, which interfaces with people's lives from birth until death. And it's an absolute fiction that we've sort of taken these disparate parts out of a process and a relationship that's built over years between an individual in their own care, and said, "Oh, no, like, you know, the insurance is separate, and the hospital is separate, and the doctor is separate, and the payer is, contingent on work." And then you have the PBM, and you have all these fictitious, socially constructed barriers that we've put in which really, at the end of the day, do nothing for patient outcomes. I think we can do away with it, I think that there's so much room right now to be rethinking how we are allocating resources, which is really what healthcare is all about.

Dr. Adam Gaffney 46:58
Yeah. And I think one of the ways — we talk about goal budgets a lot in PNHP, and the importance of globally budgeting hospitals, and we, and this will tie in with what you just said, but just to explain, so just for the audience, a global budget is sort of the way you pay a school, right? So schools don't get fee for service for every time a teacher picks 10 minutes with a student, they don't like write a bill for that. Like, I mean, that's how healthcare works, right? If you were to finance schools, the way you

finance healthcare, every teacher all through the day, would be writing bills for every little thing she or he did. And the school will be then charging the parents like copays as a proportion of those bills, right. So you can envision that it would be dystopia. So a global budget is more like how the school is paid, whether a school gets a lump sum of money from which it takes care of, or provides education to all the students in its community. And that's also how a fire department gets paid, it's how VA hospitals get paid. It's how Canadian and British hospitals get paid. And we often talk a lot about how that results in a lot of administrative streamlining, because you could imagine if a school was paid fee for service that like that would take half the teachers time would come from submitting and bargaining over these dumb bills would make no sense. And that's absolutely true. And if you move a public school, to a sort of hospital model of billing, a quarter of the school's budget would just go to its billing department. Efficiency arguments are very true. But putting that aside for a second. Oh, and just to be clear, the data does support that about a quarter of the hospital revenue in the United States goes into administration, which is twice the portion of Scotland or Canada. And part of the point of reenvisioning the hospital, as a globally budgeted institution, it's not just an efficiency argument. Going back to what you said about elective procedures and how this shortfall of elective procedures produces big falling hospital revenues, and they were laying people off this year, it didn't make any sense in the middle of a pandemic. Part of the reality is that if you did pay hospitals a lump sum to take care of the whole community, they could aim services at those things that are needed by the community, and not necessarily those that happen to be separately billable, lucrative things. So community programs and outpatient care and inpatient care and all the kinds of things that, some of which may be programming that may not even be able to be billed to an individual patient, a hospital could do all of those things. And it could take on a more holistic character, as you're suggesting, as opposed to a you know, well, what are the specific services that reimburse well, not that every hospital does that but but you get the idea. So that's why I think rethinking not just who is paying, but sort of how the payment is made is important.

Beatrice Adler-Bolton 50:09
Yeah, I think that's such a good point. And I really appreciate you getting into that. Because that's that's one of the things that I think is one of the strongest reasons why I prefer the house version of Medicare for All because it's not simply about just disrupting the one fiscal relationship. It's about reframing what our priorities are, when it comes to patient care, for a very long time, we've had a system that pretends that its markers for success are health outcomes. And that actually is not the case. At the end of the day, it comes down to costs. And, and I think it's funny, because at the beginning of the pandemic, I think a lot of people were under the impression that we would sort of be like, saved by some fantastic pharmaceutical intervention or discovery that would happen, or the vaccine would come out and everything would be fine. And we'd go back to normal. And it's been really telling that the vaccine development and research process was accelerated by the fact that community spread was completely unmitigated. But these fancy technologic cutting edge pharmaceuticals have not materialized. It's been pretty old school stuff that seems to be helping; proning, steroids, NPIs are very effective, lockdowns are very effective — with fiscal support, of course. I think we're so trained to associate good care with clean medical esthetics that we have created this transformative process where people only think of good care as being somehow related to the hyper profitable cutting edge systems that we have of care instead of thinking about the small interventions like mold removal, and how much that can do to improve an entire community. And so you just see an opportunity, I think, in COVID, to reframe the

priorities of our entire care system, not just from an infrastructure standpoint, but in terms of how people think of their own care, and how people think of their relationship with their doctor and their hospital. These are opportunities for community building, but right now, they're not being used that way at all. We're underutilizing something that could be a great resource, just because of the system of extractive capitalism that basically dictates that these things have to be part of the market when they really shouldn't be.

Dr. Adam Gaffney 52:43
Yeah, no, I mean, I agree with your points. I think the other thing I'd add is going back to the whole medical research side, and I was emphasizing, how systems might help you do something like the recovery platform, but also just that, you're right, that when you are getting out with this sort of intervention, that sort of pharmaceutical and non pharmaceutical interventions, that currently, there's very limited relative resources for doing saved randomised trials of, of non pharmaceutical interventions, because, right, there's not much money to be made there. Or to study new usages of old pharmaceuticals. And that's ultimately a public goods problem. And that's why we need public financing of much more medical research and much more medical trials, because the pharmaceutical industry is not going to fund trials that are not going to make it wealthy is the simple reality. But I think the larger point here is that if we want to improve the practice of medicine, I think we need to triple down on our public investment in research, including in publicly publicly funded clinical trials.

Beatrice Adler-Bolton 54:04
Yeah. What would your call to action be for physicians who feel like they want to to get involved in trying to advocate for this because I hope that some people are listening right now and they're like, wow, this would be a much better job condition to work under than the current system where I have to deal with all this coding and billing. Physician advocacy was a huge driver of support for original Medicare, you have the capacity to influence patients, you have the capacity to influence the community, doctors are considered to be leaders in the community, and I feel like it's really important for as many people who work in this profession as possible to get involved because you guys really do know what you're talking about. You do this day in and day out.

Dr. Adam Gaffney 54:50
I think that when it comes to Medicare for All activism, we each sort of all have our own niche. Because at the end of the day, there's no question that you're often most able to sort of speak to the concerns of people within your community. It's often true. So I think there's no question that one of the key areas for physicians, although I think we have a role to play in educating the public, and in participating in this political discourse, I think education within the medical community is absolutely essential. And a lot of the bread and butter kind of work that I've done for Physicians for a National Health Program, has been education within the physician community. And I will say that I mean, you know, 2020 started off really good that way. It's funny, just thinking back a year ago, how long ago, it feels right. The years started off, the primary was still ongoing, it was sort of a very hopeful moment, I don't need to, I know everyone knows this, I don't need to remind you of what happened in January. But I'm just setting the scene a little bit. We wound up actually publishing this full page ad in the New York Times, with all the names of physicians from across the country, saying that it's time to stand for Medicare for All and that coincided the same day, as the American College of Physicians, which is the nation's second largest specialty

society, it represents internists, American College of Physicians, came out with a position statement basically endorsing universal health care, and endorsing Medicare for All explicitly, or more single payer, as like one of two ways to get there. And yes, you know, what, guys, as a single payer purist, I would have preferred if Medicare for All was the only way mentioned but like, but still, that's a huge win. Right. A huge win. Society for General Internal Medicine followed suit later that year. And that was that way, back in, I guess, February, I want to say, and so, I mean, there has been progress in this. And I think that kind of that though, the fact that the ACP switched gears, you know, that wasn't something that happened overnight. That's something that happened as a result of god knows how many years and hours of people within it, pushing for it to, and obviously, the work with people from outside of it. But that's an example of where all of us can make a difference. So, if I was like an ophthalmologist who was in favor of Medicare for All, I would probably do work within, among ophthalmologists to some extent, and within the ophthalmology society, and push to get them on board and those things. I think sometimes we get into a situation where we're kind of looking for the one big trick to like pass Medicare for all, like this, one thing, we'll do it, and at the end of the day, as we know, it's, you know, a massive, it's going to be a massive battle. And it is going to be perhaps one of the defining political struggles of our time, and there is going to be no "one thing," it is going to be an enormous amount of work, both traditional activism and intellectual work and grassroots advocacy, and at every level you can imagine, of people working towards this goal. And so, for each of us, that's going to be something different. But each of the points, each of the parts, each of the pieces of the puzzle is going to ultimately be necessary to achieving the ultimate win.

Beatrice Adler-Bolton 58:40
That's such a great point. I mean, I feel so often you do hear people like just waiting for "Oh, well, what's the one thing? Do we need, like a purity test? A vote? Yeah, what's the miracle? What's the organization that everyone has to join, and then we get there?" and it's like, I get that desire, right? Because this is something that people really want, and people really need. But at the same time, both from the standpoint of building the kind of constituency that we would have, under Medicare for All, to fight against policies of austerity, and cuts to social and public spending, etc. We can get there also in the process of building support for Medicare for All. And I think that this sort of like, game of like, "Well, you know, we have to figure out the RIGHT way. And we have to figure out the, you know, the right pathway to Medicare for all or the right glide path or incremental directional policy or whatever," just really ignores the fact that like, No, actually people need to... This is a project of political education. This is a project of community building. This is a project of having conversations about how policies can change our lives versus how much policies are going to cost and this is like a BIGGER, LONGER project than can just be accomplished by joining an organization. As we fight for Medicare for All — I feel if we will build the kind of constituency that is needed to pass it, we will then be even more powerful once it's passed. But it doesn't mean that in the meantime, we have to just sit and take it. It's important to talk about Medicare for All every day to be thinking about it, to be thinking about what's beyond Medicare for All, because as we've said multiple times, it's not a silver bullet itself, and that's something that I think is a nuance that's really missing from the conversation.

Philip Rocco 1:00:29
No, and I think Adam, that's the value of your experience with PNHP. And I think that the potential that I see is that there are ways of unlocking, not just, public opinion, there's all of these conversations about

like "the public supports Medicare for All," and it's, and, and for me, it's like that public opinion is pretty, you know, manipulable, it's pretty inert. It's pretty reactive to a lot of things. But what you're talking about — this seems so important — is unlocking numbers of people who are able to act together in unison, collectively in a concerted way. But also just the valuable takeaway is, you're able to make changes in what I would have guessed would be very, very difficult fields to till. And I think that's a valuable thing to remember about, like, what the task is now.

Dr. Adam Gaffney 1:01:27
Yeah. Yeah, I think you both raise great points. One thing I think it's also good to get away from the binary. And this somewhat relates to what you were saying. It's a little separate. It's good to get away from the binary of like, "Oh, do we fight for Medicare for All? Or do we not know, which might take no one knows how long? Or do we sort of fight for x,y, and z things that might be more short term achievable." And I see no real evidence that that trade off exists, I think that the Medicare for All, movement is very capable, I mean, there's gonna be some of us that we're gonna sort of just, you know, stay on message and hammer one thing home, but you know, those who are connected with the movement are going to be very capable of fighting for environmental justice, against racial health inequalities, for even short term kind of incremental improvements, or at least helping to, inadvertently, indirectly to pave the way for incremental improvements, if only by making sure, making crystal clear how modest they are in relationship to what it is we really want to achieve. I think that we need to get away from that binary. And I think this is part of a larger movement, this is part of a larger movement for environmental justice, racial health, justice, climate for against climate change. And I think by linking with those movements, or those who focus on those, it only makes Medicare for All stronger. And I think that's simply going to be the case. The reality is that there is no roadmap, there is no roadmap to success, unfortunately. And I think there's a natural desire to have a roadmap, but I think there's a lot of things that can be done, but no one knows what are the steps? What are the allies? What is the coalition that exactly needs to come together and crystallize, in order to have enough power to achieve this? All we can do is just continue to fight like hell for this today. Because if we don't do that, today, it's never going to be a reality tomorrow. And I think that's the way I view it all.

Beatrice Adler-Bolton 1:01:29
Yeah, that's such a good way to put it. It's like we all have to just cure the austerity brain that we all have, where we think you can only do one thing at once. We can fight for health justice and the same fight that we're fighting for environmental justice, for racial justice. And I think it's all really in a way, part of a larger fight to reassert valuation of people's lives to assert that people have value that they have the right to survive, regardless of their "deservingness" to survive or whether or not their conditions, which impacts their ability to survive, are their fault. And it's part of this larger project to move away from eugenics in the United States and move towards care that actually reflects the resources that we have to distribute and can distribute. It's just a matter of reassessing what the parameters are that are dictating where things are distributed now.

Dr. Adam Gaffney 1:04:51
Yeah. Yeah.

Beatrice Adler-Bolton 1:04:52

Well, thank you so much for giving us your time.

Dr. Adam Gaffney 1:04:54
Absolutely! This was great.

Beatrice Adler-Bolton 1:04:56
Where can people find you if they want to follow you and your work?

Dr. Adam Gaffney 1:04:59
Oh, @awgaffney is my Twitter, that's probably the best.

Beatrice Adler-Bolton 1:05:02
Well, listeners, thank you for joining us for another episode of Medicare for All week. Adam, thank you again, I can't thank you enough. And as always, Medicare for All now. Solidarity forever. Stay alive another week.

Dr. Adam Gaffney 1:05:17
Onward.

Beatrice Adler-Bolton 1:05:18
Onward. One week at a time. Yeah, exactly.