Transcript
Episode 31: The Tremendous Good a Publicly Sponsored Insurance System Can Do
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Donald Berwick, MD – Guest

JS: 0:05
Welcome to Medicare for All Explained. This podcast will enlighten our listeners and dispel the distortions that's around Medicare for All. Medicare for All Explained is produced in collaboration with Physicians for a National Health Program and is hosted and produced by Joe Sparks. I'm your host, Joe Sparks.

JS: 0:28
This is Episode 31, "The Tremendous Good a Publicly Sponsored Insurance System Can Do." My guest, Donald Berwick, MD, has a Master's of Public Policy and is a Fellow of the Royal College of Physicians. He's President Emeritus and senior fellow at the Institute for Healthcare Improvement, an organizations organization that Dr. Barrett co founded in lead is president and CEO for 18 years. He is considered one of the nation's leading authorities on healthcare quality and improvement. Dr. Berwick is a pediatrician by background and has served as clinical professor of pediatrics and healthcare policy at the Harvard Medical School, Professor of Health Policy and Management at the Harvard School of Public Health, and on the staff of several hospitals. He has also served as chair of the National Advisory Council of the Agency for Healthcare Research and Quality. In July 2010, President Obama appointed Dr. Berwick to the position of Administrator of the Centers for Medicare and Medicaid Services, and he served as administrator until December 2011. Dr. Donald Berwick, welcome Medicare for All Explained.

DB: 2:04
Great to be with you, Joe. Thank you.

JS: 2:07
So I'd like to start. You were the administrator of the Centers for Medicare and Medicaid Services under President Obama. Could you explain to me why the Affordable Care Act was structured the way it was?

DB: 2:23
Sure, I can I can only speculate about it because there wasn't part of the team that put that back together. I arrived after it had been passed, but I think it represents a compromise.

President Obama had apparently decided that one of his key legacies, he wanted to be the expansion of health care coverage in America. We have 50 million people who weren't covered, so he was seeking legislation that would make health care closer to a human right in the United States. Plus, there are some other changes in the activity of the government and helping improve the quality of care that were also part of the Act. To do that he had a win over enough support to getting the majority in Congress and public support, and so that involve compromise. For example, I believe one of the early ideas was to have a public option so that people could buy into Medicare. That was abandoned. I assume that was because of opposition from the insurance industry, which wanted to keep the action. And so the fundamentals, the Affordable Care Act rests largely on expansion of commercial insurance, affordable commercial insurance. Another example would have been the negotiation rights of Medicare. One could have saved quite a bit of money by getting Medicare a chance to negotiate drug prices. That was not part of that bill, and I assume that was partly a concession to the pharmaceutical industry. The bill did not fundamentally change the payment levels or patterns of payment to physicians or not much to hospitals, and I think that was an attempt to win over the hospitals. So case by case I think he didn't look at the elements of the bill and see what was crafted to win political support. It's how you get legislation passed in Congress.

JS: 4:01
Did you support the ACA?

DB: 4:04
Yes, very much like, I think most clinicians, you know, I'm very concerned about a country, which is still the only Western democracy that doesn't make healthcare human right. And it's it's not just an embarrassment. It's a tragedy to at least 10s of millions of people out of coverage, so I supported the coverage expansion. Also, My, my career has been devoted to trying to improve the quality of health care, and I know all too much about some of the problems we have in quality in this country, problems like patient safety hazards, lack of use of scientific data in clinical care, Patient, the absence of patient centeredness, and I saw in the Affordable Care Act the number of opportunities to accelerate progress for the improvement of care. So I don't think it was a perfect step forward. It was a compromise, but I think it was a step forward and I was delighted to be associated with it.

JS: 4:54
And you have since come out for our single-payer system or what is also called Medicare for All. What has led you to change your approach to support single-payer?

DB: 5:09
Well, several things. And by the way, we'll talk later about it. I don't think Medicare for all, single-payer, quite exactly the same idea. We'll come to that, but I think three things made me maybe move into that direction. First was my experience in Washington, I got to run Medicare and Medicaid. I saw the tremendous good that having a publicly sponsored

insurance system can do, and we could we could do things to secure care for individuals, extended preventive care, protect people by looking hard at quality of care. These were things we could do because we're a public agency. And I thought all people should benefit from that. A second and actually more important than that was I ran for governor in Massachusetts when I got back from Washington. And I got to look at the state budget in Massachusetts, and I saw how How difficult it was for the state to maintain investments in really important things like education and public higher education and early childhood education and infrastructure working on a public transportation system. The reason was state costs of health care in Medicaid and the coverage of state employees was just eating into any other possibility. And if we wanted to have progressive policies in the state that would work to improve communities had to find the money somewhere. And the only responsible way that I could see to actually reduce healthcare costs without harming anybody would be to simplify the system, and so I began to advocate for at that level of state level, single-payer system. I think the third is my interest in the kinds of changes we need in health care. We really need to focus on prevention and upstream causes of illness and kind of move some of this resource around, and I don't think we're going to get to do that unless we are able to get money into a single pool and then invest those resources where they're needed. It's very, very hard to do that in a in a multi, in a complex multi-payer system. And I think we need some pretty big changes in care that will help people far more than we can at the moment.

JS: 7:16
Wow, there's so much there that I would love to cover. But I would like to start by moving to some of the falsehoods. And one of the things that I found interesting is that you mentioned that you thought the single-payer system in Massachusetts would save money at the state level. Yet one of the criticisms of Medicare for All or single-payer is that'll cost money. So for me your work or studies, how much money do you think Massachusetts would have saved if they would implement a single-payer system at the state level?

DB: 7:55
Well, I assume that the situation in Massachusetts is about as it is in the rest of the country. So the way to answer that question that I choose is to look at waste in healthcare. Things in healthcare that are actually spending taxpayers hard earned money without any benefit at all, not helping patients. So there's a number of pots of waste. The biggest one is administrative expense, and we can start with that one. Generally, scientific research on levels of waste of waste in American healthcare suggests that about a third of our money's being wasted. We're spending over 3 trillion, so I'll say roughly a trillion dollars is waste. About I would estimate 200 to 300 billion of that trillion is administrative complexity. It doesn't go away entirely, but it gets severely reduced in a single-payer environment. You don't have multiple billing processes. In fact, in some cases, you don't have any billing processes at all. You don't have the complexities of appeal processes and finding out if someone's covered or not. Everybody's covered. You don't have differences in coding. All of this is eating into the efficiency of American healthcare system. So at the national level two

or 300 billion at the state level, you know, I would say something like, five or maybe 10% of the total state expenditure on health care would be reduced by that administrative simplification. That's just the first way that you save money, but I think the saving would be big. I think a lot of the benefits also come from being able to invest in more coordinated care, more continuous care so people aren't being dropped because they're changing their insurance or because they're falling between the slabs. A single-payer system would allow you to craft much more integrated care. So those two pots alone are saving a ton of money. I would, I would guess that the state would be able to save it in the midterm, not absolutely day one, something around 10% or 15% of its total expenditure by going to a single-payer system. Even it's 5%, that would be a ton of resources that could be devoted to other uses at the state level,

JS: 10:01
Plus people are saving time, and everybody is covered.

DB: 10:07
Yeah, and you're not wasting the time of the workforce, doctors and nurses who are spending, you know, they're spending substantial percentage of their day filling out forms and going through billing and appeal processes in pre approval processes. And you could simplify that that a lot. And that means you're using the workforce more efficiently, which itself is a way to save money. So I think it would be a win. No one knows exactly how big a win but I think it would be substantial.

JS: 10:34
Let me say, I've interviewed several doctors for this podcast. In all of them always complain about how much time they have to waste fighting insurance companies. That's a really big deal, and that would just basically go away.

DB: 10:52
Yes, well, you still have to administer the national insurance system, you know, the public system, and that does so it doesn't totally go away, but a lot of it would go away. And there's also more transparency and accountability, so you'd know where funds are flowing, and you could if you didn't like direction things are going you could change it as a matter of policy. It we have good by the way, empirical studies, really time motion studies of doctors in doctors offices. It was a major one published by Chris Sinsky [Christine Sinsky] at the American Medical Association about a year after two years ago, I think, which she was showing something of the order of two or three hours a day of physicians being devoted just to record keeping and administrative processes that time should be spent with patients, not with paper.

JS: 11:41
One of the things I'd like to discuss with you is what have you seen as the major falsehoods that opponents of single-payer propagate?

DB: 11:54
How long have you got. I mean, a lot of people oppose it, and I think, by the way, let me just say a lot of the opposition is good, good hearted. I think people are legitimately worried, and they need their questions answered and there's an education process that's just respectful. But I think there are people who are reading alarms, quite knowingly that aren't part of this. One big one is that having a single-payer system, which is which I would call national health insurance--that's a way to think about it--a national health insurance system would be a government takeover of health care that you often hear that phrase. That is really far from the truth. Health care deliver, your hospitals, your doctors, your laboratories, your ambulists, those don't, those aren't taken over by the government in a single-payer system. The delivery system remains if you wish the same. You're only proposing to have the government take over the insurance function, the payment function, so that's one deception, government taking over your health care. No, government becoming the insurer for everybody. Second one is that it that it would raise costs, especially in the single-payer debate, in the presidential campaign. You hear these numbers turn $30 trillion over 10 years 40 trillion? Well, that's a deceptive conversation because we're talking not about new money. We're talking about the shift of the flow of money, so that same money is now going into the payment system. It's coming, because it's coming in employer contributions to health insurance, out-of-pocket contributions to health insurance. In a flow that is pretty opaque and pretty hidden. The advocates for a national health insurance system are saying, let's take that same money, and instead of having it flow through these, frankly, somewhat hidden channels, will move all that money into into the government program, where the government now is your insurer. And in fact, most of the calculations that I believe in show that the total amount of money being spent would then go down, partly because the administrative costs we talked about, with savings going back to workers and into companies that now pay for health care. so that, those numbers, their numbers about the amount of money that may shift from the current private flow to a public flow. I understand that, and that's a that's a conversation we have to have with the public. That is not new expense, and I think that's a big deception. A third is that it would somehow hurt Medicare. So, you know, Medicare is one of those popular public we've ever had in this nation. Elders like me love it. It's a great that it is single-payer coverage for me, and it's great. I think somehow the conversation got distorted when we said Medicare for All. It would be like, we're going to take the identical Medicare system and now everyone's in it. That's not quite the way we need to think about it. We need to think about what a national health insurance system for everyone would be. And the current Medicare system, the way we're paying the Medicare for the care of elders, we could leave that the same or change it if we wish, but it's not it's not an attack on Medicare, and it’s certainly not a loss. It's a gain from many, many others. Another is that the government would do such draconian underfunding of care that care would be hurt. I mean, people say, well, rural hospitals will close or doctors will leave practice? No, not necessarily at all. On the contrary, if we had a single-payer system and national health insurance system, and we felt rural hospitals were vulnerable, we could then adjust payment to keep the rural hospitals

vibrant. Right now, we can't do that, because the payment system is so messy. So you actually get to solve problems that currently are very severe. With respect to paying doctors or hospitals, how foolish it would be to cut back payment levels to the point where doctors leave practice. Of course you wouldn't do that. You need to have a payment system that is attractive to the people that give care. It may not be the same as it is now. It wouldn't have as much waste in it. And we might want to push back very hard and negotiating with drug companies, for example. But the content somehow we're going to strangle the delivery system, that's just not true. We get a chance to have a rational conversation of where we want to put the money.

JS: 16:04
Well, you hit on some very important points. And one of the things, too, is for hospitals that are in poor areas or underserved areas, we could actually fund them properly, so health care would likely improve in those areas,

DB: 16:22
You get the opportunity to have more logical, more supportive payment flows than you do right now. So, I personally believe that under a national health insurance system, we could improve the well being of rural healthcare much more efficiently, much better than we can in the current environment.

JS: 16:40
The other thing I think that you said was important was your point about it's a shift of money. The way I like to describe it, it's just moving money from one bucket to another bucket. And then in that other bucket, we actually need less money because it's more efficient. And that's...

DB: 16:58
Yes, that's the overall, yes that's exactly the overall vision in this.

JS: 17:03
There's one other thing I'd like to address about the falsehoods, and that's the point about delivery. And as you pointed out, we are changing the way we finance healthcare, not the way we deliver healthcare. But, I would argue that currently, we have a corporate run health care system, because the insurance companies are deciding what care you get, often without basing it on medical decisions, but just on cost decisions. And I've talked to a lot of doctors who feel that way. Could you just quickly comment on that?

DB: 17:38
Yeah, well, one of the benefits of having a national insurance system would be transparency, because we don't actually know the decisions that are going on. No, we're not in the decisional pathways of the commercial insurance companies to know how they decide what to cover, what not to cover. Sometimes it's regulated, but a lot of it's not

regulated. Running Medicare and Medicaid, you're in a fishbowl. You really, you know, your decisions have to be public by law. We can do that in a national insurance system, which would increase knowledge. We know where money's flowing, to whom. We could have better knowledge of results. The other equally important matter to me is, I would call it opportunities to invest. And we can see that in the Affordable Care Act. The Affordable Care Act was not national health insurance, but it did expand the coverage for many people under law. And it also had provisions that allowed us to help change the care. For example, it's absolutely true that today there are lots of people in institutions, nursing homes, and long term care settings where they actually could be home with their loved ones if we could move money to support home based services, home based care, home based facilities, healthy professionals. Well, in Affordable Care Act, we got to do that. We actually had many, many projects and programs which which had thousands and thousands of people now able to move from institutional settings and be much happier, and by the way, usually lower costs. So you get to ask questions about where the money where you want to invest the money. And that's not just, that's not a matter regulating care or protocols, It's a matter of just thinking hard about where you want the money used. In the private insurance system, you really can't do that. It's too complex. And since private insurers can basically pass costs through to the payer to the taxpayer and the employee and the employer, they don't have a strong incentive to actually figure out what's best for the people. That was my job running Medicare, Medicaid. What is best for the 110 million people that we were covering. That's what I went to work thinking about every day. I didn't have shareholders, didn't have to worry about the stock price. And it was a much liberating environment for moving resources where the resources are needed.

JS: 19:55
Gee, putting patients first what a radical idea in our healthcare system.

DB: 20:03
Yea, it's patients; it's families first, communities first. We work with communities. We could now say, you know, to a rural area, you know, how can we help with investments in support there that allow people not to be dependent on inpatient settings that they don't want to be dependent on.

JS: 20:20
Of course, one of the things that's going on right now is the coronavirus. And one of the big things is how people pay for testing and treatment. And how do you think that a Medicare for All system would help them or hurt that?

DB: 20:41
Well, many ways...

JS: 20:43
It would help, right?

DB: 20:44
And I think the failure of national White House leadership now in the coronavirus era is really costing us a ton. Put that comment aside. If we had a single-payer system, and we could do a couple things. First upstream, we could have prepared for this better. We could have had. There's a whole bunch of issues in this country around preparedness. Coronavirus, maybe the worst we've seen right now, but it's not the only 21st century threat. And we have no way to invest in a healthcare system and supports that are prepared for this kind of stress. We're just running a gerbil cage of productivity and production in healthcare instead of saying, wait, how are we going to invest in the future? Number one, a national health service system could do that. A national health insurance system could do that. Second, coverage of everybody. Right now as conferences are canceled, and hotels come emptier, and airlines are shutting down, and think of all the dislocations of people who depend who live hand to mouth for their income. People who don't have the benefit of an ongoing salary during this period of time. What's going to happen to them? Are they going to go to sleep, wondering if they get coronavirus, they're going to be bankrupt, that they won't be able to find health insurance. National health insurance system covers everybody. Nobody has to lose sleep because they're going to be unable to afford their care. And right now, we're struggling. How are we going to pay for testing? How are we going to pay for individuals who need care, but don't have coverage? Well, that all goes away. We finally have justice, equity, true universal coverage where people can rest easy about at least that part of their lives. Coronavirus is just raising the vividness of that problem, and there going to be a lot of people hurt medically, but also financially, and that would go away if we had a national health insurance system. That's not one of the things that people right now in countries that have universal health coverage are worrying about

JS: 22:35
Do think that with what's going on with the coronavirus will cause more people to support a single-payer system.

DB: 22:44
An interesting question, Joe, I don't know. I think a lot of people are gonna find themselves at a great disadvantage, and if we have public servants and political leaders who are able to make this case, maybe people say ah, now I get it. Now I get it. I don't have to lose sleep about coverage in a national health insurance system. I don't have to beg and borrow to try to get a test I need or payment for a hospital stay. Maybe people will realize they would be, so many would be better off.

JS: 23:15
Now, is there anything that you would like to add that we may have missed in this discussion as to how you think Medicare for All would help?

DB: 23:26
No, you've covered a lot of the territory. It just allows us to take what was currently 15 or no, 18% of our economy, and begin to ask really important questions about where we want to spend that money to help people. Not to help corporations, not to help stockholders, not to help, you know, keeping the status quo just in place, but what changes we want to introduce to help make care and health better for people. I say that in interrogating a single-payer proposal or any proposal there are four questions you should ask. This is the way we should ask about the question, Number one, does it ever everybody? if not, let's change that. Let's get everybody covered and join other Western democracies and be the nation we should be, health as a human right. Second, does it improve quality of care? Does this invest in much better care for people, much more patient centered care, more home based care, more care, that is safer care? With a national health insurance, you can do that. You can have projects and programs to improve care. Third, does it allow us to move some resources to causes. Health care is like a repair shop. People have heart attacks because of the conditions in their lives, the food chain, and the exercise, and recreational opportunities, and stresses in their lives. People end up in trauma because of violence in society. We have a broken criminal justice system, and that's creating tremendous problems in mental health care and substance abuse. And in a national health insurance system, we could decide actually to put money where it's needed to prevent things. You show me other proposals. I'm happy. I'm wide open. My mind's open. And the fourth goal was reduced total cost. We're spending nearly twice as much as any other nation. That's because of waste. A lot of the waste is administrative. There's other forms of it. Let's ask about a proposal, does it reduce costs? I say a national health insurance system would cover everybody, improved quality, allow us to put some resource, more resources into social determinants of health, and it would reduce total costs. I'm wide open to other suggestions. And one of the things to keep in mind is there are countries that have healthcare systems that perform better than ours that are not single-payer environments. And I'm not falling on my sword on the single-payer idea. I don't think it's like the only way to get better care. I think we should ask very trusting and respectful questions about other things we can do to improve care. So I don't think, especially at this time, when it's so important to have a change of administration, I don't think at this time, anyone should be falling on their sword on the single-payer agenda. I just think it’s better. And I think we need an ongoing, respectful, mature national conversation about whether this is the way this country should go, at least in the long run if not now. And I think when we cool down and look at what kind of country we want to be, I think it's gonna look awfully attractive.

JS: 26:16
And on that note, Don, I would like to thank you so much for being on Medicare for All Explained.

DB: 26:26
Thank you so much, Joe, for your leadership and your help for understanding this important area.

JS: 26:32
You have been listening to Medicare for All Explained. Information about this podcast can be found at our website, MedicareForAllExplained.org. The music for this show is “Super Bubbly” by Jesse Spillane. The logo was created by Lilly sparks. Thank you for listening.

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