Transcript
Episode 32, If There's an Argument for Medicare for All That Ought to Convince Everyone, It's This Epidemic
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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: 0:29
This is Episode 32, "If There's an Argument for Medicare for All That Ought to Convince Everyone, It's This Epidemic." My guest, David Himmelstein, MD, is a Distinguished Professor of public health and health policy in the CUNY School of Public Health at Hunter College. Dr. Himmelstein is a co-founder of physicians for a national health program. He has authored or coauthored more than 100 journal articles and three books, and is the top expert on the waste and abuse of our current healthcare system. Dr. David Himmelstein, welcome to Medicare for All Explained.

DH: 1:18
Thanks for having me.

JS: 1:20
So, you are one of the co-founders of Physicians for a National Health Program. And I would like to ask how that started, and was there a national emergency or a medical crisis that cause you to start PNHP?

DH: 1:40
We started PNHP back in the 1980s during a period when Ronald Reagan was president and really the care for for people and people of color and many working Americans was under attack. Medicaid programs were being cut nationally and in many states. And we really thought we needed a vision of what the healthcare system ought to be not just trying to defend Medicaid and other really inadequate programs for the poor, which had been pretty much what the Democrat. Democratic Party's strategy has been is they took a defensive stance. And a number of us said, you know, the health care system in the US is not something we can defend at this point. We need a vision of something much better than this. And said we needed to put forward a view of national health insurance, of national health program that would, would really not just keep where we were, but move us much forward. And so in the 1980s, a number of people started

really developing ideas for single-payer national health program. And at that time, the Gray Panthers, which was a progressive seniors group was going to run a ballot initiative in Massachusetts, instructing messages to Congress people to support single-payer national health care reform. And they were concerned that the Massachusetts Medical Society, the physicians group would oppose this publicly and would cause problems in the referendum. And a number of us who were physicians involved in that effort, the ballot initiative for single-payer said we need to rally physician support to counter possible opposition from the Mass Medical Society and other groups. So we came to a conference for clinicians caring for the poor that was being held up in New Hampshire with a proposal that we needed to start a physicians group that was explicitly in favor of national health insurance or single-payer reform. And our colleagues greeted that enthusiastically and said let's, let's go ahead and do it. So we moved ahead with it at that time, that was, I think, the summer of 1985.

JS: 4:31
And why specifically, did you choose a single-payer system?

DH: 4:36
Well, we've looked around the world at what worked in other countries and what wasn't working. And it seemed to us that the most functional systems were single-payer and really what used to be called national health insurance. And a second reason was the Canada's program by 1985 had been in existence for nearly 20 years, and looked to be working quite well. And it was an easy system to imagine a transition to it in the United States. So there are many other systems that that work well and that might have been useful models. The British National Health Service at that point, which had not been really starved of funds the way it was subsequently by Margaret Thatcher and others, but or the Swedish system or Danish system. But it was much easier to imagine a move to a Canadian style system because Canada, before its single-payer system, it had an almost the identical system to what we had in the US and still have today. And in in many respects, Canadian medicine, the way medicine is practiced and the way hospitals are organized and so on, is closely similar to to the US. So, it was very easy to imagine adopting a Canadian style program and that provided a concrete example of what we thought would work in the US.

JS: 6:15
I'd like to shift gears a bit now and discuss the coronavirus and I'd like to know what are the major issues with the coronavirus now?

DH: 6:29
Well, I mean the Coronavirus is an extraordinary disaster that has revealed the weaknesses in many aspects of US society and many aspects of US healthcare. I mean in on the health side.

DH: 6:50
It's really spotlighted how inadequate our public health preparedness is. I mean, we've been cutting public health funding for almost a generation in the US. Since 2002, the proportion of our health spending that's gone to public health has been falling. So we're now about 2.4% of total health dollars going to public health, and just as an example, Canada spends 6% of its health dollars on public health. And what that's meant on the ground is we have about 50,000 fewer

state and local health department employees than we had back in 2008. So we've lost 20% of all of the public health personnel in our country, and those are the people who do the contact tracing and and the epidemic control on the ground. They're the frontline health workers for controlling epidemic. And as I said, we've lost 20% of them. So the first thing is the COVID epidemic. really highlights are inadequate planning for public health and staffing and funding of public health and planning at the federal level. I mean, the first thing that President Trump did after his inauguration on public health is he implemented a hiring freeze at the Centers for Disease Control and Prevention. The CDC had 700 unfilled positions, and we're still suffering from that today. The inadequate staffing and inadequate preparation that the CDC. On the, on the healthcare side, so those are really public health things. But on the healthcare side, we know that tens of millions of Americans are afraid to go see a doctor or go to the emergency room because they're worried about the cost that they might be stuck with. And again, in the face of an epidemic, that's a horrendous problem, because the only way to stop things early is to find them early. And when people are afraid to seek medical care that keeps us from from knowing what's going on early on. A related thing is the lack of sick leave for tens of millions of American workers means people really have to go to work even if they're feeling sick because they can't afford not too. And that means that diseases get spread because people in normal times work with the flu or with other communicable diseases. And that's problem even at the best of times, but it's disastrous, with things like the coronavirus. A third thing is we have no national coordination healthcare systems, so the market determines where beds are, and how many beds there are, and how many ICUs there are, and how many doctors of different specialties there are. So, rather than having some rational plan distribution of facilities, and, and personnel, we really have a market distribution. So you see today, what it means to have an excess of have some kinds of specialists who in this emergency we really don't need. We've got lots of orthopedic surgeons and gastroenterologists and cardiologists sitting around really not doing anything. And we have a shortage of primary care workforce in the hospital, hospitalist specialists who care for inpatients who are so vital in this time of need. And also the lack of Central coordination means that there's there's no not just authority, but no government agency that can say well, here's where we have the resources and things like masks and, and other protective equipment that's vital here, or respirators because no one keeps track of how many respirators there are in different hospitals and where they're needed.

DH: 11:21
And under any reasonable national health insurance program, we have government monitoring, monitoring, and coordination of where the facilities are, where they're needed, and where, where they can best be deployed. So all of those things have tremendously weakened our responses to the coronavirus. And I guess the last thing is over the last 30 years, we've said hospitals ought to be run by businesses, like businesses. And what that means at a hospital is you don't want spare capacity because you want to make a profit. That's the only way you stay in business as a hospital today. And if you have unused, unused facilities, extra stuff around, that detracts from your profit, but that's exactly what we need in an emergency like this. And again, you know, if we were planning, healthcare as a human need, not as a commodity and not as a profit making business, we would say, not just what's the most efficient way of running a hospital today, but what do we need from this hospital? In case of emergencies, let's provide for that. So, we don't pay to our military, just have the number of boats that you'd need for everyday operation. We say to them,

how many you need in case of an emergency. And that's what we ought to be doing with our healthcare system as well, and private businesses can't do that. We really need government to coordinate and really take the load in that way.

JS: 13:12
In that regard, I'd like to ask a couple questions. Do we have enough hospital beds and ICU beds?

DH: 13:21
It's hard to say we have a maldistribution of hospital beds and ICU beds. We may have enough nationally, but they're really distributed according to where they're most profitable. And what's most profitable in the way of building particular facilities. So, we got, for instance, lots of beds for high high profit procedures like cardiac surgery and, and orthopedics surgery, but not enough there are many other kinds of problems out there. We're trying to convert on the fly the beds that we don't need into the beds that we do need, but that's cumbersome operation. But it's not just the beds, it's for personnel as well. So again, we have a lot of personnel who were devoted to things that at the moment we don't really need. We probably should have a little bit more of a reserve of hospital beds. They don't need to be in hospitals the way we're used to thinking of. So, for instance, in building new hospitals or renovating hospitals, they can be built in a way that spaces can be converted in emergencies. For other uses, but that's not been done by and large in the US because it's not what you do if you're trying to financially succeed in the hospital. So You can build ambulatory care space that can be converted into a hospital bed, even if it's not used in that way every day. And in Israel, for instance, one of the new hospitals that was built a few years ago, the garage was built in such a way that it can be quickly converted into a large additional hospital space with the equipment actually stored in in the walls and storage facility of the garage really ready to be converted on short notice into functioning hospital beds. So, in designing our system, we need to design that redundancy that may not be just sort of extra beds waiting to be filled, but thinking about how spaces and and personnel can be used for other than their everyday use.

JS: 15:57
And one of the issues also is of course ventilators and personal protection equipment. Is it that hospitals haven't stored enough? Or is there, or is it that there are problems with the national stockpile or both?

DH: 16:12
Well, I think two things. One is that there is a problem with the national stockpile, which, by the way, the government agency that holds the national stockpile was moved from a competent health agency to a part of the government that has no experience with that sort of thing. That was another thing that Trumps did. And we have heard now reports that some of the ventilators when they have arrived are not in working condition, which may relate to the agency that was actually storing them not doing a proper job with it. But I think you mostly need a centralized stockpile of extra supplies like ventilators and protective equipment, and that our government has really fallen, fallen down on the job of that. The second thing is, the government didn't move with any kind of speed to say, let's get stuff being manufactured. So it's just about a week ago, I guess, or even less than that, that Trump ordered GM to go ahead and produce ventilators Well, it

was foreseeable eight weeks ago that that was going to be needed. And frankly, GM had started to do it a week before Trump ordered them, but if they'd had an eight week head start and the president had ordered it at that time, which public health experts were saying needed to be done, we'd already have those ventilators being delivered today. So it's both failure to stockpile stuff adequately, and maintain them in the stockpile and a failure of government once the epidemic was headed our way to act quickly.

JS: 18:09
One of the big issues is having the right number of tests or getting people tested. Then of course, the World Health Organization has developed a test and we're still working on getting a test. How do you think that has affected things, and do you think we should just be using the test kits from the World Health Organization?

DH: 18:35
Well, I think there's no doubt that the lack of early testing was part of the reason we have a disaster today. The key to containing an epidemic is knowing who is infected, isolating them so that they don't infect additional people and caring for them while they're being isolated. And because we didn't have tests, we couldn't find out who who had the infection, and who was spreading it. And by the time we began to do large numbers of tests, we, we clearly had many, many, many people already infected and spreading the disease. So large scale testing early on was critically important, and we failed in it. And we clearly should have accepted the test from the World Health Organization. We now have tests that have been developed in the US that are are in the field that are being used, but we still don't have them in large enough numbers. And that remains an enormous problem in our country. So other countries that did a much better job at containing the virus, like South Korea did, large numbers of early tests, and the didn't take this jingoistic approach of we're not going to accept the test because it's not American.

JS: 20:03
So what do you think we need to do to mitigate the effects of the coronavirus at this point? Is there anything that you haven't discussed?

DH: 20:14
Well, I think we need to do a couple of things. One is we actually need sick leave for every American worker. So the Congress passed a bill which they claimed was going to provide sick leave, but it exempted firms that had more than 500 employees, and that's about half of all American workers who aren't covered by that law. So we need we need a law that says every American is entitled to sick leave. That's critically important. The second is Congress again passed a law saying that every American could have free coronavirus testing once the tests are available, But what we don't have is we don't have coverage for people to get care if they actually get sick. So we're headed towards a financial disaster for many Americans, both because many who are uninsured, and then the number of uninsured is growing very rapidly work. We know that. Our best estimate is that about a million and a half Americans have lost coverage in just the last two weeks, and probably another six or 7 million more will be losing coverage in the next month or two. So we have a huge number of people who are uninsured, and if they do get sick from coronavirus, will face disastrous medical bills. And even for people with coverage, the co-

payments and deductibles will will bankrupt many many tens of thousands of them. So we actually need urgently coverage for everybody for not just coronavirus, but for every kind of medical care. But at this emergency there's no reason Congress can say we will extend Medicare to cover all corona coronavirus expenses at this point. But in the longer term we need universal coverage to to address not just this epidemic, but future epidemics. If there's an argument for Medicare for All that ought to convinced everyone, it's this epidemic.

JS: 22:35
Well, that was going to be somewhat my next question. How do you think Medicare for All would help in battling the coronavirus? And in general, is there anything else you'd like to add about how Medicare for el, how Medicare for All would help?

DH: 22:58
I think it would have allowed people to get medical care earlier in their illness and would have helped us in the isolation. But as I've said, we need a restructuring of our healthcare system, which will take some time even after Medicare for All is passed. But it would provide us the tools to restructure our healthcare system. So, one of the things that we've always said about Medicare for All is we need to change the way we fund hospitals. We don't want to just pay them the same old way, and and really let them choose what services they want to offer based on what's profitable. We want to say hospitals get global budgets, like fire departments or schools, and rather than billing patient by patient, and the decision about where new hospital investments are made shouldn't be up to just the hospital. It actually needs to be based on planning for where facilities are needed, so we needed a different way of distributing the money that's used to upgrade hospitals and other healthcare facilities and build new ones. And that Medicare for All would also allow us to do, but it would take probably five or even 10 years to really build out the healthcare infrastructure that we need to fight epidemics optimally. But in the meantime, we could quite quickly assemble the data systems that would allow us to collect data from hospitals about whom they're treating, and what kind of facilities and stockpiles they're holding. That would allow us to coordinate the response much better. So, we're hearing from colleagues around the country at this point that the CDC was basically calling around to hospitals to try and get reports on coronavirus patients or coronavirus test results rather than having in place some data systems that would allow the timely collection of that data as a routine and ongoing thing. And that really reflects the fragmentation of our system and the lack of of any government coordination of our system.

JS: 25:31
So one of the things, just building on that point, and it's something you mentioned earlier, is Medicare for All would make it much easier to have a national health care policy where we do a strategic allocation of resources.

DH: 25:49
That's exactly right, and that's part of what we need is over the last four or five decades in this country, we've said we will give hospitals incentives and other facilities incentive to build what's profitable and regardless of whether it's needed or not, and the result is that we have a surplus of some kinds of care, and some kinds of facilities, and a real lack of other kinds of things. And we

need to move in a very different direction than that and really base our system on, on making sure we have what's needed. And that's reflected in all kinds of ways. So, we have a tremendous shortage of primary care in the United States, and we know that health systems that have ample primary care have better outcomes. Patients lives are longer and better. But primary care doctors make much less than specialists, so we've we've got a surplus of many kinds of specialists, and a shortage of primary care, and a shortage of mental health care in our society. So we need to move towards a system that meets needs rather than seeks profits.

JS: 27:17
I have another question, what is your prognosis for how bad or what the effects will be of the coronavirus?

DH: 27:28
I think we're facing a very, very rough period. I think we're going to see many, many, many, many, many deaths. I guess the estimate that currently being issued is something like 120,000 deaths. That may be even conservative. So this is a national disaster on a scale we haven't seen since the 1918 flu pandemic. And the question of what comes out of that for our society, I think we haven't even begun to grapple with. We could take that as a cue to do some very good things and, and understand what led us to this disaster and lack of preparedness, lack of ability to effectively deal with this epidemic. And recognize that we're all in this together that actually a dog eat dog world where we say if someone else is homeless, if someone else doesn't have medical care, that's not my problem. I think one of the lessons of this is that that's everyone's problem. That rich people are in trouble along with poor people in an epidemic. So one possible outcome is an understanding that we need to change our society in a big way, similar frankly, to some of the things that came out of the Great Depression where, you know, we got Social Security, and many other critically important social programs out of out of that terrible period. So I think the optimistic view is that we can learn important lessons and move ahead in important ways. And the pessimistic view is that we'll go back to the old ways and and set ourselves up for yet another disaster.

JS: 29:24
Before we end, is there anything else that you would like to add?

DH: 29:30
Well, I think that the time is now to begin to plan not only for what we're doing during this terrible pandemic, but really to contemplate what needs to be done next. So, I think both for Medicare for All, for the public health workforce, for security of people in their jobs and their homes, we need to think about how to rebuild our society after this epidemic is over. And progressives need to start with that task very soon if they are not starting there already,

JS: 30:09
Dr. Himmelstein, thank you so much for being on Medicare for All Explained.

DH: 30:16
Thanks for having me.

JS: 30:19
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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