# The Powers Report Podcast

**Episode 21**

**COVID-19 Puts a New Lens to the American Health Care System**

Welcome to The Powers Report Podcast. I am your host, Janis Powers. The show brings you candid, unique and data-driven perspectives on the health care industry. I believe that any solution that is going to positively impact the American health care system has to satisfy two major criteria: financial viability and behavioral incentive alignment. In other words, access to high quality care can only be achieved if we can afford it, and if we behave in ways that optimize our health. Please subscribe to our show on iTunes or on your preferred podcasting platform and connect with us on social media. Again, this is Janis Powers, and welcome to The Powers Report Podcast.

Maybe by the time you listen to this, the panic over COVID-19 will have passed. Maybe there will be a vaccine or a cure. Or maybe the flu season will be over, and we'll just be managing the disease by nipping it in the bud with much improved testing capabilities. As we record this show, I think a lot of us are feeling coronavirus fatigue as well as a big fat dose of cabin fever. So let it be known: this podcast isn't about making predictions about how many people will die, or talking up potential cures, or slamming our leaders for not doing a better job, or comparing the American response with other nations, or anything like that.

Instead, I want to talk about what the virus tells us about the American health care system. There's a lot to learn.

Probably most importantly, we're going to get a renewed respect for the health care worker, especially the nurses and other support staff. The people doing, literally, the dirty work. They're not just diagnosing, but more critically, they're taking care of the patients. These are the health care practitioners at the highest level of risk because they are in continuous person-to-patient exposure.

The virus isn't changing our minds about what we think of nurses. It's fortifying our opinion about an already well-respected profession. For years, Gallup has been polling people, asking them if they trust individuals with different occupations (1). When it comes to rating people on honesty and ethical standards, nurses have reached the top spot for 17 consecutive years. 84% of Americans rated nurses "very high" or "high" when it came to these criteria. Last on the list…members of Congress. They scored a pathetic 8% confidence rating. Clergy was at 37%, which was better than lawyers. They were at 19%.

So I think the nurses are going to come out of the COVID-19 crisis with enhanced status. Savvy nursing organizations are likely going to use this unpaid societal debt as a means to better negotiate terms of employment. And I'm not just talking better pay and better benefits. I'm talking robust health and/or life insurance policies. If (and dare I say when) something like this happens again, nurses and their families need to be protected. We give veterans lifetime health insurance (OK…it's not the best, but it's free). Maybe we're going to start giving that to nurses.

Now onto the doctors.

Over the past few years, hospitals and doctors have been on the forefront of aggressively billing patients for medical care. Maybe it's the insurance company that's structured the contract for the bills, but we get the bills from the doctor's office. That doesn't make us happy. In fact, in the Gallup survey where 84% of people rated nurses as "very high" or "high" vis-à-vis their ethical standards, doctors scored significantly lower. They scored 67%. That's one tick above pharmacists. 66% of Americans had reasonable trust in pharmacists.

Now that right there ought to tell you something about the health care system. Doctors go through years of medical training and one of their jobs is to assess patients and prescribe medications. Pharmacists have a lot of schooling too, but they are the "face" of the meds. They explain what the drugs do, even though a doctor should have done and probably did the same thing. But the patient gets the info from the pharmacists right when they're getting the meds. They want and need the meds (at least they think they do), so if all goes well, they are going to trust the pharmacist. And if things don't go well, it's the doctor's fault for prescribing the wrong thing.

Most of us have this interaction with the pharmacist a lot. Almost 40% of people aged 18-44 are on at least one prescription medication (2). About 70% of those between 45 and 64 are on medication and those over 65 – about 90% of them are on something. No wonder we like our pharmacists.

But back to the coronavirus and what we think of doctors.

Doctors are trained to be sleuths. They talk with patients, run tests and review studies so they can diagnose and treat patients. Diagnosing COVID-19 doesn't take sophisticated expertise. While doctors are supposed to approve the need for the test, we would-be recipients of a coronavirus test already know the questions we're going to be asked, so we know what to say to get approved.

Question: Have you been in contact with someone who tested positive for the virus?

Answer: Yes

Done. We need a doctor for that?

Now, there have been some regulations getting waived in this time of crisis, and having a doctor approve your need for a COVID-19 test may be one of them. Some companies, like

EverlyWell, are selling tests directly to consumers. Why should anyone need a doctor's approval if the customer is paying for the test him or herself? Because there's a shortage of tests? Well, that's a short-term view. We'll have plenty of tests before we know it (that's the optimist in me speaking) and adding a doctor's approval to get one just adds unnecessary costs and time to the equation.

Aside from that, doctors are on the front lines tracking the virus's mysterious variations in how it manifests from patient to patient. Why do some people get better and then suddenly worse? What treatments are working, and which ones aren't? What should be tried and on whom? This is doctor territory. And doctors are under immense pressure to figure this stuff out, and fast.

We expect doctors to know what to do, but no physician knows what to do in the face of a global pandemic. The work doctors are doing is not as transparent as what we're seeing with nurses. That's because doctors are learning with every patient and amassing knowledge along the way. They are getting better at treatment. And they, like the rest of the medical professionals out there, are putting themselves at risk too.

I think, interestingly, that the epidemiologists are taking the limelight away from the work doctors are doing. Everyone wants to know when this is going to crest, so we can know when it will end. So we're hanging on the projections made by epidemiologists.

Well, as far as I am concerned, epidemiologists who are making projections on a never-seen-before virus are about as useful as economists who are making predictions about when we're going to have a recession. In other words, not all that useful. Epidemiologists would have more credibility if all their models came up with similar answers. But they don't. Even better, most provide these hysterical ranges. The Centers for Disease Control, the CDC, published a study on March 13 (3). Its key take-away is that the death rate from COVID-19 ranges from 0.25% to over 3%.

That's an absurd range for a number of reasons, the first of which is because it takes into account death rates from other countries, like China. I don't know about you, but I have zero faith that any statistics that come out of China, or Russia for that matter, are legit. Second, and more importantly, the calculation is flawed because the data set is flawed. We all know that tons of people could have the virus and they're not showing symptoms. So they're probably not being tested. And those with symptoms haven't all been tested. We don't have a true denominator. We can't calculate an accurate death rate because we don't know how many people had the coronavirus in the first place.

Please, let the doctors do their jobs and tell the epidemiologists to stop freaking everyone out.

Then there are the hospitals. They are becoming the center of everyone's concern. In times of crisis, we always look to the hospitals in our community. But I think that needs to change in the coming years. We need to consider what a hospital is going to be like, germ-wise, once this virus thing settles down. Hospitals have long been considered the worst place to be when

you're sick. According to the CDC, and I quote, "On any given day, one in 31 hospital patients has at least one healthcare associated infection." (4) In case you're into the math, that's 3.2%, or about the calculated death rate of the coronavirus, according to some epidemiologists.

People get infections not just from dirty instruments or from bacteria on health care providers' hands. There's just nasty bacteria in the guts of the facilities that cleansers cannot remove. And these bacteria sound as terrible as they are, like Clostridium difficile and methicillin-resistant Staphylococcus aureus, known respectively as c diff and MRSA, which are a lot easier to say. Now throw in some COVID-19 and you've got a mélange of germs floating around the hospital. Honestly, the central core of hospitals that are over 100 years old just need to be demolished. That's probably not good enough. Maybe everything needs to get levelled and we start with something new.

The main reason to have hospitals in 2020 is the provide a central location to perform complicated, highly acute tests and procedures. You need special equipment for that kind of thing. Operations that require patients to be in the hospital for days for monitoring and recovery need to be done in a hospital. Emergency cases with life-or-death situations require hospital-based care. Everything else needs to be done somewhere else.

First, we shouldn't have relatively well patients anywhere near the really sick patients who are being treated in a hospital. We shouldn't have people getting routine ANYTHING in a hospital, from CT-Scans to colonoscopies, because we don't want to spread disease.

Second, it's cheaper to deliver care outside of a hospital. That's because the provider doesn't have all the financial overhead of a complicated facility to jack up their prices. They don't need to allocate these dollars to all different kinds of services and better yet, they can't hide behind the overhead as a means to inflate prices. Keep it simple, make the prices public and drive up competition. That's better for everyone.

Third. The Medicare population is growing, which means more and more people are going to be in the hospital. There will be more very sick people to use the expensive equipment that's in the hospital, so we don't need other people around using it too, as an excuse to maintain efficiency. In other words, say you've purchased an MRI. You, as a hospital administrator, get your return on investment by using the machine a lot, so you can bill a lot, so you can make the money back that you've invested in the machine. You want it highly utilized. In the past, when there weren't enough hospital-based patients to reach the utilization goals administrators needed, hospitals relied on outpatients to make up the difference. We shouldn't have that need anymore.

Better yet, hospitals should simply stop buying stuff because they're creating more supply than there is demand. There should be a rationalization of equipment, where the new, galactic stuff stays in the hospital for emergencies and complex cases and the older, but still reliable equipment moves elsewhere.

For more about what to do with hospitals, you can check out an earlier episode of The Powers Report Podcast called “Let’s Find Out About the Hospital, Part II” (5).

As a last topic, I’d like to get a little philosophical. Global pandemics don’t come around all the time, so this should be a time of reflection. We’ll spend plenty of time deconstructing what was done right, what was done wrong, etc. The response to the coronavirus has not been and will not be executed perfectly. There will plenty of blame to go around.

The key tension point in this drama has been how to balance an economic standstill with the need to save lives. We don’t have enough resources to treat everyone. People have and will continue to die who may have been able to be saved, had circumstances been different. We are dealing with a rationing problem of epic proportion.

What guidelines should be used to distribute constrained resources? Treat the elderly first? Do a first-come-first served model? Allow rich people to pay more, enabling more people to be treated later, but putting them in the front of the line? Have a lottery? Most ethicists have come to the same logical conclusion. Resources go towards methods that maximize survivability.

In simple terms, that means they go to the young, not the old. Treating the elderly requires, on average, more resources because they are usually sicker to begin with, they take longer to recover, and they have a higher chance of dying. Why waste money and time on one person who could die, when you could spend those same resources on three or four people who have a better chance of living?

While that sounds reasonable, the ethicist isn’t the one who has to look people and their families in the eye and give the patient a veritable death sentence. Imagine if all these patients were in a rowboat and the ethicist decides that the older people shouldn’t be in it. Who pushes these people out? Not the ethicist! No one wants that job. No one should have to have that job.

We are spending a lot of money right now so we can avoid making as many of these decisions as we can. No matter what you feel about rationing – you love it, you think it’s immoral – a bill for the coronavirus is coming and it’s going to be gigantic. We should take this opportunity to think about how we will deal with the rationing. We’re going to need it sooner than we think.

Why?

Medicare, Medicare, Medicare.

Before COVID-19, Medicare spending was a major reason why the national debt was exploding. Now, the fastest growing element of the federal budget is interest payments, because we have to pay back old loans. The debt is going to grow significantly after the coronavirus passes. That means we’re going to be even more fiscally strained. We’re going to have to put controls on everything, and that includes Medicare. But how?

American health care has morphed into a system that flourishes by keeping people alive. Not necessarily well, but alive. According to the World Health Organization, the average life expectancy for an American at birth is 78.5 years (6). The average *healthy* life expectancy is 68.5 years, or ten years less. The last ten years of your life, on average, will not be healthy. Earlier I mentioned that 90% of Americans over aged 65 were on at least one medication. Either they need the medication because they're sick, or they're taking medication and it's making them sick. We take too many drugs, so you never know. Regardless, the older you are, the sicker you are.

About a quarter of Medicare spending occurs in the last year of a person's life (7). Think of the health status of a person on Medicare in the last year of their life. It's scary to think that one in three people dies with Alzheimer's or another form of dementia (8). Maybe your parents are getting old, or your friends are. Maybe you know some older folks who've died, and you've watched them go through a slow decline. Now think that person is you.

We have some legal means to control how we die. We can use Do Not Resuscitate orders or DNRs. These are orders written by a doctor and they are signed by people when they are in their right mind and mentally capable. The DNR prohibits health care providers from performing lifesaving activities, like CPR or the use of breathing machines, if the patient stops breathing or their heart stops beating.

Now I'm not going to discuss the use or the non-use of DNRs in the case of COVID-19. But I will say that we need to start expanding a person's legal ability to control how they die beyond the power that's conferred via a DNR. There are so many life-saving capabilities, but we don't all agree that they should all be used on everyone. Yet that's, broad brush, what goes on in the Medicare system today. We spend tons of money trying to keep people alive because it seems morally right. But is it?

We'll never agree as to whether it is, or it isn't. Since we can't agree, we should, morally, offer lifesaving care as recommended by a physician to those who want it. But there are people, and I am one of them, who do not want to expend my resources or worse yet, burden my children and the rest of the American community with debt, to take care of me when I have little chance of getting well and the quality of my life is beyond substandard.

We should take this time to determine how we want to live and how we want to die. We should start to get clearer on what "substandard living" is. Maybe it's mental incapacity. For another person, it may be an inability to stand, shower and clean themselves. I want to live a full, healthy life for as long as I can. I want access to life saving treatments when I am young. But if I ever get to the point when I am infirm and/or demented and can't help myself or communicate with the ones I love and care about, it's time for me to go. I'm not talking assisted suicide, but more of a humane cessation of medical care that allows me to go out on my own terms. I should get to decide how I die. That choice needs to be made while I'm healthy. And I hope other people get that opportunity too, before it's too late.

I wish you all a joyous, virus-free spring. Nurture your immune system, live life to its fullest and be as healthy as you can be.

This is The Powers Report Podcast. Please subscribe to our show and please follow me, Janis Powers, on social media. Please see our website at powersreportpodcast.com to submit questions and ideas on the Contact page. I look forward to hearing from you. Thanks so much for listening!


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