



## 'Out in the Cold:' America's deadly un-insurance problem

*Dispatcher: 911, what's your emergency?*

*Caller: America's healthcare system is broken and people are dying! (ambulance siren)*

Welcome to **Code WACK!**, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar**.

This time on Code WACK! How many COVID 19 deaths could have been prevented with a single payer healthcare system in America, and how much money would America have saved during the pandemic with Medicare for All? To find out, we spoke to Dr. **James G. Kahn**, a professor emeritus of health policy, epidemiology, and global health at the University of California, San Francisco. An expert in health policy and economics, he's an advisor for **Code WACK!** as well as editor and primary blogger for **Health Justice Monitor**.

*Welcome back to Code WACK! Dr. Kahn.*

***Q: A peer reviewed journal of the National Academy of Sciences that you co-authored and that was published in June found that more than one quarter of all COVID deaths – some 339,000 – are due to the absence of universal insurance. That is a shocking number. How did you and your colleagues determine that figure?***

***(01:12):***

**Kahn:** So we estimated that number in two steps. The first step was empirical. My colleagues did an analysis of COVID case rates, hospitalization rates, and deaths by geographic area, and used as a predictor in that analysis, the percentage of the population that was uninsured. And what they found is that lack of insurance explained 26% of COVID deaths. In other words, they were able to determine using, again, empirical data that if everyone had been universally insured, we would have seen 26% fewer COVID deaths. And that reflects the fact that when people are insured, they're more likely to get care early, they're more likely to see the doctor who can then say to them, 'you might have COVID, you should really protect your friends and family and coworkers by staying home for a few days.'

So there are a variety of ways in which medical care access helps reduce COVID. Of course it definitely helps when you start to get really sick and, and need care, which may be expensive. We then took that empirical estimate and applied it to the estimated death rates that have been observed for COVID, which include both the documented deaths and the fact that the number of deaths is an underestimate because there are COVID deaths that are not well documented. When we put all that together, that's how we came up with 339,000 deaths up to the time that the article was submitted beyond what would otherwise happen in COVID if everyone were universally insured.

[\(02:56\):](#)

**Q:** *Got it. So basically the figure, the 339,000, is it entirely due to inadequate health insurance coverage?*

[\(03:03\):](#)

**Kahn:** It's not about inadequate health insurance coverage. It's about being uninsured. We did not look at the question. We did not look at the question of what if people say had high deductibles – they were insured, but had high deductibles – that would add to the total, but we were not in a position to look at that. So this is kind of a bare minimum and the consequences of our inadequate insurance would add to that.

[\(03:32\):](#)

**Q:** *Wow. So that's interesting. Is there any sense of how much it would add?*

[\(03:36\):](#)

**Kahn:** It's really hard to say. We've been doing some work, not COVID specific, but for other conditions like hypertension and diabetes, and it's pretty hard to pin down. I mean, I like to think about it. There's another way to look at it, which is to look at the excess deaths in the United States compared to other countries and how that changes when people turn 65, because when people turn 65, they become Medicare eligible and while Medicare isn't perfect, it does mean that very few seniors are uninsured. Very few. So if you compare the excess death in the United States before 65 to the lower level of excess deaths after 65, you can get an estimate of how many deaths in the United States are due to this constellation of a lack of insurance and inadequate employment based insurance and so on. And by using that method, I've estimated

in the past that there are approximately 150,000 excess deaths per year in a non-COVID year – any year.

**(04:39):**

**Kahn:** So what we saw in a COVID year is that that went way up even further because of the huge health threat posed by COVID. So what we're talking about in a, you know, in a normal year is something on the order of 150,000 people dying because of the inadequacies of our health insurance system. Now in my field, when I'm on full geek mode, I do something called cost effectiveness analysis, which tries to answer the question 'if we spent more on health care, how much would it improve health and is it worth it?' And sometimes we find that you can add a year of healthy life for \$10,000. That's no question, that's definitely worth it. Or maybe \$10 million dollars. . Maybe not, maybe that's not something society wants to invest in. That's cost effectiveness analysis. But what's interesting here, as I said earlier, is you don't need to use that kind of trade off calculation because you can save those lives and save money and that is what we in the biz call a dominant solution. It dominates because it's cheaper and it's better and so that's what covering everyone with universal health insurance would do. And that's how we can avoid those 150,000 excess deaths per year, and the 339,000 excess COVID deaths due to lack of insurance

**(06:08):**

**Q: *Mm-Hmm <affirmative>. Wow. Are there other ways that universal health care would've prevented deaths during the pandemic?***

**(06:15):**

**Kahn:** Well, again, I think there are several things going on here. One is people when they're just a little sick or maybe they're just exposed to the virus or might have been exposed, they are reluctance to go to the doctor because they don't want to pay a hundred bucks to see the doctor. And then if they do get sick, they may think, 'ah, I really don't want to go to the emergency department. That's going to cost me literally thousands of dollars. I'll be fine. I'll just wait it out at home.' And when that happens, you know, they're two risks, first of all, they're more likely to expose other people, but more importantly, to the risks of death for themselves, they're more likely to get sick in ways that are much harder to treat. So all of those dynamics come into play.

**(07:00):**

**Q: *Wow. How much of a role did the loss of employer-sponsored health insurance play into this?***

**(07:06):**

**Kahn:** You know, it's interesting when the pandemic hit, and we saw tens of millions of people losing their jobs, laid off from their jobs. We thought, including the Kaiser Family Foundation, that there would be a big drop in insurance coverage as a result. It turned out that part of the

problem was not as bad as we expected. Partly, some employers paid for insurance just to help out their employees. Some employees use something called a COBRA extension of insurance that can, after you're laid off, you can pay to keep your insurance. Medicaid programs added some people so that helped and then some people had another family member, who was insured and they could be added to that other person's insurance. So definitely a lot of people lost job based insurance, but that was substantially corrected. The numbers are in the article. That's not really the reason we had that terrible problem. The reason we had the terrible problem is that our baseline level of people being uninsured is too high.

**(08:08):**

***Q: Right. And I remember the government tried to encourage people to see the doctor, you know, especially during the beginning of the pandemic, by getting insurance companies to promise coverage for COVID. How did these promises fall short?***

**(08:22):**

**Kahn:** Well, that's a great question. Indeed. Some COVID care was covered by insurers under this promise to the government, but it was based on good faith of the insurance companies and on evidence that the care provided was due to COVID and that gets really complicated. Number one, if you are just a regular person and you are a little bit sick, and you're wondering whether to go to the doctor, maybe you don't know that your insurance company has promised to pay for COVID related care and even if you know that, and even if you go, what happens if the doctor says 'this isn't COVID, this is ... you have a cold, or you have the flu'. Now the care is not covered. So now instead of a free visit, you now have to pay \$200 to the doctor. Well, that doesn't work. And then if you have significant comorbidities, that means you have health conditions that can exacerbate COVID, let's say diabetes or congestive heart failure.

**(09:34):**

And you go to the emergency department and you do have COVID, but the way the emergency department codes your diagnoses in the medical record, they happen to put congestive heart failure first. That may mean that your care is not covered. So it's this unbelievably complex overlay to our insurance system, which did help a lot of people, but left a lot of other people, you know, out in the cold with huge medical bills that were in fact COVID related. Wouldn't it be simpler to cover everyone with good health insurance and save money in the process? Sorry, if I sound like a broken record. Do we all remember what records are? Anyway, it's a refrain that I keep repeating that we can do better and save money at the same time instead of having this ridiculously extraordinarily complex system that makes no sense to anyone except to the people who make lots of profits,

**(10:45):**

***Q: Except to the people who make lots of profit. Exactly. You and your team also calculated that U.S. 5 or 6 billion in medical expenses associated with COVID 19***

***hospitalization could have been averted by a single payer universal healthcare system over the course of the pandemic. How so?***

**(11:04):**

**Kahn:** It's avoiding the 26% of COVID cases, COVID hospitalizations. The number for hospitalizations is a little different, but the same basic idea – that a large portion of the costs that we incurred for hospitalization would go away. If you had fewer cases and fewer hospitalizations and fewer serious cases that lead to deaths. We should have had a smaller pandemic. Now, there are other things we could've done to better control the pandemic that are beyond the scope of today's discussion, like a better public health infrastructure, to have better monitoring, to have better, better testing, clearer and quicker policies to control spread all sorts of things. But just on the side of getting prompt medical care, we could have averted a very substantial portion of the cases, and that includes avoiding all these excess hospitalizations. By the way, one of the big challenges in the pandemic was that healthcare workers, doctors, and nurses and others were overwhelmed because the capacity of the hospitals, including especially the intensive care units was challenged and that huge struggle to maintain capacity, would've been really greatly relieved if we'd had a quarter fewer cases.

**(12:35):**

***Q: As animal to human infections increase, what does this mean for America's future if we don't have single payer?***

**(12:42):**

**Kahn:** <Laugh> Well, again seeing a doctor, going to an emergency department has the potential to help control pandemics. If that animal to person transmission can also then be person to person, people need to isolate themselves. If there's an infected animal vector near someone, you can't go and catch that animal and remove it as a vector unless you know that someone's been infected. So it is a really important means to monitor this situation and to prevent person-to-person spread. The country which did the best in the pandemic is Taiwan. They have universal health insurance and also a really good public health data infrastructure so they were able to use the fact that everyone had universal access to care plus really good data systems to track and intervene in the pandemic and they had a very mild pandemic compared to other countries.

**(14:05):**

And that's what we should be doing in the United States. We have world leading technology. Silicon Valley is a global leader in developing data systems. So we're best in the world in certain things, but worst in the world, certainly worst in the wealthy world on health insurance. If we could put those together that would really be terrific. Another one of my geeky ventures is thinking about how having a unified data system under single payer would facilitate clinical research and public health efforts. Right now, every insurance company has its own data system. Public programs have systems and it's a massive effort to put it all together and make

sense of it. And it can take years to put together data before you... and then by the time you look at it, the situation has passed. If instead we had a single data system with instant reporting we could within days spot a hotspot, for example. So the value of single payer for public health monitoring, hotspot identification would be tremendous.

(5-second music stinger)

**[\(15:31\)](#):**

***Thank you, Dr. James G. Kahn.***

***Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at [heal-ca.org](http://heal-ca.org).***

***Find more Code WACK! episodes on [ProgressiveVoices.com](http://ProgressiveVoices.com) and on Nurse Talk Media. You can also subscribe to Code WACK! wherever you find your podcasts.***

***This podcast is powered by HEAL California, uplifting the voices of those fighting for healthcare reform around the country. I'm Brenda Gazzar.***