



## The Deadly Design of U.S. Health Care

**“I think what we're seeing in the United States is that there's a widening inequality in both wealth and health. And those are very disturbing trends that we need to address to make this a healthier and happier country.” Dr. Adam Gaffney**

*911. What's your emergency?*

*America's healthcare system is broken, and people are dying.*

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.**

*(music)*

This time on **Code WACK.** Why do Americans live about four years less, on average, than people in similar European countries, despite spending far more on health care? And why are so many dying from illnesses we already know how to prevent or treat?

To help us unpack this, we spoke with **Dr. Adam Gaffney** — a pulmonary and critical care physician, public health researcher, and Assistant Professor of Medicine at Harvard Medical School. He's a former president of Physicians for a National Health Program, and his research and advocacy focus on health care financing and

national reform. He's also the author of *To Heal Humankind: The Right to Health in History*.

**Welcome to Code WACK. Dr. Gaffney.**

**Gaffney:** Thank you so much for having me.

**Q: Thanks for being here. So tell us briefly about yourself. Who are you and what inspired you to become an advocate for healthcare reform?**

**Gaffney:** So I'm a practicing intensive care unit doctor. I practice in a community hospital system north of Boston -- many disadvantaged patients and patients from immigrant backgrounds are part of our patient population. I also do healthcare research on equity and access and national healthcare reform. And finally, as you mentioned, I've been a longtime advocate for universal healthcare reform. I served for a couple years as the president of Physicians for a National Health Program, which is a Medicare for all advocacy organization of physicians that was formed in the late 1980s. So that's the sort of the three things I do. And what brought me to it was a desire to meld my career path and medicine with the cause of social justice that I've always been committed to.

**Q: Wonderful and so needed. So thank you for your service. The US spends more on healthcare than any other wealthy country, yet our health outcomes are worse and still falling behind. From your perspective, what explains this deepening paradox?**

**Gaffney:** Well, the reason why we spend so much on health care in this country is not because we are sicker than other people in other countries. It's not because we have more unhealthy habits. The reason why we spend so much on health care is because of the way that we have designed our healthcare system. We have a fragmented, privatized healthcare financing system in which enormous amounts of resources go towards the administration and the profit of our health insurers. And meanwhile, on the provider side, huge amounts of resources go towards administration to deal with that welter of insurers, each with their own rules and

regulations, prior authorizations, and so on and so forth. There's also huge amounts of profits that get siphoned out of the system and increasingly into the pockets of shareholders or even private equity firms. So that's why we spend so much. Now why are our outcomes worse?

There's many things. It's not only healthcare, of course, many things contribute to poor health other than healthcare, but healthcare matters. And in fact, even when you look at mortality rates for diseases that are potentially preventable through medical care, so you take out the car accidents and things like that and you just look at things that medicine matters for, well, it turns out we do bad in that category too.

Why is that? I think there's a few things. No. 1, we leave more than 25 million Americans uninsured. They don't get any care. We leave even more underinsured -- copays, deductibles, co-insurance, so high that they often avoid care even when they need to use it.

I don't think we invest enough in primary care. I think we're a specialty heavy healthcare system and I can say that 'cause I'm a specialist, but I think that's a problem as well. So really at the intersection of those two forces is the picture that you paint.

***Q: Right. And that's a really good point. Correct me if I'm wrong, but primary care, those are the frontline doctors that catch anything that could be referred to a specialist. And so if we don't have adequate primary care physicians or they're not able to do their jobs, well, then that's a real problem for the health of all Americans.***

**Gaffney:** Yeah, I think it's fair to say that the lion's share of benefits in our healthcare system do come from primary care. Obviously, we need specialists of all sorts because there are rare and complicated conditions and procedures and so on and so forth that need to be done. But yes, I think that the meat of what medicine can do is often delivered in the primary care arena. As you said, that's picking up diagnoses, but it's also treating conditions. Things as simple as, and none of this is

simple, but things like high blood pressure, something that can be totally invisible, left untreated can cause strokes, heart attacks, kidney failure, heart failure and mortality obviously. So, things like that. And the reality is we're not doing a great job of doing that kind of routine care. Far too many Americans don't have a dedicated physician with whom they have a longstanding, trusted relationship. And that matters for things even beyond, you know, for so many things.

There's a lot of discussion of vaccine hesitancy and that's obviously being driven by political factors and RFK Jr. and everything that was going on during the pandemic in terms of some of the anti-science rhetoric and propaganda. But at the same time, I do think that those things are modifiable by having, you know, close, longstanding, trusted relationships with primary care physicians. So it matters in every department.

**Q: Right. Thank you for speaking to that. US life expectancy started falling behind peer countries in the eighties and still hasn't recovered since the pandemic. What does that long-term trend tell us about the structural failures of our healthcare system?**

**Gaffney:** You know what's interesting, going back to your first question about spending and outcomes, they actually both started to head in the wrong direction around the 1980s. Our healthcare spending, at least as a percentage of our GDP really started to shoot up in that era. And as you said, we started to diverge on life expectancy from other sort of wealthy nations around the same time in the decade before the pandemic life expectancy plateaued. Obviously it fell through the floor during the pandemic, but it is not fully recovered and it has recovered in fact in, for instance, Europe where the life expectancy now is higher than it was in 2019 before the pandemic started. So something is very amiss in American health care and American society. I think the health trends are complicated, but factors that contribute include some of the healthcare issues we've been discussing, but also rising economic inequality.

During the 1980s, obviously there was a surge in economic inequality under the

Reagan administration. There was also environmental deregulation and other policies that set us back the increase in spending.

What's that about? You know, actually researchers don't really have a great answer for that. There's no official answer to that question – what happened that we seem to really start going off in the wrong direction? But I do think part of the problem was the increasing corporatization of American health care, the entry of big managed care giants, the rise of privatized Medicare, the shift towards more for-profit provision. Colleagues and I did a study looking at the hundred years of sort of ownership and financing of health care and we found that, you know, there's been a gradual ongoing shift towards for profit, corporate provision – even though the public is actually picking up more and more and more of the tab. It's just that the money is flowing to private interests.

**Q: So interesting and unfortunate. You've noted that mortality from common treatable conditions is now higher in the US than in countries like Canada and the UK. Why are Americans dying more often from conditions we know how to treat?**

**Gaffney:** You know, again, I think that there are different factors contributing to it, but I do think part of the answer is in health care. Far too many Americans don't see a doctor regularly. Far too many Americans don't have a regular doctor to see. Far too many Americans can't afford the physician or find the barriers to getting in the door to be high. And so the reality is there are other things that, you know, in American society that harm health as I said, it's not all about health care. In fact, it's not the biggest issue, but it's important to focus on it 'cause it's something we know how to modify and know how to deal with. One thing that we could do immediately is not go further in the wrong direction. And that's what's happening right now. We're seeing as a result of changes in the Trump administration, the One Big Beautiful Bill Act that was passed last year is estimated to make 10 million more people uninsured -- in addition to the 25 million people uninsured.

We're seeing environmental deregulation that's gonna result in more Americans being exposed to pollution in the air and in their water. And we see tax cuts being expanded for the wealthy. So I think the rise of economic inequality, enriching

polluting corporations at the expense of everyday Americans' health, combined with the healthcare cuts that we're seeing now, are all going to synergize in terms of their negative impacts on our health.

***Q: Wow. That's all bad news. And you mentioned healthcare is one issue when it comes to poor health, but not the only issue. Is there a main issue? And if so, is it economic inequality or something else?***

**Gaffney:** I think that these things are all related, and I can't say one main issue, right? What I can say is that there are many different pathways to poor health, right? So one can be not have vaccines that can improve health. One can have poor housing, one can be exposed to climate change, and we can go on and on and on and one can face poverty. And as a result of that, life choices can be very constrained and healthy behaviors can be more difficult. And unhealthy behaviors are an understandable way that people address, you know, really adverse circumstances not good for the health, but we can all sympathize with that. And so I can't say what one of these things is what drives Americans' worse health. What I can say is that our economic position is upstream of all of those different things, right?

So on average, of course, wealthy Americans will live in less polluted neighborhoods, will have secure housing, will have access to clean water, will have access to top notch healthcare, and will have access to good food and will be relieved of the strains and stressors that drive that can contribute to unhealthy behaviors and may even have a direct biological impact of the body through, you know, various inflammatory pathways and so forth. Although I'm not sure what the latest, the latest science in that question is, but the simple fact is, is that upstream of these different mediators and mechanisms of poor health is class position as well as racism and other sorts of systemic injustices.

***Q: So differences in health outcomes in the US are increasingly linked to wealth, not just income, uh, probably for many of the reasons that you just mentioned. Is there anything else you wanna say about why wealth plays such an outsized role***

## ***in who lives and who dies in America?***

**Gaffney:** It's always been true. It's not that there's been a time in history when wealth hasn't played a role in health. I think what we're seeing in the United States is that there's a widening in inequality in both wealth and health. And those are very disturbing trends that we need to address to make this a healthier and happier country.

***Q: So Medicaid, the public health insurance program for low-income Americans is supposed to be a safety net, yet many people lose Medicaid, not because they make too much money, but because of confusing paperwork or missed deadlines. It seems like the red tape is an intentional decision by the states that manage Medicaid. What can we do about it?***

**Gaffney:** So, great question. And Medicaid is one of these really complicated things because it's sort of a little bit different in every state, and that's a weakness of Medicaid. You know, Medicaid and Medicare are past the same time. 1965 civil rights era legislation, great society and Medicare was a fully federal program, sort of the same benefits. Eligibility is universal when you hit 65. And a state can't choose to be cheap with their Medicare or beneficiaries in the way they can with Medicaid. So as you said, Medicaid, people do churn in and out of that. Part of that can be mitigated by good state decisions or exacerbated by bad ones, as you said. But part of it is intrinsic to the means testing that is inherent in the program. Right. So let's start with the latter. You know, at the end of the day, Medicaid requires you to have a very low income.

Now that was improved by the Affordable Care Act, but it still means that if your income goes up a little bit goes down a little bit, goes up a little bit, goes down a little bit, you might be coming in and out of Medicaid eligibility and so you will be kicked off or lose coverage once you no longer meet those eligibility criteria. And it's not just income, there are other ways that people qualify for Medicaid sometimes, you know, being postpartum or pregnant, age, other factors. There's these categorical sort of eligibility. So put that all aside. The point is it's complicated. It's

means-tested. And so it's possible your eligibility will change over the course of a year or two or three. That's in the best case, right? The problem is that on top of that, states have to assess that eligibility.

So that means a process of documentation and eligibility assessment typically annually. More on that in a moment. And we know from studies that a lot of people lose Medicaid over time. One study found that over a two-year period, 20% of Medicare beneficiaries experience a lapse in coverage. The rates are higher if you're a new enrollee. And we know that right at that one-year mark, when people are up for re-enrollment, there's a big drop in participation. The forms get sent to the wrong address, or people are confused at what they have to do or they just can't get through the paperwork. So there's a lot of administrative red tape and paperwork that we impose on some of the most poor people in the country that understandably people struggle to deal with. I would struggle to deal with it and I study health policy. So , it's very understandable. There are things states can do to make that better. We get into details, they can try to minimize it, they can try, but again, their arms are partially tied by the realities of what the system is, which is a means tested health program.

***Q: Wow. We've heard a lot in the news about Medicaid work requirements. Supporters argue they promote employment and responsibility. What does the real-world data from states like Arkansas show about how these policies actually affect health and access care?***

**Gaffney:** Well, we have two examples of work requirements, both dating back to the first of administration. The first was Arkansas, and they were only around for a while with these work requirements because a federal judge declared it illegal. And the program ended in that very brief period that it was active and I wanna make sure I get this right. I think 16,000 or more people suddenly lost coverage. And we know that there was a lot of confusion among beneficiaries. We know that 95% of the people who were targeted by work requirements according to one study, actually worked or should have met an exemption. And we know that the state had to spend a large amount of money on bureaucracy just to sort of create the system, to have people set up an online portal and submit the documentation and fill out

their work hours and so on and so forth.

Georgia wasn't implemented until after Trump had left office the first time. But the story similar in Georgia, it wasn't so much being imposed on existing Medicaid and beneficiaries. It was imposed on new beneficiaries who wanted to sort of gain access to Medicaid but weren't eligible for the traditional pathways. And same thing, very few people signed up. It was very burdensome. People had to clear administrative hurdles, and the administrative costs were high. So upshot work requirements mean people kicked off their health care because of red tape, because they have trouble navigating the administrative maze. It burdens taxpayers with new bureaucratic costs and it leaves patients in the lurch.

**Q: So, in other words, there's nothing good at all about these Medicaid work requirements?**

**Gaffney:** If you are a corporation that wants to do consulting and you can get a contract with one of these states to run their work requirements bureaucracy, then you'll make money, I guess. But, uh, beyond that, no, I don't think it's gonna help anyone.

**Thank you, Dr. Adam Gaffney. Stay tuned for next time, when we take a closer look at why health care in America may be getting worse — and what we can do about it.**

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