March 19, 2024

LWV Health Care Reform for the US Newsletter

Healing Moral Injury in Our Shrinking Medical Workforce

Health care in the U.S. doesn't cover everyone, and we already don't have enough health care providers.

A 5- or 6-month wait for a doctor's appointment is not unusual, even when it is to confirm a probable diagnosis for a serious disease like Parkinson's. Or, when you move to a new area, many people (including the author) find there are **no** providers accepting new patients.

Analysts increasingly point to rates of "burnout" and "moral injury."

We can blame some shortages on the uneven investment by private companies that locate health care facilities only where they can both provide the needed services and produce a large profit from them.

But there is also true scarcity. Instead of adding new providers, we are losing them. Many sources predict increasing shortages in doctors (122,000) especially primary care physicians (40,000), nurses (>200,000/year), nurse practitioners (29,000), dentists (12,000), midwives (9,000 min.), and home health workers (400,000), to name just a few.

Clearly, there are many reasons that account for our declining medical workforce, but analysts increasingly point to high rates of "burnout" and "moral injury." A classic definition of burnout is the "fatigue, frustration, cynicism, and inefficacy"—that individuals feel from excessive demands, especially in the workplace, while "moral injury" is a category of psychological injury when circumstances force people to act contrary to their morals--against what their beliefs dictate. It takes away providers' sense of autonomy and fulfilment in their practice.

Moral injury is a systemic problem that must be addressed at a systems level. Keeping providers in the health care professions may require rooting out the for-profit business model (profits over patients), restoring medical ethics (patients over profits), and promoting democratic governance in the creation and allocation of medical resources. Key among the required resources is additional health care workers.

A remedy for the workforce is embodied in S2840, the bi-partisan bill introduced by Senator Bernie Sanders (VT) and conservative co-sponsor Roger Marshall (KS), the "Primary Care and Health Workforce Expansion Act." Among its provisions are: 10,000 new training slots for doctors (especially primary care and at minority-serving medical schools), >$2 billion for nurses, including incentives to return to nursing, loan forgiveness, rural residences, and expansion of community health centers.

The bill does not bring us Single Payer, the main mission of many in our HCR Interest Group. Still, its ideology-neutral goals could broaden the political base of support and make cost-effective provisions of health care a NON-PARTISAN issue again.

What will it take to get the S2840 co-sponsors to reactivate the journey they have begun for us?

NEXT HCR4US MTG
Sunday, March 24
8:00 p.m. ET
5:00 PT

Register at
https://tinyurl.com/HCR4US-Mar24

Agenda:
New Attendees
Announcements
Program Planning
Education/Advocacy
Break-out Sessions

Gen Z Mental Health: A Mixed Bag

Behavioral Health Affinity Group

A recent Axios article offered a bleak view of Gen Z: "They dodged familiar teen pitfalls — with lower teen pregnancy rates, and lower rates of alcohol use. Instead, they're grappling with alarming rates of loneliness, depression and suicidal thoughts."

However, a 2023 Gallup and the Walton Family Foundation study of 3,114 12- to 26-year-olds in the US portrays a slightly more optimistic view. Like many Americans, most want to have the finances to live well, even though 47% report they are not thriving. Three quarters of them – especially those who have an encouraging adult -- anticipate a good future, but less than half of them feel prepared for their future. Still, only 64% of Gen Z report excellent or good mental/emotional health, the lowest of all the generations, 13% lower than millennials.

In Case You Missed It

Mar 5 The Federal Trade Commission hosted a 3.5 hour program "**Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care**" Chair Lina Khan, Eileen Applebaum, RI AG Rehonha, Brendan Ballou and many other heavy hitters

Mar 6 Boston University School of Public Health "**The Future of Reproductive Health in the US**" Six panelists explored the current landscape of reproductive health including range of services, equitable access to and possible actions the public health community can take to better navigate the politicization associated with reproductive care.

Mar 13 National Single Payer hosted "**Rural Hospitals Under Fire: How National Single Payer and Global Budgets Can Save Them**" Journalist Maureen Tkacik and Health Justice Monitor Editor Jim Kahn discuss global budgeting as a reform model that could "achieve universal coverage at an affordable cost and facilitate more equitable funding of hospital infrastructure."

Websites

HCR4US Youtube Channel:
https://www.youtube.com/c/LWVHealthCareReform
HCR4US Web-Contact Form:
tinyurl.com/Contact-LWV-HCR-4US
HCR4US Google Drive:
https://tinyurl.com/HCR4US-Minutes-etc
HCR4US Toolkit:
https://lwvhealthcarereform.org

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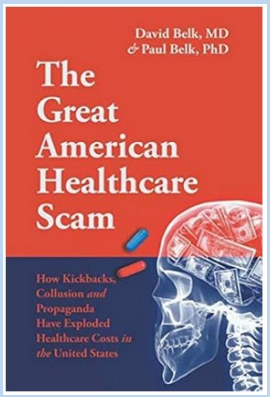
HCR4US : *Dedicated to educating and mobilizing League members to work toward legislation that enacts the goals of our LWVUS health care position*

Newsletter Committee: *Barbara Pearson, Jon Li, Candy Birch, MaryLynne Courtney*

Confusing Medical Pricing - Why?



Would you buy a car, or even a toaster, without getting the price ahead of time? By contrast, since almost all the financial transactions in healthcare are hidden from providers as well as patients, we buy medical goods and services without knowing their price.

To shed light on the matter, author Dr. David Belk asked the simple question: How much do drugs, x-rays, or procedures cost?

Belk's book starts with an example familiar to most of us of how arbitrary and inconsistent prescription pricing is: On Day1, his patient Patricia presented a prescription for a common, generic migraine drug. The insurance company denied coverage, and the drugstore told her she could buy the 40 pills out-of-pocket for $1,500 ($37/pill). Belk called and got the insurance company to reconsider. Back at the drugstore on Day 2 of the migraine, **with** insurance— Patricia's copayment would only be $17/pill—but she could have only 10 pills at that price. In the end, she went to Costco, where she got 40 pills for $41.21 (or about $1/pill).

Success maybe, but why, Belk asks, were the pharmacy and the insurance company conspiring to inflate the cost of Patricia's headache? Likely, "because they can"--and we'll never be the wiser. In the next 250 pages, Belk shows us "the kickbacks, collusion, and propaganda" behind the prices we end up paying.

A Kaiser Family Fund study revealed similar inconsistency and lack of transparency. The 2020 Cares Act mandated programs to post the price of Covid testing and provide it without a co-pay, or for free to those without insurance. Experienced KFF researchers struggled over 3 months to find out, in every state, whether the testing was free and whether prices were clearly posted.

For federal programs like Medicare, the answer was "Yes and yes." For 25% of the private programs, the answers were "No and no. " Prices ranged from $20 to $850, and clinics found many strategies to make the procedure less free and less open: they used illegible, non-standard codes; withheld "proprietary" information, didn't charge for the test, but charged for a visit, a facility fee, or a specimen collection. In several cases, if the facility couldn't test, they called it a non-Covid visit and charged anyway.

Sadly, they found that people were discouraged from seeking the universal testing we desperately needed to fight the spread of the virus — held back by the secrecy and loopholes.

Upcoming Events

June 27—30: LWV US National Convention in Washington, D.C. In-person and virtual attendance is possible. Does your local League offer financial support for attendees?