KHN's 'What the Health?'

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Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Nov. 11, at 10 a.m. Happy Veterans Day! As always, news happens fast and things might have changed by the time you hear this. So here we go.

Rovner: Today, we are joined via video conference by Alice Miranda Ollstein of Politico.

Alice Miranda Ollstein: Good morning.

Rovner: Anna Edney of Bloomberg News.

Anna Edney: Hello.

Rovner: And Rebecca Adams of CQ Roll Call.

Rebecca Adams: Thanks for having me

Rovner: Later in this episode, we'll have my interview with Rebecca Love, a nurse leader who warns that it's not just a doctor shortage we're facing, but a potential nursing crisis as well. But first, this week's news. So, Congress is out this week, and lawmakers are either closer to or further from a deal on that huge social spending bill than ever before. For those of you who spent last weekend doing, I don't know, weekend stuff, the House worked late, passed the bipartisan infrastructure bill that the president is going to sign early next week. And apparently, the House worked out a deal where moderates have agreed to vote for the social spending bill, assuming nothing surprising jumps out when the Congressional Budget Office finishes a full score on the bill. Do I have that right and when do we expect to hear from the CBO?

Ollstein: So they're not expected to have a full score in time, but they're releasing the pieces of the bill as they score them. And the moderates said that they got a little funny with the language. They said they need fiscal information, not necessarily an exact score. And so the CBO is working through this massive bill and cranking out their analyses as they go. We have not gotten the scores of the new drug pricing language yet. I know we're all waiting for that. It is expected that the House is going to pass this next week. The real question is then what the Senate is going to do and when.

Rovner: Yes, I did notice that the CBO sent out yesterday their score of the Homeland Security piece of the bill and I'm like, Oh, they're just going to send this out in pieces. So just to recap on the health parts where we ended up after this long negotiation, there's still an extension of subsidies for the Affordable Care Act; new eligibility for those caught in the Medicaid gap in states that didn't expand under the ACA; some modest but still far-reaching changes to prescription drug prices; four weeks of paid family leave; and hearing aid coverage, but not dental or eye care for Medicare. Is that it? Am I missing something? Home care, right?

Ollstein: Yeah, but a lot less than they originally wanted, even a lot less than the House originally put in the bill. It got cut back even further.

Rovner: OK, so now let's talk about what happens. The deal, as it's been explained, is that the moderates will go ahead and vote for this and it'll get out of the House in this current form next week. But it will not stay in this current form when it gets to the Senate for a variety of reasons, right?

Adams: That's right. There are lots of moving parts to this, Julie. So, you mentioned the paid family leave. We also are probably going to see negotiations on climate change and taxes, including an e-cigarette tax. But the thing that we're all watching very closely is the drug prices, which you mentioned. Obviously, this has been a long time coming. I remember when this passed in 2003, I remember the House Ways and Means Committee Chairman, Bill Thomas at the time, talking to us about how the private plans were going to be able to negotiate so well and there'll be so much competition that we wouldn't need Medicare as a whole to come in and leverage all its clout. But we've seen Democrats call for this for years. I also remember at one point standing backstage with Tommy Thompson, who is the HHS secretary. I was going to moderate a panel and he was talking about how he had wished that he had the power to negotiate drug prices, and this was back in 2005. So there's been a lot of talk about this for years, and we will see what happens. I expect there to be lots of horse-trading and discussion in the Senate. We're watching the moderates, Joe Manchin of West Virginia, Kyrsten Sinema of Arizona and Bob Menendez from New Jersey and others. This has been scaled back quite a bit from what originally was talked about, but it still is a pretty interesting change.

Rovner: Now … assuming that we get the moderates to sign on to this, because they need all of the Democrats in order for this to pass, there's still that "Byrd bath" thing that has to happen, right?

Adams: Absolutely, yes. There are lots of rules with the "Byrd bath," so you can't have things that are extraneous. There are particular rules about the spending within a 10-year window. There are lots of things that it has to survive in order to be able to go through this process, known as reconciliation, where you only need a majority instead of 60 votes to pass.

Rovner: You should memorize the name Elizabeth MacDonough, who is the Senate parliamentarian and gets to make a lot of very consequential decisions in the next couple of

weeks. But the chances of this whole thing getting done before Thanksgiving seem pretty small, right?

Adams: Well, my colleague Mary Ellen McIntire talked to Tom Carper the other day and he said, “Oh, maybe it'll be a Thanksgiving miracle,” but it would have to be a miracle. I don't see it. I think there are so many things that have to be done with this, so many things need to be worked out. I think December is going to be a pretty interesting time for Congress, given that we have to deal with the debt ceiling, appropriations, all sorts of things, and we'll see what happens with this. It's already taken longer than you would think it would have.

Rovner: They gave themselves until Dec. 3 on both the debt ceiling and the continuing resolution for the appropriations — the actual spending bills. We talk about this as the social spending bill, but there'll be actual annual spending bills and they're going to run right into that deadline and it's going to get pretty ugly pretty fast right after Thanksgiving, right?

Adams: Absolutely!

Rovner: Alice, do they have any idea how they're going to solve any of these things?

Ollstein: So the latest is that they actually want to try to knock out some things that they think might be easier before taking this up, like the NDAA, the National Defense Authorization Act, just to get that out of the way.

Rovner: I have never heard the defense authorization referred to as something that's easier.

Ollstein: I know, that really tells you how much they're struggling with the social spending bill, but it's also important to remember that “Byrd bath” doesn't happen in a day. This is something where Republicans are going to try to challenge as many pieces of the bill as they can and make arguments before the parliamentarian that they don't work under the reconciliation rules, and Democrats are going to have to try to mount defenses. We've already seen this happen in the immigration space and raising the minimum wage; it's going to happen in health care, too. We don't know what the outcome will be. We don't know what kind of backup plans Democrats will try to cobble together. So all of that could really drag out the calendar as well.

Rovner: This is not done, by a long shot. All right. Well, let us move on to covid. Apparently, we can't go even a week without talking about a court case in Texas. The breaking news is that a federal district court has blocked the Texas governor from stopping mask mandates. (There are so many negatives in this story.) Texas can no longer block local school mask mandates because it's a violation of the Americans with Disabilities Act, but this is just sort of the first stage in what's likely to continue on through the courts, right?

Edney: Yes, certainly. Texas has said that they will appeal this, but it's a tactic that's being taken in several states that have bans on mask mandates, whether it was the governor that put it in place or the legislature and disabilities rights groups are suing because children with disabilities

are, in many cases, the most at risk for a severe consequence from covid. So, essentially, if you say you can't have a mask mandate, you're keeping them out of school.

Rovner: Yeah. So this will definitely go on. And we've also seen lawsuits now filed against the Biden administration's vaccine mandate. … That's also going to sort of wend its way through the courts here. I mean, are we getting any closer on these vaccine mandates? I mean, on the one hand, they seem to be working. On the other hand, there seems to be an awful lot of pushback. It's just sort of another piece of, now, the culture wars, right?

Ollstein: I think that the filing of lawsuits and the idea of a widespread backlash aren't necessarily the same thing. I think we've seen mandates successfully get the vast, vast majority of people vaccinated upwards of 90% in these large companies and large government departments that have implemented them. Yes, there are lawsuits. There are groups that go around seeking out plaintiffs and convincing them to be a part of these lawsuits for ideological reasons. That's always going to happen, but I don't think that's necessarily indicative of a broader society backlash.

Rovner: Although we do see the broader society backlash in things. David Leonhardt in The New York Times had a really interesting update in his continuing series about how, since the vaccines came out, covid is hitting red states and counties a lot harder than blue states. We know from surveys that people who self-identify as Republicans are less likely to be vaccinated than people who identify as Democrats. Does this fade when covid goes away, or is this going to be sort of a permanent part of the culture wars?

Edney: I'm really interested to see that outcome because it feels in a lot of instances like it has pushed the culture wars. You know, if you are a conservative who is against mask mandates or vaccine mandates, you're angry and it doesn't, I don't think, by any means extend just to those things. I think it's going beyond. And that similarly with liberals who are angry at conservatives who, they feel, are making the pandemic last longer. So I think the question you asked is one that a lot of people are wondering like, “Can we bring civility back? Can there be some sort of middle ground?” I'm not too optimistic, but I think that depends on so many things.

Rovner: This was sort of my takeaway from the midterm elections that everybody is some combination of anxious and cranky, and it's just not a great combination. And I just don't know when it goes away. I mean, things are not quite normal enough yet.

Ollstein: We're already seeing some of this partisan anger bleed over into other realms of health. And we're seeing, you know, people who start arguing that there shouldn't be covid vaccine mandates, they're now arguing that there shouldn't be any vaccine mandates whatsoever. So kids should be able to go to public schools and spread measles, for example, or all kinds of other things. And we've seen a lot of conservative state governments rolling back the power of public health to be able to, you know, swoop in and deal with outbreaks when they happen in different kinds of things, you know, close down restaurants that have food

outbreaks. So we are seeing the backlash against covid public health measures turn into a backlash against all public health measures — in some places, at least.

Adams: In my mind, it raises questions about where we're going from here. Obviously, this piece in The Upshot really demonstrated the divide and how it has health consequences for people who are living in these areas where people are reluctant to get the vaccine or reluctant to wear a mask or anything else. For people in those areas, it's about liberty and freedom. I think public health experts would say, you know, you also need to allow other people to have the freedom to live, and not spread covid. So I think it is an open question about what we're going to see in the months ahead. I think, you know, we're still at 70,000 cases a day of covid. Parts of Europe are seeing increases. You know, obviously, people are saying that we're not going to see quite as much death and hospitalization as we did last year because we have these vaccines. But really, we should not be at the point that we're at now. We should be at a better place than we are now.

Rovner: I wanted to point out that it's not just the United States. In China last week, they locked 30,000 people inside a Disney theme park in Shanghai after one person tested positive. They wouldn't let them out until they tested all 30,000 people. In Singapore, you're free not to get vaccinated, but if you don't and you get covid, their health system won't pay for your care. We're not about to go that far, right?

Ollstein: Well, we've seen calls for that, but I think, you know, people have rightfully pushed back and said that that's sort of rationing health care. I mean, we already have rationing of health care just based on scarcity of resources. But doctors deciding who to care for based on their opinions of their own personal behavior is not a road we want to go down.

Rovner: And not a road we have gone down *yet*. But all right, well, I want to talk about opioids because we haven't done that in a couple of weeks. This week, the Oklahoma Supreme Court threw out a conviction against Johnson & Johnson for violating the state's, quote, "public nuisance law" by flooding the state with painkillers. It's the second time this month that a case has been found in the drugmakers favor. A judge in California similarly ruled that there was no direct evidence that drugmakers are responsible for the misuse of opioids. Although if you've watched or read any of the documentaries or books on the subject in the past couple of years, you'll see there's quite a bit of evidence. But, pardon the editorial comment: Are drugmakers ultimately going to get off here because, unlike tobacco makers, we actually need the products the drugmakers make.

Ollstein: I recently read one of those excellent books. I read "Empire of Pain," and the author did an interview recently, and he was talking about how he had to finish the book and file it before some of these legal cases finished in the courts and the outcome was known. But he said, you know, something that really stuck with me — it was very depressing — he knew how it was going to end. He knew they were going to basically get away with it. And even if there was some sort of penalty, like, it wouldn't really reach the people who made the decisions. And that cynicism seems to be bearing out right now in very grim ways. And it's just grim that it's

happening at a time when overdoses are just worse than ever. They got so much worse during the pandemic. The harm is so evident all around us, and yet we can't seem to hold anyone accountable for it.

Rovner: And I think we're going to see a lot more of these lawsuits, but there'll be these big verdicts and then they'll get reversed on appeal and then people will forget about it because this is one of these huge problems that's been a little bit dwarfed by even huger problems. So it's a little later than usual, but my colleagues over the firewall at KFF put out their annual Employer Health Insurance Survey this week. There were some interesting tidbits, mostly that the average individual health premium is now over $7,700 a year. The average family premium is over $22,000 a year. That really is a small car. That's up 22% over the last five years and 47% over the last 10, even though the last couple of years have been relatively flat. Deductibles are also up. In 2021, nearly 3 in 10 people with employer coverage had deductibles of $2,000 or more. That's up from only 7% as recently as 2009. It appears that covid didn't actually add much to health spending, or more likely it did, but that was offset by declines in health care usage as people avoided medical situations where they might catch covid. But even with things relatively flat, are we like the proverbial frog in the pot of water here? Not noticing that we're boiling because it's getting hotter so gradually?

Adams: Well, one thing I noticed was just the long-term trends that family premiums were up 284% from 1999 to 2021. And wages were only up 90% during that time. And so, you know, we're not seeing the huge increases that we saw back, you know, at the beginning when you all started this, but we are still seeing these increases that are higher than inflation. It continues to be an issue. High-deductible plans have continued to rise during this time, and I think the strain on consumers is a real issue. And I think that's why Democrats in Congress are so interested in doing something about these things to shield consumers from the prices, even if it's just the Obamacare plans or dealing with people in the Medicaid coverage gap and dealing with prescription drugs. I think the political interest among people of both parties, voters in both parties to do something about health care costs is palpable and a real concern.

Rovner: And of course, one of the big reasons that wages haven't gone up is because employers are paying so much more for health insurance. That's money that would have gone into raises.

Ollstein: Right. And unions say this all the time, and unions are very active in lobbying Congress right now around different pieces of the bill that have to do with their health care because we've reported that they see it at the bargaining table all the time, and the cost of health care is one of the biggest factors affecting their members. And it's just interesting that, yes, there is such high interest among lawmakers for tackling this. But I think one of the biggest criticisms of the Affordable Care Act is that it did so much for coverage but didn't really take on costs in a real way. But we're sort of seeing that pattern repeat again because it's just way harder and it's way politically harder to go after cost than to just subsidize the coverage for everyone.

Rovner: I think this latest fight over drug prices is a really good example of why the Affordable Care Act didn't go more strongly after cost because the health industry is really, really powerful,

and it can stop stuff by just picking off a few votes, which is so far at least what has happened, right?

Adams: Absolutely. Just, you know, because you have because the chambers have such small margins, Democrats really don't have a whole lot of room to maneuver. And so, you know, what Democrats are talking about now, you know, Alice makes a good point. It's easier to shield consumers in the health exchange plans from the cost than to really lower the costs. Same is true in the prescription drug space because, you know, we do have these things related to capping inflation, starting in 2023, and capping insulin. But the thing that consumers, I think, are really going to feel before the presidential election is that catastrophic cap of $2,000 in out-of-pocket cost per year. That's going to take effect, and that's going to really prevent seniors from feeling the high prices of drugs. So, you know, it's so much easier to do that than to do other things. Now we do have the drug price negotiations starting in 2025 as part of this reconciliation package and that starts with the 10 drugs and insulin, but that's scaled back so much from what they originally had talked about. So I think it's very difficult to lower drug prices or to lower health care costs. It's hard to do that.

Rovner: Well, I think the bottom line is that you could lower costs or you can change who pays. And I think it's been easier over the years for the government to just say, "OK, we'll pay for it," than for the government to say to providers, "You'll take less." So basically, they're putting the cost on the taxpayers rather than on the health care industry. Because when they try to put the cost on the health care industry, the health care industry fights back. All right. Well, something else that was interesting in the KFF employer survey feeds into something I've been trying to bring up for a couple of weeks now: the future of telehealth. Apparently, employers figured out that they needed to expand telehealth access, both in terms of the types of care covered and where it can be covered. For a while under Medicare, you had to actually go someplace for telehealth services. You couldn't do it from home. In the survey, now 95% of employers offered some kind of telehealth services, up from 85% the year before. But I'm curious as to what happens to telehealth when the public health emergency ends. Will eligibility be cut back? Is this a genie we can't put back in the bottle because both providers and patients have gotten used to it? And will it really reduce more expensive care? Or will it be like urgent care where it just multiplied how much care is given? I mean, I'm seeing some studies that say, Oh yeah, telehealth is saving money because we're catching stuff early and people don't need to go to the emergency room. But that's not what always happens. When you sort of add a mode, you just get more of it, right?

Ollstein: And I think also the data could be skewed by who is able to use telehealth, who has access to it. And so I think that, you know, these are going to be, you know, wealthier people in areas that have good internet. And I think that could also skew, you know, based on their health usage behaviors, you know, not being representative of the general population, too. So I would just want to see more data before being able to understand what's going on.

Rovner: Yeah, I keep seeing telehealth being, you know, cast as this "This is a great thing." And it is. I mean, for people who have difficulty, you know, getting to places to get to, particularly,

specialists, it can be a great thing, but I've seen this happen enough times that when you sort of expand something like this, usage — and if there's money attached to it — usage will grow to fill in the gap.

Adams: I think it's hard to take it away. And I've heard lawmakers in both parties say that they would like to make some of these telehealth changes permanent after the public health emergency. I think they're talking about that. We'll see. The cost is a big question. And, you know, CMS [the Centers for Medicare & Medicaid Services] already did make some changes. They just changed the telehealth for mental health and the physician fee schedule on Nov 2. So they, you know, relaxed a lot of those rules. So you're already seeing the administration try to do what it can. I think that there are people in Congress who want to do something to expand it. And if you have seniors who are able to use FaceTime or are able to do a Zoom call or something, if they can do it, other people certainly can do it. And I think it's hard to go back and take that away from people if they want it. And I think that you mentioned mental health, which is extremely important, like if you're taking away a stigma in a way, like people may be afraid to get services and different things, you know, it's not just your typical, like, “Hey, Doc, what's this thing on my arm?” It can extend to a lot of other places where even if there's a boom in use, it's a necessary boom in use, not something that's extra.

Rovner: There's a shortage of mental health providers. I mean, one would think that this could only actually be helpful for that. That seems to be the one place where it's kind of unquestionably needed and that loosening some of these requirements has been a good thing. We'll talk about mental health completely at some future point. All right. Well, that is as much time as we have for the news this week. Now we will play my interview with Rebecca Love. She's a nurse and academic and entrepreneur, and she's thought a lot about the future of the nursing profession and where it fits into our health care system. So here's the interview, and then we will come back with our extra credits.

We are pleased to welcome to the podcast Rebecca Love. She's the chief clinical officer of IntelyCare, a nurse staffing platform. And she's the first nurse to be featured on TED.com, where you can watch her talk. Welcome to the podcast, Rebecca.

Rebecca Love: Julie, thank you so much for having me.

Rovner: I confess to someone whose hobby is thinking about the nation's health care workforce, nurses are rarely top of mind, yet nurses are a large and irreplaceable part of the health care delivery system here in the U.S. Still, they are not seen as leaders generally. Why is that?

Love: You know, Julie, I think that, substantially, nurses have always been seen as a commodity, an endless resource that regardless if there was health care in any kind of conversations, they were going to be that source that was always going to be at the base of the health care platform, delivering care and being there through thick and thin. And I think that that has just been the foundation of which health care has been built. So nurses, because they are so

integral and in fact, actually, I think it ties into some of the payer model that nurses are rolled into room rates. They cannot bill separately for any of the services that they perform, that they are often left out of the conversations with health care leadership because they are a line item to the cost side of business structures, as opposed to a “value add” into health care from a financial model. And that, to me, is probably the biggest driver why you see nurses not often in positions of health care leadership. Because when you speak to them as part of a workforce issue, they are simply seen as a 24/7, seven-days-a-week necessity within health care, as opposed to an instrumental factor in terms of driving outcomes and health care innovation and the future of our entire nation from a health standpoint.

Rovner: And yet they are the ones at the bedside closest to be able to see what works and what doesn't. You've run a program on nurse innovation. What is nurse innovation?

Love: So I think you're going to hear this from nurses around the country that we constantly “MacGyver by the bedside.” So, studies show that nurses by the bedside are often dealing with technologies that were not designed to help them actually do their jobs, so they're doing workarounds on regular shifts. So, on average, nurses are doing 27 workarounds per day on a hospital shift because the devices that they're working with were not designed to actually help them in their job or actually improve patient outcomes.

Rovner: Can you give me just an example of that?

Love: Absolutely. So, in this situation, I can speak back to a long time ago: I was in a situation where a new voice recorder came out that was supposed to be a communication platform that when we were told, “Hey, you know what? Use this, it's going to create less work for you.” And I was in a situation that, when they rolled it out onto the floor at that time, it had no ability to be dimmed or to turn down. So we'd be sitting in a patient’s room. It would be like “Dr. So-and-So is on the call.” “You need to get a glass of water to this patient's room.” “You need to make sure that this order is done,” and it's yelling at you constantly as you're sitting there trying to deliver care. And by the end of that shift, all of us as nurses had taken it and put it at the front desk. Now the other examples are EHRs [electronic health records], right? We're dealing with EHRs that are supposed to help us track and do better outcomes. We're finding that we're actually spending three hours a day in the charting system, detracting us from health care and performing what we're supposed to do, take care of patients' lives.

Rovner: It’s just become data entry, right?

Love: It's data entry and everything they say, “Hey, this is going to create less work for you as a nurse” often creates more work for us as nurses, and we're constantly innovating in highly inefficient health care environments because, again, we are not involved in those decisions on which products, projects or processes are rolled out onto our floor. And we are often the end user of nearly every one of those situations. Everybody leaves us out of those conversations, further driving burnout, inefficiencies … and if you just simply brought nurses to the table

earlier into the process, think of all the money, efficiency, time and resources you would have saved if they simply had been involved earlier in those conversations.

Rovner: So this, as we know, has been a really tough year and a half for everyone in health care. But nurses, in particular. How serious is the burnout problem right now?

Love: Well, you know, the numbers are coming out, but we know that the largest exodus of nursing happened between the year 2020 and ’21. We are predicting another 500,000 nurses to leave by the end of 2022 and, at most, 900,000 nurses to leave in the next five years. This is the most significant exodus we have ever seen in the history of nursing and the most critical moment of time for the United States health care system. Because nurses are the basics of the foundation of health care. They sit at the bottom. They are the largest health care workforce. If they crack, if they crumble, health care will follow. Because the reason you're in hospitals, the reason you are in nursing homes is not because you need to see a doctor or have O.T. [occupational therapy] or P.T. [physical therapy]. The reason that you are there is because you need nursing care to keep you alive. Otherwise, O.T., surgery, everything could be done in outpatient centers. The reason you are in hospitals and nursing homes is because your life is deemed so unstable that if you don't have a nurse monitoring it, you are at risk of dying. And that is what I think we are fundamentally missing in the conversation today. And all of these conversations around value-based care and the new models that are coming out are actually decreasing the impact and reimbursable models for nurses, not increasing them, which we had hoped. And because of this, nurses are going to just burn out because nobody is recognizing the value our profession adds, and we keep getting asked to do more with less.

Rovner: So one of the problems we've heard about, particularly during the pandemic, is travel nurses getting paid more than staff nurses, who actually stick with their employers, which just encourages more nurses to up and become travel nurses, drives up costs for the entire system, and hurts continuity of care. Is there some way to address this problem?

Love: You know, I think that, fundamentally, there is a real lack of coordination between health systems looking towards their nursing workforce as an investable resource. And so travel nursing, in line with those who have been by the bedside, is creating incredible animosity in our systems. And one that is very poorly understood. When you talk to a bedside nurse — “Why is this nurse next to me making $150 an hour when I've been with you for 8½ years and I'm making $32 an hour?” And the answer is: It comes from a different budget line. Fundamentally, that is a flawed discussion. It's also a value that the truth is that nursing for a long time has not been part of free market enterprise because they're rolled into room rates. There's a lot of regulation that actually goes back that says how much people can pay nurses, which I don't think we're aware of, as a profession, that actually there's a lot of state guidelines that say this is the maximum amount you can pay to nurses. And why many nurses, when they hit 20 years in their career, they're told, sorry, there's never going to be another raise you see, because you've hit the top of that pipeline. Fundamentally, that metric is broken. When you have a demand for a resource, the truth is you must allow market dynamics to happen. And there has to be a fundamental alignment within our health care systems, too. On average, the increase of

nursing salaries only increases 1.5% — less than half the cost of living — over a 20-year career for a nurse. I mean, these dynamics are something we must address, and it's really coming down to payer issues bound, based on Medicare/Medicaid payer reimbursement models that fundamentally are going to need to happen within health care systems to address these issues because it is going to be a breaking point. And the truth is, I'm not sure why anyone would stay in conditions where they could make the same amount of money, I mean, [vs.] three times the amount of money doing the same job within the same location.

Rovner: So I've been hearing for years that the root cause of the nursing shortage isn't that there aren't enough people who want to become nurses, but because there aren't enough teachers to teach them to become nurses. Is there something we can do to repopulate that pipeline of nursing instructors?

Love: It's not a quick answer, unfortunately. There's neither the number of seats in nursing schools, nor can the programs actually speed up and deliver nurses in any sort of time frame within the next two to five years. Fundamentally, I do believe that what you saw in the 1980s and 1990s was a decreased funding into nursing education, that a lot of nursing schools actually shut their doors, they closed their nursing programs. You look at the top 50 colleges in the United States [that] are universities. Many of them no longer have nursing schools. The truth is, nursing programs are very expensive to run. They're three times as expensive as a program in business. Because you need simulation, you need clinical, you need all of these issues that exist. And really, it is going to take us as a nation federally funded to start reinvesting in nursing school and education, and also more clinical pathways to say, "Hey, if you're a CNA [certified nursing assistant], here's how you become an LPN [licensed practical nurse]." And if you look across the history in the last 20 years, LPN programs have virtually disappeared in the United States because we saw it as a less-skilled workforce. But the truth is, we need to be reimagining what nursing education looks like. New clinical pathways — if you're a CNA, here's how you become a nurse. Here's how you become a master's-prepared nurse, and we start looking at that as a cost benefit to our health care systems, as opposed to a detraction.

Rovner: In the U.S. health care system we tend to sort of do things only when we reach a crisis point. Are we at the crisis point with nursing?

Love: We're beyond the crisis point, unfortunately. The crisis has been well sounded. We're at the point that we are going to experience significant pain within our hospital systems and nursing homes for the next two to five years. People are now going to die because they are not getting access to care. And I wish to tell you, I just left a nursing conference where nurses were reporting to us that, you know, they have patients showing up into the ER, and by the time they get to them, they're dead in their chairs because we don't have enough nurses to keep those hospital rooms open and the beds open, not only in hospitals but in nursing homes. And when nursing homes can't staff, that means bed throughput stops, which backs up the entire hospital system. And unfortunately, we are at that crisis point. The only thing we can do, Julie, in my opinion and to your point, the only thing we can do is there may be enough nurses to work in the United States, but they are not willing to work in the environment in which health care

exists today. So we know of the 4 million RN licenses that exist in the United States, there are 570,000 active RN licenses who are not practicing by the bedside. And the truth is we know that with another 500,000 nurses retiring by 2022, this 1.1 million[-person] nursing shortage that was supposed to hit in 2030 is now going to accelerate and really start hitting us between 2022 and 2025. So fundamentally, if we're going to do something differently, we have to reimagine how nurses work, provide them with a work-life balance, more flexibility, access to shifts that they want because that is the only way they're going to re-engage with us. They're no longer going to allow systems to dictate to them what their work-life balance is going to look like and their opportunities to exist by the bedside.

Rovner: Rebecca Love, we will definitely come back to this subject because I think it's underreported and really important. Thank you so much for joining us.

Love: Really, it was a pleasure and thank you for reporting on it because it is an issue that is going to bring down health care if we don't address it.

Rovner: OK, we are back and it's time for our extra-credit segment where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it, we will post the list on the podcast page at khn.org and in our show notes on your phone or other mobile device. Rebecca, why don't you go first this week?

Adams: Sure. So, I did a KHN story. “Patients Went Into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out” by Christina Jewett. So this was a really heartbreaking story about people who went into the hospital for other conditions and acquired covid while they were there. And, of course, hospital-acquired infections have been a problem for other conditions for a long time. But for covid, this is often a deadly issue, certainly before vaccination. And she found that about 21% of the patients who contracted covid in the hospital from April to September last year died compared to 8% of other Medicare patients who died in the hospital. So that's quite a contrast. And, you know, over the past year, you’ve seen anecdotes about that. You've seen people writing editorials about that. But she did a good job of going through and looking at some of the studies telling some of those anecdotes. She talked about Brigham and Women's Hospital and how they had touted how few patients in their hospital got covid. It was only about 0.3% of patients. Well, right after that, there was a big outbreak. So it's another tale about the toll of the pandemic.

Rovner: Alice.

Ollstein: So I picked a story from NPR. It's called “Despite Calls to Improve, Air Travel Is Still a Nightmare for Many With Disabilities.” And it's just a very depressing piece about how difficult it is for people with just a range of different disabilities and medical conditions have when going through security at airports. You know, we're going into a time of year where the people are going to be traveling a lot for the holidays and the treatment they undergo is just terrible. There are some programs to help them navigate, but they're just inadequately staffed. And so you have people who have autism who are, you know, very unable to deal with, you know, being

shouted at by officials and, you know, bright lights and sounds and all of that. You have people who have medical equipment or medication that has to be kept at a certain temperature that's been messed with by security agents. And so I hope that this really shines a light on the problem and leads to some reforms.

Rovner: And a shout-out to my former NPR colleague Joe Shapiro, who covered the Americans with Disabilities Act's passage with me 30-some years ago and has stayed on this beat ever since. Anna.

Edney: I chose a story by a colleague of mine, Kristen Brown at Bloomberg, "All Those 23andMe Spit Tests Were Part of a Bigger Plan." And she took this really interesting look deep into 23andMe, you know, lots of people sending in their DNA samples, and 23andMe wants to become a drugmaker by using those DNA samples. I thought it was just so interesting to think about. A lot of people probably mindlessly clicked the box, like, sure, use my data, whatever. And now, like, they could be paying for drugs that were created using their data. It's an interesting situation. It's also a profile of the company. It's fascinating to see this has been the plan all along and it's actually been stuck with, and that can be unusual sometimes. And so I think it's a good feature of health care and data story.

Rovner: It actually reminded me of the story about the cell lines that have been, you know, people had their cells taken and then, you know, they were used going forward.

Edney: That's a really good point — it's the next generation.

Rovner: Exactly. It's the next generation of cell lines. Well, my story this week is kind of a companion to the Rebecca Love interview. It's about the crisis in primary care. It's by Merrill Goozner in the Washington Monthly, and it's called "The Doctor Will Not See You Now." The subhead is that "Primary care is a disaster. Consolidation is making it worse. And a revolution is coming." There are some really strong suggestions about fixing primary care — that could be one really good way to squeeze some of the excess cost out of the health care system that we've just spent the last half an hour talking about. If only we could actually do some of these things! But it is well worth a read. So that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks, as always, to our ace producer, Francis Ying. Also, as always, you can email us your comments or questions. we're at WhattheHealth, all one word, @kff.org. Or you can tweet me, I'm @jrovner.

Rovner: Anna.

Edney: @AnnaEdney.

Rovner: Rebecca.

Adams: @RebeccaAdamsDC.

Rovner: Alice.

Ollstein: @AliceOllstein.

Rovner: We will be back in your feed next week. In the meantime, be healthy.