Death Panel Podcast

TRANSCRIPT: Arrianna M. Planey on Medical Geography and the Surplus Population (Medicare for All Week 2021)

SPEAKERS
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Beatrice Adler-Bolton 00:00
Welcome to Medicare for All Week. Today's guest is Arrianna M. Planey. Arrianna is a health and medical geographer and an assistant professor in the Department of Health Policy and Management at the University of North Carolina Gillings School of Global Public Health, as well as a fellow in the Cecil G Sheps. Center for Health Services Research. Hi, Arrianna! Thank you so much for joining us for this special interview.

Arrianna M. Planey 00:24
Thank you so much for having me today!

Beatrice Adler-Bolton 00:26
We're so excited — last year the series really focused on taking a look at some of the historic fights for single payer, just looking at lessons in how things have gone in the past, the tactic, stakes, propaganda. But this year's a little different. It's all about building forward looking power behind a global health justice movement. And we're really excited to talk to you today. I'm a huge fan of your work, just conceptualizing healthcare access, looking at spatial equity and the ways that policies doom populations to premature death. So for people who aren't familiar, do you think you could give us a brief overview of what you do and what your research area is?

Arrianna M. Planey 01:03
Yeah, so I'm a health slash medical geographer by training. And the briefest definition that I can give is that we study the interaction between health and place, with particular attention to places, people, and also the relationship between people and places. And my work is more specifically focused on health care, with attention to healthcare access, for example, so most models of healthcare access, they're better suited for conceptualizing Acute Care access or acute or episodic use of healthcare. But right now we have an aging population, we have a growing burden of chronic conditions, or chronic illnesses in our population, that require more than episodic care, they require coordinating continuous care. But these models don't necessarily capture those aspects, those necessary aspects of coordinating continuous care, or the management of chronic conditions. And so that's the sort of niche I'm trying to carve out now. And so there's multiple dimensions of access, it's really important to think about them all. Most people tend to focus on affordability or the cost of care to a patient or the cost. And even if

affordability is barely there, their definition of affordability is fairly narrow, what they are interested in primarily out of pocket costs. But for me, affordability is also very closely related with accessibility or spatial adaptability. For example, in my own work, I have found that in both rural and urban contexts, black residents or black people, patients, have longer travel distances to care. And especially when you're talking about these academic medical centers, where, and this is a brief sidebar, when we're talking about healthcare, healthcare systems, we're also talking about property. The strategic placement of these facilities, they're typically placed on high value land. So this is partly why we see such vertical construction, because that land has such high value. And often there's not enough parking. That's a big problem, because there's not enough parking and they monetize that little parking there is. So what happens is that people may have to travel long distances to care, and then they get there and they have to pay for parking.

Philip Rocco 03:55
Yeah, I used to work at UPMC in Pittsburgh, and I remember that I mean, that's the part of town that is routinely impossible to park, I remember people saying, it's routinely impossible to park there. And then the hospital garages were so unbelievably expensive, the hourly and daily rates were insane.

Arrianna M. Planey 04:14
Yeah, yeah. And I mean, there's even research on, I'm this is one area that I'm fairly new to, but I'm beginning to work in but financial toxicity among cancer survivors. If it was up to me, I would use a different term. But for the sake of legibility, I had to use financial toxicity. But there is some research in that area, showing that the cost of parking actually adds up quite a lot for cancer survivors, who are actively receiving radiotherapy or chemotherapy because they have to, you know, it's several times a week and that's on top of the drive, the travel time, and the cost of travel, the forgone income — it all adds up. But the thing is, with these episodic models of healthcare access, you also get these conceptualizations of portability that are very narrow, and that are very specifically focused on medical bills. But they're not necessarily attentive to all these additional costs, such as the travel time to get there, the actual cost of fuel to get there, the cost of parking, the forgone income when we use healthcare, so in the absence of paid sick leave, or in the absence of generous leave for whatever purposes you need, people are having to forego income and pay out of pocket for health care services. So it's a net loss. In my work, I'm focused on spacial equity and access to care. So I study spatial access to care primarily, I do a lot of other things. But in my own work, I'm particularly interested in spacial access to care, equity, along the lines of race, ethnicity, class, and disability status. And thinking about what that inequity, what is that burden for patients. And so for example, there's a current study, I'm going to resubmit soon but I collaborated with some geographers and health services researchers. And we looked at the effects of hospital closures and mergers on spacial access to care. And what we found was that, and this was between 2005 and 2020. And what we found was that there are persistent racial and ethnic inequalities and spacial access to care across the rural south. So in the beginning of the study period of 2005 to 2007 and the end of the study period 2020, we find that majority Black and Latino rural places in the south, residents in those places have longer travel distances to the nearest and the next nearest hospital, compared with residents and majority white hospitals. And on top of that majority white places that have better spatial access can be even more remote than the places that have majority Black and majority Latino residents. So it's not necessarily a function of reality, or a degree of reality. And it's not just a rural problem, we see this within metro or urban metro regions, or

metro service areas. I mean, there are some exceptions like Baltimore, where Johns Hopkins Hospital was historically placed in red line majority Black Baltimore neighborhoods and there is a history of Johns Hopkins Hospital serving as a charity hospital. But the charity model was also quite extractive and you still see the vestiges of this extractive relationship with the community around and in academic medicine, you still see that. But so there are some exceptions to that spatial relation, but it's still true that proximity isn't necessarily the same as access. So there's this tension I have to navigate too, thinking about spacial proximity, or spatial inaccessibility, as a cost to patients, but also recognizing that spatial proximity to healthcare systems isn't the same as access. Because we see this in New York City where majority Black residents in majority Black boroughs or neighborhoods don't necessarily go to the nearest hospital, because we see that academic medical hospitals or academic medical centers can and do divert Medicaid insured patients. So Black and Latino patients who are closest to, say, Columbia Hospital, they're not going to go to Columbia. They're not necessarily going to go there. They may have to travel a longer distance to get to an emergency department that will take a Medicaid insured patient. So that's another cost because that longer response time in the ambulance can be a life and death difference depending on the condition that's being treated. And we also see and then some work on this in the area of birth outcomes, where there's just this facility level segregation, where you have majority Medicaid insured mothers giving birth in hospitals that primarily serve Medicaid insured patients. Yet these hospitals have fewer resources, less capital. So certain types of screening, certain kinds of tests they may have to actually refer a patient to another hospital because they don't have the capital or infrastructure to do those tests on site. So there's a lot happening there. But basically thinking about just primarily thinking about healthcare, in terms of that spatial arrangement and what that means for social equity.

Philip Rocco 10:43
Yeah, I mean, this is a thing that seems to be really missed in the debate over Medicare for All, which ends up just being a debate about, you know, who pays and what they pay? But I think it seems like what one implication of your research is that when we have segmented financing for health care, that it really ends up mattering for the quality of care that people receive and how far they have to travel to get it and so on, and so on. Is that is that one potential implication that you see following from some of the work you've done on spacial inequality?

Arrianna M. Planey 11:22
I think so. There's also the interaction where mergers and closures can often show — what happened with mergers and closure is that you actually have less competition. I don't believe market competition is the answer but... ...but with mergers and closures, we do see that there's actually less competition in those healthcare market areas. And so what that means for patients is that some of these patients may actually have longer distances for care, to access care. And now they face higher healthcare costs, or high healthcare prices, which may translate to higher healthcare costs. So longer travel distances, so longer time to get to care, probably higher costs to actually use healthcare, and on on top of higher healthcare prices? I haven't seen much work on that intersection.

Philip Rocco 11:37
Neither do we. [laughs]

Beatrice Adler-Bolton 12:15
Yeah, I mean, I think there are just so many more factors to understanding equity and distribution of health outcomes that are just not often considered in the popular discussion of Medicare for All obviously, I understand that, rhetorically speaking, I think there was a decision made to really focus on how it hits people at an individualistic level, how everyone is experiencing their own financial burden of health care. But I think ultimately, this is part of a larger problem. And I was listening to a talk that you gave the other day where you talked about how so often we have these individualistic solutions for structural problems. Instead of trying to address some of the larger causes of structural inequity, we have this habit of individuating the experience of healthcare, the experience of health, and wrapping this up in this whole finance package, which ignores a lot of the things that you've been talking about, like spatial distribution, rural access, etc. I was wondering if you could talk a little bit about that push and pull between individual versus system wide interventions?

Arrianna M. Planey 13:23
Oh, yeah! How do I? Where do I begin? I did give a talk recently at the School of Public Health in Boston, where I was talking about the uses and misuses of spacial data, in health services, by health services research, by health systems, and even insurers where they use this spatial data, these aggregate level data at say, neighborhood, typically zip code, to try to identify risk. So to me risk is such a slippery concept, it can be anything you define it to be. But what happened is geography is treated as destiny and there's no consideration of how places have come to be what they are.People give lip service to social determinants of health, fundamental causes, but when it comes down to it, they're using these population level measures to identify individual risk and typically that risk is only defined and identified, or screened for in a clinical contact at an individual level. And right now too, in the past year, though, the paper came out that showed that health systems are spending billions of dollars on what they're are calling social determinants of health interventions to improve, well, they call it population health, but what it really is, is the health of a subset of the population that currently has insurance coverage and is in their service area, their health service area, and maybe a potential patient, typically patients. So it's not actually population health it's more customer health, it's your customer base. Yeah. We have these very fragmented and very expensive interventions designed to improve what they call population health. And this isn't just health systems, this is insurers too. Insurers are beginning to sell these packaged, these sort of prepackaged interventions that are supposed to improve to health of, well, enrollees for a given fiscal year. And it's a very, well, their business is, they're in the business of reducing losses, and maximizing revenue. So that's it, that's what it is. But they're able to package it up as, "Oh, wait, we care about population health!"

Philip Rocco 16:06
Yeah, it's almost as if they're sort of redefining what health is.

Arrianna M. Planey 16:10
Umm hm.

Philip Rocco 16:12
Whether it's for the reasons of marketing or whether or not they genuinely believe that the interventions that will reduce their losses in a given year also coincide with health, it doesn't sort of matter. But that's

sort of one function of having insurers dominate not only the marketplace, but the intellectual sense of like, what health is, is that then some of these ideas just get replicated, maybe even in the scholarship, or the public understanding of health is like, 'Oh, yeah, these these interventions, which are purely designed to help operating margins. Oh, that's sort of like what you do to keep people healthy.'

Arrianna M. Planey 16:55
Yeah. And then I would say another point, an important point too is, this definition of population is really, really important. Because, so if we're doing a public health driven, population health centric intervention, there wouldn't be the direct kind of rationing we see with these health systems or insurer-led population health interventions. And so not only are they delimited in terms of what is defined as the population, they also delimit it in terms of the timeframe for those interventions. So, because they're primarily interested in a pool of people who have coverage, or within a geographic range in a given fiscal year, that already limits the temporal scale of the intervention, if the temporal and geographic scale of the interventions were public, if we had well funded public health infrastructure, we would be able to do this kind of work at scale for a fraction of the cost. And honestly, it would have a much bigger economic impact in these communities.

Beatrice Adler-Bolton 18:06
Yeah. Yeah, I agree. One thing that I've found that's interesting, just in my own research is for example, how many different definitions we use of "disability" to study populations, and how a lot of these ways that we conceptualize the groups that we're trying to target with interventions ultimately shapes the way that these interventions are designed, right? I guess, if we're supposed to be looking at these already, not like, biased, but it's yeah, but it is bias. Actually.

Arrianna M. Planey 18:41
It is a bias.

Beatrice Adler-Bolton 18:42
Yeah, you're approaching designing this targeted population intentionally. And, and one thing that I've always found is really interesting is the use of race as a risk factor. Yeah, how, studies to try and "adjust for race," and how there's this sort of social reproductive process of saying that race, in and of itself, is some sort of like "biological fact," which determines health outcomes and almost frames a lot of interventions as intervening in like race itself versus like, actual structural violence. Do you think you can explain, maybe for someone who hasn't heard this before? What the idea behind when studies try to factor in race as a risk factor?

Arrianna M. Planey 19:31
Yeah. So by treating race as a risk factor or a predictor variable — these studies are typically treating race as an individual trait and not a relational trait or not even, I wouldn't say it's a really a trait. How we are racialized is an outcome of racism. So I'm racialized as Black based on my ancestry based on my perceived phenotype, based on my social positionality, and all that is related, we can't quite extricate them, because that's what well — that's structural racism. We are living it all at once. When researchers like myself, I don't do it personally, I've been able to avoid it so far, plug in race in a model as a covariate, or a predictor variable, the assumption is that race is an individual trait, and that race

correlates with or is biological. I would say, this is just simply fallacious, because racism, what we know is that racism itself has biological consequences, but that doesn't mean race is biological. What it means is that the structural violence of racism has consequences for the health and well being of people who are racialized — as Black, as not white, as however you want to say it — in a racist society. So when we treat race as a risk factor, we are just simply distilling all these social relations, the consequences of those social relations, and the inequitable distribution of these resources and hazards we're distilling that down to the body, of people who are racialized or Black or whatever, and saying, "Okay, this person is Black, and therefore, their Blackness must predict this bad outcome." It's, [sighs] it's easy, but it's wrong. I mean, it kind of goes back to what I was saying about the misuses of spatial data or spacially referenced data, it treats geography as destiny. And so what's happening there is places that have majority Black residents, places that are basically the living legacies of racial segregation, and not just redlining, but the enduring practices of segregation, and environmental racism, all that, all at once. That is, what happened is, "Oh, well, people who live in these neighborhoods are probably Black, and they probably have poor health. And so therefore, they're more at risk so let's target an intervention there. And we'll teach them to be financially illiterate, and teach them to use healthcare appropriately." And this is also in the context of healthcare systems, particularly private hospitals, receiving community benefit incentives, where they receive a sum of money for if publicly insured, or uninsured, low income patients come into the emergency department. So this is like the original intent of this policy was to disincentivize hospitals, private hospitals, from turning away patients who couldn't pay for care. But what happens then is these patients because they may not have access to primary care, they use the emergency department, as their first site of care. And what happens then is their care is marked that, like their help seeking behaviors are treated as inappropriate, even though they are perfectly appropriate given the options that they have. Yeah. So then they are targeted with, "Oh, financial literacy. Oh, call this hotline, talk to the nurse and figure out if you actually need to come to the emergency department." And one example I like to give in my teaching is Baltimore. I don't mean to beat up Johns Hopkins...

Beatrice Adler-Bolton 24:00
It's okay, I think Johns Hopkins can handle it...

Arrianna M. Planey 24:02
They can handle it! But um, for example, Johns Hopkins, the neighborhood around Johns Hopkins, is historically Black but also historically disinvested, with poor housing stock, there's also less sanitation in these neighborhoods. So what happened is that because of the structural factors, residents in the neighborhoods have higher burdens of chronic or inflammatory or chronic illnesses, such as asthma. And a lot of that is environmental as well. Not just a daily exposure to race, which is related to exposure to policing. They're being exposed to, well, a neglected environment where rat, rodent and roaches — where they thrive. And on top of that, the housing stock is not great. So the places where they spend the majority of their life are driving these inflammatory responses. So residents in these neighborhoods are much more likely to go to the emergency department for asthma attacks. So in the emergency department, they get treatment for the immediate asthma attack, but they don't get any primary care for asthma. So this is again, getting back to the acute versus chronic models of access and healthcare use. So when you're simply incentivizing acute care use, and not investing in longer term primary prevention, or continuous, or coordinated management of chronic conditions, this is what you're gonna

get. You're gonna get into more and more costly care that we have to pay for, I don't have a problem paying for it, I think we have to do better and provide care that's actually more appropriate, that better matches with what people need, rather than the care that is the best choice out of a few bad choices.

Beatrice Adler-Bolton 26:00
Right. There's an interesting parallel to that we're seeing how this really poor focus on acute treatment is playing out during COVID. One example that I've found particularly horrific, is the fact that a lot of patients who have COVID, who may be discharged from the hospital, because COVID is considered to be an acute condition, there aren't really the billing structures yet to support a chronic diagnosis o, what people are calling, Long COVID, which is also potentially just the sort of tale phase of the disease, in which we're seeing a lot of people develop long term chronic conditions, which are closer to my autoimmune disease than the initial disease itself of the respiratory illness. And so...

Arrianna M. Planey 26:41
Yeah it's not just respiratory.

Beatrice Adler-Bolton 26:43
...right, exactly! There's a chance that this is going to be lifelong for a percentage of the people who have contracted COVID, which as we know, is a number that grows insurmountably higher day after day, and people are being sent home from the hospital. On supplemental oxygen, of course, if your county has enough oxygen to ration to send you home with, and insurance companies are denying supplemental oxygen, saying that you need a "long term chronic diagnosis" in order to qualify to be eligible.

Artie Vierkant 27:18
There's no code for it yet, yeah.

Beatrice Adler-Bolton 27:20
And, yeah, there's no code for it yet, there are people who are applying for short term disability or worker's comp, and COVID is not listed as a chronic disease yet. So you have again, this focus on the acute creates downstream problems, it creates these exponential problems, which ultimately just further expand the gulf of health equity.

Arrianna M. Planey 27:44
Mm hm. And then we have, I won't name names, but I did see a doctor the other day tweeting about how, "Oh, COVID's gonna go out of style and journals are going to stop publishing papers about it." It's just like...so you're assuming that COVID is simply acute, and that when the pandemic ends, the effects of COVID end, and those who survive, the effects are not going to reverberate across their lifespan? And those lifespans may be short! And we don't know yet! It's to me — it's just callous. I think there's this image that people have in their head that the "average patient" is kind of like "the average man" or whatever, who is a twenty-five year old, maybe twenty something year old, and then everybody else is just a deviation from that "non-disabled, healthy" twenty-five year old, when that's just simply not true.

Philip Rocco 28:44

Right, and that sort of even creeps into the debate over Medicare for All, as we saw initially, the sort of exclusion of Long Term Care from the discussion is like, yeah, who are we assuming is the population that will ultimately benefit from this?

Arrianna M. Planey 28:59
I think that has serious implications for how we financial care, we already know this, how we allocate healthcare resources, how we train healthcare workers, because for decades now, there has been a decline in the number of medical trainees going into primary care. And at the same time, they've already struggled over nursing scope of practice, where, "Oh, we don't want nurses as primary care extenders. We don't want nurses doing what we do." And it's like, well, you're not doing what you do. Somebody's gotta do it. Especially in rural places where we have growing shortages of physicians, and nurses and physicians assistants are filling those gaps.

Beatrice Adler-Bolton 29:48
Yeah, one of the things that, as Phil was saying, we've we've been railing on as a pet issue in our project is the specifically how the exclusion of Long Term Care from a Medical for All proposal is a horrible idea for all the reasons that we've just discussed, but also because it's about instituting a new policy, which baked into it, has already got this distinction between acute and Long Term Care, this idea that Long Term Care is too expensive. And I think what your work shows really well, is the fact that from a structural standpoint, the very fact that policies are framed this way results in some pretty horrible outcomes for people, in the shortening of people's lives. in reduction in their access to care or reduction in their, you know, what is it considered to be like? Quality of life years or something? And then these perceptions...

Arrianna M. Planey 30:45
Oh goodness. Ugh, or disability-adjusted life years? Both of them...

Beatrice Adler-Bolton 30:47
Exactly, yeah! And then these assumptions are, then baked back into additional structural controls, which just creates this really impossible to overcome blanketed system of inequity that I think people treat as if it's a force of nature or some sort of inherent law to society, instead of understanding what it is actually, which is design, right?

Arrianna M. Planey 31:15
I mean, I honestly. So for example, we do see there are some studies showing that people who did not have insurance coverage prior to aging into Medicare, have higher healthcare expenditure, worse off status, and so forth. We would not see that if people had actual access to care throughout their lifespan. And I think that's partly what drives what we see in somebody, that even differentiate between Long Term Care facilities where you can see pretty profound differences in health status and functioning of residents of Long Term Care facilities. Depending on class, racial composition, ethnic composition, another couple of studies showing that nursing homes that are in segregated neighborhoods that have majority Black residents, there's higher rates of 60 and 90 day, rehospitalizations among Medicare beneficiaries, and that outcome has pretty profound implications for penalties for nursing home and, or hospitals, too. And so it actually may be a disincentive for the

provider, the for profit provider, to operate in segregated neighborhoods or neighborhoods that have high rates of uninsurance, among working age people.

Beatrice Adler-Bolton 32:49
I mean, it really highlights how sometimes simple universal programs that don't immediately start off on the bat with these "border making" carve outs of who is and isn't eligible of who deserves or doesn't deserve care, because every eligibility decision is also a value judgment. And that's something that I feel people don't talk about enough. And so one of the things that I think I try and always emphasize when I talk to people about Medicare for All is that, the pay for is not the question, it's about ensuring that structurally speaking, from day one, that we are building a foundation of a public policy, which seeks to try and address these structural inequities, and not reproduce them in future policy decisions. And that's a really conscious decision that needs to be made. And it's, it's something that I think is often lost in the discussion of this policy, I'm sure probably because people are desperate, and they really want their own health care managed. But I think it's very important to consider how harmful these sort of individualistic framings are, and what this ultimately results in, which is further rationing of care and the cementing of these fantastical notions of like some sort of like, biologically identified value system as like real at the end of the day.

Arrianna M. Planey 34:16
And this is kind of a hard one to disentangle, too, because the political feasibility of Medicare itself was based on the budget rationing by age. And just idea that, "Oh, well, people over age 65 probably worked their whole life and so they deserve to enjoy their retirement without worrying about health care."

Philip Rocco 34:46
Yeah, it was definitely a "deservingness frame."

Arrianna M. Planey 34:49
And then we see that with veterans as well, right? And under a very narrow slice of qualifying disabilities, so one of the big challenges is going to be disentangling all the layers and intersections of rationing, because with every slice a new industry was made.

Beatrice Adler-Bolton 35:14
Right, exactly. And those are, you know, "sacred jobs that we must protect," which are much more important than people's lives? Of course. Yeah, I think one of the things that is really frustrating, particularly when you start to see, it's great to see, as you were saying earlier, health institutions make gestures at social determinants of health. But I think that a lot of times, also, there's this collapsing of what that means. And, you know, none of these, it's not like Medicare for All, in and of itself, will change everyone's lives completely. But I do think it's a huge start for a lot of the reasons that you were mentioning earlier, particularly about spatial relations and people being redirected, or having longer distances to care because of limited provider networks, or under uninsurance. As well as dealing with a lot of the problems. For example, I'm on Medicare, it sucks. I'm not a fan. I mean, I'm a huge fan, I'm alive because of it. I'm incredibly grateful for being on SSDI. But it is really difficult to use, and still really unaffordable, and 11% of people who are certified disabled, of the deserving few who qualify and are

eligible, 11% of those people die in the two year waiting period before you become eligible for Medicare. And that ignores the fact that the more people who make it to 65, who become eligible for Medicare, people who can prove their eligibility that they are disabled to the Social Security Administration, you need access to care to get to that point in the first place. So it's just the programs that we have now just further reinforce who deserves to live into old age.

Arrianna M. Planey 37:09
Oh, yeah. I mean, the life expectancy of Black men didn't get to 65 until 1995

Beatrice Adler-Bolton 37:16
Wow, I didn't realize that, but that is a...

Arrianna M. Planey 37:19
Yeah.

Artie Vierkant 37:19
Yeah.

Beatrice Adler-Bolton 37:19
That makes sense [sigh].

Arrianna M. Planey 37:21
For white men that was around 1950.

Beatrice Adler-Bolton 37:24
Wow.

Artie Vierkant 37:24
Oh, God.

Arrianna M. Planey 37:26
There are serious racial and ethnic and equities in terms of who ages into Medicare, and also in terms of health status when they age into Medicare, and so that again, reflects that inequity. Like we see Black beneficiaries who are more likely to have aged into Medicare, because they had end stage renal disease, one of the few qualifying conditions?

Beatrice Adler-Bolton 37:52
Right.

Philip Rocco 37:53
I think this is an important set of observations that you made. I mean, certainly from your work on disparities and access, but also the, the broader implications of the design of the health system for the life course and life outcomes. From that perspective, it seems to me that the debate for and the constituencies for something like Medicare for All, are almost, by ignoring those things being defined,

unnecessarily narrowly, right, like, Medicare for All, it would seem from from your research is not just something that has implications for people who currently don't have insurance, which I think is the way that the constituency gets framed, and that's, that's quite narrow. And then it's also not just the people who currently have insurance through their employer and worry or are worried about losing it. It's also people that don't necessarily, like even if they have Medicaid, for example, they might not be able to get care at a place that has all of the necessary tests and services because they're being diverted,from a hospital that's close to them or, or they're subject to the the whims of these financial transactions that happen among insurers in the place that they live. And so it would seem to by just pretending that this is labout, I don't know, the the really ungenerous version is like by pretending this is just about lowering the cost of health care, which is really a dumb way to frame it. But also thinking about it's like, "Oh, this is just about filling in the gaps" what your research shows is that it's about transforming much more than just who happens to not have insurance right now.

Arrianna M. Planey 37:53
So...[sighs]. Right We can do a lot better than filling in the gaps.

Beatrice Adler-Bolton 39:54
Oh, for sure. I think this is one of the biggest arguments against reformism. In pushing for reformist policies, for example, like Medicare Advantage for All, "we're gonna expand healthcare access" and everyone can "buy into these private plans" or "into the public option" or something like that.

Arrianna M. Planey 40:17
When I think about that, there's just a certain duplicity in the arguments that people make here, where they see administrative burdens and they see administrative complexity as bad, except when it comes to low income, Black, Latinx patients who are treated as less deserving.

Artie Vierkant 40:40
Right.

Arrianna M. Planey 40:41
So there's this idea that, "Oh, well, this complexity is okay if, say we parent with an initiative to encourage financial literacy, and help people navigate these options they have to pick from a marketplace, when even people who study these marketplaces have difficulty navigating," Well, in studies even the people involved in the design of these marketplaces have difficulty navigating them. So they're already set up so that the blame for the shortcomings of the piecemeal solution is already placed on the people that these solutions fail.

Beatrice Adler-Bolton 41:21
Right. And then of course, you use choice rhetoric to take away the blame for it, right. Because if the whole point is that we need to develop "individual consumer literacy," that "the real problem with healthcare is not that it's inaccessible and inequitable, it's that we're illiterate when it comes to making good health decisions." I'm laughing while saying that.

Arrianna M. Planey 41:44

Or, "the prices need to be more transparent." [all laugh]. The list prices, the actual cost of care, is very different from the list price, depending on who's paying for the care. Someone who is self-paying, is probably going to be charged at the list price. Someone who's covered by Medicare and Medicaid is probably going to get covered charges, what Medicare Medicaid will cover, and may possibly receive a balanced bill, without those protections. While someone who has employer sponsored insurance that charge will go to the insurance company before they ever see it. Generally, the list price isn't the actual cost of care, I think it's really important to distinguish between the list price and the cost of care. Yeah, because in that debate over price transparency, there's so much focus on list prices, and not on what people are actually paying for care. And that even goes beyond what they're billed.

Artie Vierkant 42:50
I think that's one of the key things that really makes us so that whenever someone suggests these blanket, not even blanket, but these health reforms, saying like, "Oh, why can't we just do? Why can't we do?" Yeah, like you're saying, "education programs to tell people how they can get their healthcare," or "why can't we just do more price transparency so that the market can work it out," it ignores the fact that the idea of those reforms, does absolutely nothing for any potential political coordination or leverage that could be done through whether it's something like a single payer system or instituting an American NHS or something like that, I keep thinking about this thing that I want to bring us back to which is towards the beginning, when you were talking about parking lots, and financial toxicity. One of the things that you mentioned, really struck me, which was talking about hospital locations, and the material reality of hospitals as you know, just imbricated, like anything else, as within the realm of property relations, which I think is obviously objectively true. I think we so rarely think of the geography even, of hospital locations, in terms of in terms of geography or power structures, unless we're talking about, the press will write about rural hospitals or, I guess people will maybe Yelp the hospital near them to see if it's like, you know, people in gentrifying neighborhoods will Yelp hospitals near them to see if they should go there to the ER, or to like another place, which is a super gross practice that people legitimately do. And, I think, for valid concerns, but not for, again, ignoring these sort of structural problems, and I think that it just strikes me. One of the reasons I think that your research and the focus on for instance, even just talking about, the geography of healthcare is so important is because I think it really demonstrates some of these things are things that we can't really change without having a mechanism of public leverage. If instead, it's going to be just left to the historically racist and historically exploitative, regular processes of capitalism, so you either are putting a hospital in a place where it's going to be a real estate investment, or you're going to be putting a hospital somewhere where it's going to be an extractive force with within a community, right?

Arrianna M. Planey 45:39
Yeah. I remember when I was reading about the history and geography of hospital closures in New York State, there was a hospital in Harlem that closed, it wasn't closed because it wasn't financially solvent, it was closed because it would have been more profitable as a development versus as a hospital. So that neighborhood lost a hospital because the developer wanted that land. There was this idea that like, that it’s a life saving enterprise. Well, I don't know if you can call hospitals simply that but it was less profitable than a condo building or a mall. I mean, I do mean to say, I don't mean to cast aspersions on hospitals, it's just that I have to navigate this careful tension as my training is in social and spacial epidemiology, my heart's work is mostly focused on health equity. But the niche I found was

healthcare equity. I believe that healthcare is actually a smaller slice of population health than public health. But we have a lot more investment in healthcare. And we have a lot of work to do in that area of healthcare. So that's where my work ended up being — there's a statistic that's always floating around, "Oh, well, healthcare only accounts for about 20% of population health." But the thing is — that statistic is also based on the notion of an "average patient." I don't like the idea of an "average patient" or an "average person." It's a fundamentally eugenicist concept. What we need is more dynamic concepts that recognizes that we have an aging population, we also have a changing, I don't even like the word health profile, but I think health profile is probably the closest to what I'm trying to say. So it's important to jointly address public health and healthcare. And I think ought not just jointly address them, but couple them more tightly. So that we have primary prevention in the community, in where people live, where people work. And then we have a chat about healthcare when people need it. And instead of having health systems funneling millions of dollars, that are for fundamentally stop shaving self serving interventions, while public health is being defunded at all levels of government. Right. And that's an important distinction, because there is this rhetorical coupling of good health care equals good health outcomes, which obviously, as you're saying, completely ignores all of the other things which contribute to negative health outcomes like employment, shelter, food. To get good health care, typically people who have good health, have it because it's enabled by their environment where they're spared from exposure to harmful chemicals, or you know...

Artie Vierkant 49:05
Right.

Arrianna M. Planey 49:06
It's easier to have good health if you have money and live in a place that isn't next to a toxic dump.

Beatrice Adler-Bolton 49:11
Yeah, and especially if you're able to be certified for work to the point that you can access excellent insurance and good employer sponsored health care. It's this large value system of placing a person on the continuum of readiness to work right and your worth, as an individual, is then determined through your ability to be 1) a smart consumer, but also 2) your capacity to work. And I think fundamentally decoupling health outcomes from work capacity is a really important project and my hope is that the fight for Medicare for All can try to create that wedge that seeks to say, no, this is not just about health finance, this is about decoupling the value of health being something that is only earned through work.

Arrianna M. Planey 50:10
Right. You just made me think about — so part of the reason I was able to go through a PhD program or get it, was because I had support from the Illinois State Office of Vocational Rehabilitation, so you know the name tells you what it's about, right? So disabled people, people who have a qualifying disability, and coming to Voc Rehab, for assistance, with getting the necessary training that may enable them to enter the workforce and stay in the workforce and stay financially independent and not use a social safety network. So already that's tied up with, are you healthy enough to work? Okay, well, then you can get access to these resources. So you're right.

Beatrice Adler-Bolton 51:07

Yeah, I mean, I there was something interesting, I learned this year about how a lot of times, if you're trying to sue under the ADA for accommodations, for example, then oftentimes, if you are certified by the Social Security Administration, as disabled, the certification for disability that you need to get SSDI. The certification for disability that you need to successfully pursue an Americans with Disability Act legal claim is different, because in the ADA, you have to prove that if you have the accommodation, you could do your job. And for the Social Security Administration, you have to prove that you cannot work even with the accommodation. So we have this great example of a structure that is built to support disabled people and place value on their accessibility needs, just from the very simple fact of their certification for work and their ability to be rehabilitated, so to speak.

Arrianna M. Planey 52:06
Yeah. All right. I keep, while we're having a conversation, I kept thinking about Ruth Wilson Gilmore. I don't think she coined the term but, "surplus population." And how not only prisons function to warehouse surplus populations, or surplus populations being those outside of the formal workforce. We also have nursing homes, Long Term Care facilities, homes for people with intellectual disabilities and developmental disabilities. And incidentally, all those places are where COVID was basically allowed to spread unchecked.

Beatrice Adler-Bolton 52:45
Mm hmm.

Arrianna M. Planey 52:46
And it was almost invisible, if not for the people who are paying attention and publicizing the issue. Because the people are warehoused and out of public sight.

Beatrice Adler-Bolton 52:59
Mm hmm. I mean, this is why I think your work in medical geography is so important because these borders that exist, these categorizations, those places that we put people out of sight, out of mind — directly contribute to health outcomes, and so trying to get to the whys. Why, where, how, and by what means these borders are created and enforced. That's how I think we start to try and build power to dismantle some of these system level, oppressions, I guess, as Dean Spade would say, like, "subjective systems."

Artie Vierkant 53:33
Yeah. I also think it's really important that you bring up surplus populations, because I think, historically, for instance, if you think about, and, you know, maybe I'm just saying this, because, it's Medicare for All Week, we've been talking a lot about single payer. But I think for example, one, let's say, fallacy that can be easy to fall in, for instance, there are a lot of people who say, "Oh, labor alone can win single payer," for example. And that's an important constituency, but I think that there is a I think there's a history, at least in the American left, of there being a divide between what we have of a labor movement and the constituency that is the surplus population, which is, by many accounts, you know, Ruth Wilson Gilmore's writing is one. Martha Russells is another. By many accounts, the surplus population, as it were, is just as much of a productive force of capitalism as labor.

Philip Rocco 54:36
Oh, yeah.

Artie Vierkant 54:37
As labor is right. And so, I think recognizing, for example, distribution of hospitals, for example, and talking about coordinating power. I think one of the one of the benefits of once you actually have a system where, let's say like if you even just took health, finance, Medicare for All and said, "Okay, there's going to be one blanket insurer, the federal government covers everyone's health costs", then you have like, automatically brought this constituency together, who are who are all dependent on the same thing and it becomes something where you can actually move people for leverage otherwise, I think, for example, you keep the surplus population hived off and in different parts of society, often institutionalized, and you keep labor in a different area, beholden to their employer health care, and it automatically is a huge impediment not only to organizing but to making it clear that these are groups of people who are equally being used like economic engines, basically.

Arrianna M. Planey 55:50
Mm hmm.

Beatrice Adler-Bolton 55:52
I think crucially, it frames the fight for healthcare is one that's sort of a zero sum equation where you have to like, "reallocate money." Right? And fundamentally, that's not gonna work. I think, at the end of the day, maybe my final question is, you personally, I'm assuming that you are for Medicare for All, [laughs] but for you what actually is unique about this policy proposal, which could give, if done correctly, some of the leverage that we're talking about.

Arrianna M. Planey 56:29
So I think for one, with Medicare for All, whatever form it takes, we are going to have to grapple with the spatial allocation of healthcare. Because there is research showing that closures and mergers also have implications for ambulance response times. And also mortality associated with injury. Accidental unintentional injury, but also heart attack. So this is all true. Spacial access to care is a population health issue. I don't think there's a reluctance to recognize that. And because among health economists, there's debate over, "Oh, well do closures and mergers maximize efficiency?" But when you raise the point that closures and mergers may mean longer travel times, higher costs associated with healthcare use. and also a changing pattern of primary care use. So like there's some research that among rural patients, longer increased travel time to care is associated with reductions in primary care use, and increases in emergency department use. So not only, as I was saying earlier, not only are patients experiencing longer travel distances to care, they're experiencing higher healthcare costs, and also potentially worsening mortality. Yeah. So it kind of all kind of circles back to the way we allocate resources. And allocation is often about a distribution of resources, in social, geographic and social space, the way we that we have to allocate patient resources has profound implications for the health and well being of the population.

Beatrice Adler-Bolton 58:35

Yeah, and I think the other thing too, is that the advantage that we get from implementing something like Medicare for All could also have an effect on what sort of data we're collecting and the ways that we're able to study the health of the population, and how these spatial relations, I think we'll get a much better picture of, how both spatial inequity and how spatial relations really have this huge impact on healthcare, or health outcomes rather, that we can't really measure right now, because we don't have this comprehensive, unified billing system. Like each insurance company has their own codes.

Arrianna M. Planey 59:21
Yeah.

Beatrice Adler-Bolton 59:22
Data is incomplete. Lots of people don't have healthcare. And by creating a system like Medicare for All, where you have no eligibility requirements, which I think is important, as we've talked about, any eligibility determination as a judgment of value, so eliminating eligibility requirements, eliminating these qualification barriers for accessing care, gives us a better idea of where and how to allocate spatial resources going forward, in theory, because it can actually generate some of the data that we're just missing that right now, frankly, just doesn't exist.

Arrianna M. Planey 59:55
Right and I think also, we're going to have to separate the documentation of health status when billing.

Beatrice Adler-Bolton 1:00:02
Mm hm. I agree.

Arrianna M. Planey 1:00:04
I was just reading a paper recently that was looking at some of the biases introduced, when you do tie the documentation of episodes of care with billing where basically there's a tendency to document only the profitable. One, there's a tendency to only provide services that are profitable. Two, there's less inclination to document symptoms — one, doctors, providers, are crunched for time, so they're gonna prioritize what they're paid to do. And there's also less incentive to take full medical histories and possibly capture somebody's comorbidities that are not being caught in an episode of care. I think in addition to having a centralized system for billing care, we also need, I do think that there may be a need to separate documentation for the purposes of billing, and documentation for the purposes of documenting health status or medical history per patient, because right now, the system we have right now is fragmented.

Beatrice Adler-Bolton 1:01:24
That's actually a very important point. Because right now, as it stands, most charting for patients primarily is oriented around notes that correspond to billing codes. And I think that Medicare for All presents an opportunity to introduce a different system of medical records and medical charting, that could be more oriented towards health outcomes and managing chronic conditions than it is now because right now, just structurally, functionally speaking, the chart system is so tied into the aspect of billing that it's actually pretty difficult to separate the two and the billing aspect of it is prioritized, because at the end of the day, the hospitals, these doctors, they need to get paid. Right. And so that

that becomes the primary sort of Northern Star of people's health care, whereas the ultimate goal at the end of the day should be trying to remove some of these barriers, which like as Ruth Wilson Gilmore says, mark populations for premature death.

Arrianna M. Planey 1:02:30
Yeah, agree.

Beatrice Adler-Bolton 1:02:32
Well, I really appreciate you coming on and talking to us today. It's been a lot of fun. And thank you, I feel like the spatial understanding of how Medicare for All could change health administration and health outcomes is a really important component that's just not being talked about. So thank you for coming and talking to us as part of Medicare for All Week.

Arrianna M. Planey 1:02:52
Thank you for having me.

Beatrice Adler-Bolton 1:02:54
It's been an absolute pleasure. Thank you for joining us and listeners, thank you for listening to Medicare for All Week. As always, Medicare for All now. Solidarity forever. Stay alive another week.