#1595 Pushing for Medicare For All in the Laboratories of Democracy

JAY TOMLINSON - HOST, BEST OF THE LEFT: [00:00:00] Welcome to this episode of the award-winning *Best of the Left* podcast in which we are honoring the death of Medicare For All activist Ady Barkan, who passed away this month, by looking at the progress of the movement for universal health care, as well as the efforts to reign in the power of Big Pharma that's used to gouge the American people with exorbitant prices for life-saving prescription drugs.

Sources today include *Democracy Now!*, *The Weeds*, *Code WACK!*, the *Thom Hartmann Program*, *Economic Update with Richard Wolff,* and *The Laura Flanders Show,* with an additional members-only clip from *The Brian Lehrer Show*.

Healthcare Activist Ady Barkan Dies of ALS; Watch His 2021 Interview on Demanding Medicare for All - Democracy Now! - Air Date 11-27-23

AMY GOODMAN: Healthcare activist Ady Barkan has died at the age of 39 of the neurodegenerative disease ALS. After his diagnosis in 2016, Ady Barkan dedicated his life to the fight for single-payer healthcare. He continued to speak out even after ALS left him physically unable to talk, communicating with a computerized system that [00:01:00] translated his eye movements into spoken words. In 2019, Ady used the device to deliver powerful opening remarks at the first-ever congressional hearing on Medicare for All. His story is told in the documentary, *Not Going Quietly*. In 2021, I spoke with Ady Barkan just ahead of the film's premiere.

We end today's show with one of the most remarkable healthcare activists in the country. His name is Ady Barkan. He's a 37-year-old lawyer and father who's dying of terminal ALS. Since his diagnosis in 2016, Ady has dedicated his life to pushing for Medicare for All. He's continued to speak out even after losing his voice. He now uses a computerized system that tracks his eye movements and turns them into spoken words. Ady's story is told in the new documentary, *Not Going Quietly*. This is the trailer.

SEN. ELIZABETH WARREN: Now, I want to have a chance to tell the story about my friend Ady Barkan.

JON FAVREAU: He's been an [00:02:00] activist and an organizer all of his life.

REP. JIM McGOVERN: With us today is Ady Barkan. I can't do Ady's story justice. I will let him tell it.

ADY BARKAN: After Carl was born, we felt like we had reached the mountaintop.

Say hi.

And then, out of the clear blue sky, we were struck by lightning.

I was diagnosed with ALS today.

The knowledge that I was dying was terrible, but dealing with my insurance company was even worse. I wanted to spend every moment I had left with Rachael and Carl, but then Congress came after our healthcare. I couldn't stay quiet any longer.

BROOKE BALDWIN: My next guest made headlines when he confronted a Republican senator on an airplane.

ADY BARKAN: This is your moment to be an American hero.

All right, ready to rumble.

We decided to start a movement.

To urge [00:03:00] people to stand up, confront the elected officials.

Paul Ryan, I'm going to knock on your door!

REPORTER: Did you just get out of jail? Are you going to keep protesting on Monday?

ADY BARKAN: [bleep] yeah!

PROTESTERS: What do we want? Healthcare!

ADY BARKAN: I am willing to give my last breath to save our democracy. What are you willing to give?

Liz, I'm having trouble breathing.

LIZ JAFF: I think we have to stop.

ADY BARKAN: Our time on this Earth is the most precious resource we have.

Carl, I love you so much.

Movement building allows me to transcend my body. And that's the beauty of democracy, that together we can be more than our individual selves.

AUDIENCE: Ady! Ady! Ady!

ADY BARKAN: [00:04:00] The paradox of my situation is, the weaker I get, the louder I become.

RACHAEL SCARBOROUGH KING: Who's that?

CARL BARKAN: Abba!

AMY GOODMAN: The trailer to the new documentary *Not Going Quietly*. It premiered last night in Los Angeles and tonight at the Angelika theater here in New York. On Thursday, just before the L.A. premiere, I had a chance to speak over Zoom with Ady Barkan, who was at his home in Santa Barbara, California.

Ady, I wanted to start off by saying this is one of the great honors of my life to be talking to you. So, thank you so much for making this time, right before the documentary is airing about your life.

Let me start off by asking you about the enormous emphasis on healthcare in this country right now, even in the corporate media, because of the pandemic. Yet [00:05:00] there is very little talk about Medicare for All, an issue you have dedicated your life to. Can you talk about why you have dedicated yourself to this issue?

ADY BARKAN: That is so generous, Amy. Thank you for your career of leadership.

Only a truly radical departure from our exploitative, for-profit model to one that guarantees healthcare as a right for all will ensure that we no longer live in a nation where people go bankrupt on account of their medical bills. Take this last year as a prime example of the breadth of cruelty possible in our for-profit healthcare system. COVID disproportionately devastated poor communities and communities of color. Death rates in Black, Indigenous and Latinx communities were over twice that of their White counterparts. Millions lost their jobs and, as a result, their health insurance. Hospitals that [00:06:00] primarily serve Medicaid patients shut down, prioritizing profits over people. Meanwhile, private insurers saw their profits double, because Americans delayed much-needed care. A system that profits off of death and people forgoing medical care is a system that is beyond repair. We need Medicare for All now.

AMY GOODMAN: What gives you the strength, Ady, to be the relentless activist that you are?

ADY BARKAN: You know, building a progressive movement means having your heart broken all the time. This comes with the territory. We organize for a better world, not in spite of our own pain, but because of it. We push forward because we are faced with no other option but to struggle for our freedom.

These last five years have been really tough, both personally and also collectively as a society. But take a breath and look around. You will find evidence of the profound beauty that our society has forged from the depths of pain, [00:07:00] especially this past year. Of course, there is a lot of work to be done. But placed in this context, it means there is also more community, more creation and more healing that is bound to emerge from our labor.

Why your health insurance is tied to work - The Weeds - Air Date 10-18-23

DYLAN SCOTT: The whole idea of a medical profession was pretty new. Like, up to that point, you know, there'd been, people might have gotten care at home, maybe there was somebody in your community who served as more of like an informal healer kind of person, but, like, medical science was in its very rudimentary forms.

You know, it was around that time, the turn of the century, when medical did start to become more professionalized. You saw the creation of, you know, formal medical schools, different kinds of credentialing and accreditation, and hospitals. More hospitals started to be constructed and started to become a center where people might receive critical kinds of healthcare if they were really sick or got injured or something like that.

So, around that time people were sort of, like, Alright, maybe, you know, having to pay just [00:08:00] full freight every time I show up at the doctor or go to the hospital isn't the best way to do this. So, you started to see some early experimentation with different kinds of health insurance. One famous example, back in the Dallas area in the 1920s, there was this group of teachers who came to an agreement with Baylor University Hospital that, like, they could go to the hospital for so many days per year if they, you know, were paying this monthly payment, an early version of a premium, in order to be guaranteed that kind of access. What emerged over time was the Blue Cross, a form of hospital-based insurance, like coverage specifically for hospital services. And in parallel, you know, the physicians, doctors out in the community, family doctors who didn't see people in the hospital, they saw that model emerge and they were like, Hey, we, like, want to get in on the same idea. And so the Blue Shield version of plans emerged in the 1920s and 1930s.

So, this was a pretty, you know, informal, totally, you know, locally driven kind of organic [00:09:00] system for providing an early version of health insurance for people, you know. It wasn't necessarily comprehensive, but the insurance scheme that would emerge in the United States was starting to take shape.

JONQUILYN HILL - HOST, THE WEEDS: So, the function of hospitals and doctors changed and, in turn, so did how we paid for them. And then another major change came. This one was largely shaped by the great depression and FDR's New Deal.

DYLAN SCOTT: In 1932, as dole queues lengthened across America, 13 million were out of work. Nearly a third of the people relied on handouts from private charities. There was no welfare state to help them. His allies in Congress, you know, they wanted the retirement program that would become social security, they wanted other forms of employment support, stuff like that. They were reluctant to include health insurance as part of the New Deal, even though it might have seemed like a natural fit.

Nowadays, people think of social insurance as including health insurance, but in those days it was a much less set [00:10:00] idea, and they were trying to decide what to prioritize, what wasn't worth the risk, and while his advisors cited

medical coverage as one possible area for legislative action, as part of the Social Security Act.

Over time, its importance was de-emphasized. You know, they were facing already in those days backlash from doctors, from hospitals, who had partly encouraged these voluntary private insurance schemes in order to kind of stave off a more comprehensive government control of healthcare. And FDR just basically made the calculation that it wasn't worth fighting with the hospitals and the doctors over national health insurance when he had all these other things he wanted to do as part of the Social Security Act and all the other related New Deal provisions.

JONQUILYN HILL - HOST, THE WEEDS: I would love to dig into something that shaped the way American health care functions in the middle of the century, and that's the U.S. [00:11:00] entering World War II.

ARCHIVAL NEWS CLIP: We interrupt this program to bring you a special news bulletin. The Japanese have attacked Pearl Harbor, Hawaii, by air, President Roosevelt has just announced.

DYLAN SCOTT: A couple of important things happened. For one, obviously, like, a lot of men of working age who were the bulk of the labor force at that time were instead being deployed overseas to fight the war. And so a lot of women were entering the workforce at that time. Like, there was a real shakeup of the labor force and all of the labor dynamics.

ARCHIVAL NEWS CLIP: Tens of thousands of women are already at work in aircraft. More are being added as fast as they apply.

DYLAN SCOTT: Because we had, like, seven million working age men fighting a war instead of working in factories or other jobs, there was a huge labor shortage. Businesses were desperate to find workers and were willing to do a lot and offer all kinds of enticements to try to get people to work in their jobs instead of any of the other many available jobs that were open to them at the time.

That obviously creates a [00:12:00] concern about inflation, which would obviously be a serious challenge to the economy when it's already on this war footing. So, FDR in what turned out to be a very consequential executive order, issued a directive that wages would have to be frozen. Employers started to work around those new restrictions and they were offering employees other

benefits other than just higher wages. And those included the offer of health insurance benefits.

That kind of starts to become the norm. Employers see this as an attractive opportunity to attract a workforce. And so the Internal Revenue Service decides to lend them an additional hand. In a 1943 decision, the IRS said that health insurance benefits... Being offered by employers to their employees should be exempt for taxation. Now, suddenly, like not only can you offer these additional benefits above people's wages to try to entice them, but then you can deduct the cost of those health insurance benefits from your taxable income. And so very quickly over the course of the 1940s, [00:13:00] there were about 20 million Americans who had some kind of health insurance, and I think we should be clear that, like, this could have been pretty bare bones, but nevertheless, like, they had some kind of health insurance in 1940, just 20 million people. By 1950, 140 million people had some kind of health insurance.

Rethinking the path to winning single payer - Code WACK! - Air Date 4-10-23

BRENDA GAZZAR - HOST, CODE WACK!: The movement to win Medicare for All may be slowed at the federal level, but it's a different story in the states. In 2021 alone, 18 single payer bills were introduced in states including Massachusetts, New York, Colorado, and Oregon. Yet, as the most populous state in the nation, winning in California could be a game changer.

What's the latest single payer bill introduced in California, and how is it different from previous bills? To find out, we spoke to Michael Lighty, president of the Healthy California Now Coalition and former constituency director for Bernie 2020. Hi, Michael, welcome back! It's been such a long time since we've had you on and you've been busy. Tell us what you've been up to.

MICHAEL LIGHTY: Well, thanks, Brenda. It's great to be here again.

Well, [00:14:00] at Healthy California Now, we've been developing a campaign, ironically enough, called Healthy California Now campaign. And the idea is to create a viable path towards single payer in California, so that we can guarantee health care for all residents of the state that is better, better care and lower cost. The idea is that if we take a set of steps to engage stakeholders, that is people with a real stake in the system, and bring them together to collaborate, at the same time we would talk to the federal government about the kind of approvals that they will do, which are necessary to establish a guaranteed healthcare

program in California, that those two tracks can come together and we can create recommendations to the legislature to then ultimately pass a full-scale single payer bill.

This process is embodied in Senate Bill 770, introduced by State Senator Scott Wiener from San Francisco. And the idea of the bill is [00:15:00] essentially that let's set up a process, support discussions with the Biden administration to get an understanding of what they would approve once California formally applies for that approval, and to also bring in folks with a real stake in the system to collaborate and engage with each other to formulate support for those discussions and ultimately recommendations to the legislature on a full-scale program.

BRENDA GAZZAR - HOST, CODE WACK!: Thank you. As you mentioned, you're working with Senator Scott Wiener on this single payer bill. What's behind the choice to work with him? Does he have a special interest in this issue, or is it mainly because he's on the Senate Health Committee?

MICHAEL LIGHTY: Well, it is because he's on the Senate Health Committee. It's also true that he has a special interest in this issue. As you may know, San Francisco is certainly a place where, I don't know, 80 percent of the people in the city support Medicare For All-style reform, and he, of course, was a co-author of Assembly Bill 1400 last session in the legislature.

BRENDA GAZZAR - HOST, CODE WACK!: [00:16:00] Right. The CalCare bill would guarantee comprehensive, high quality health care to all California residents.

MICHAEL LIGHTY: So, he's a long-time supporter of single payer, he is on the Health Committee, and he has a reputation for getting legislation done.

BRENDA GAZZAR - HOST, CODE WACK!: Wonderful. Senate Bill 770 seems to build on the Healthy California for All commission report. Even the campaign is named Healthy California for All now. Can you give us a brief refresher about the commission and its conclusions?

MICHAEL LIGHTY: Well, it's not a coincidence that these have similar names, because the Healthy California for All Commission came out of work that the Healthy California Coalition had done back in 2018, 2019.

And so, the Healthy California for All Now campaign essentially builds upon the recommendations of the Commission. Because you hear in the media, oh,

advocates say it's going to save money to do single payer. Well, in fact, it's the Commission that says we're going to [00:17:00] save money. And we can save money through single payer at huge levels. In fact, the comparison between a single payer approach and doing nothing is $500 billion over 10 years. A half a trillion dollars over 10 years is the difference between doing nothing and adopting single payer. That's a huge amount of savings.

But that's really secondary to the lives saved, 4,000 lives saved, the ending of medical bankruptcy, the ending of medical debt, the ending of out-of-pocket copayments, premiums, deductibles -- gone. And the peace of mind that comes from that and the equity that comes from that -- all of those things were part of the Healthy California for All Commission official report. So if you've got an official report of a pretty diverse group of folks saying, "Hey, this is a better system. We can save lives. We can save money," then of course we want to build on that momentum. And so Senate Bill 770 says, yeah, [00:18:00] legislature, adopt the findings from the Commission, build on those recommendations, and resolve those policy issues that remain from the Commission's work and formulate a program that the legislature can act on.

And that's why we have set up this process. We can't really do it in one fell swoop, but we can do it in sequential steps, building on the commission's report.

BRENDA GAZZAR - HOST, CODE WACK!: So why can't we do it in one fell swoop?

MICHAEL LIGHTY: It hasn't worked. We've been trying it since the nineties. And so it's not really like we couldn't do it, it's just that evidence and experience shows we haven't been able to do it that way. And so we need a different approach. And if we can understand what the federal government's likely to approve, use that to inform the legislature. If we can actually get supporters of single payer to collaborate on what policy recommendations they'll make to the legislature, and how we can [00:19:00] finance it, then the legislature is actually in a position to approve it, much more likely than just presenting them with a "take it or leave it" approach. We've got to engage in a process first with the federal government and also among ourselves to collaborate. And that produces a result that we think will be much more likely to succeed.

BRENDA GAZZAR - HOST, CODE WACK!: Got it. So you mentioned California would have to get federal approval for single payer to move forward. Can you tell us more about the federal waiver process?

MICHAEL LIGHTY: Well, the official process under the Affordable Care Act requires that the state legislature pass a bill that then is submitted to Federal Center for Medicare and Medicaid Services, called CMS, and they decide on whether to approve that application for a waiver of certain provisions that exist in federal law and, as a part of that process [00:20:00] then, the monies that say have been allocated from the federal government to California through the Affordable Care Act, through Medicaid, through other federal programs can be pooled into a single source as the commission anticipated and as, of course, single payer supporters understand.

So the idea then is, in our process, let's get an informal discussion going with the federal government, as the Newsom administration has done, and let's support that, and let's provide assistance to that, and set deadlines so that there's a concrete timeline for getting those informal discussions done, getting a recommendation to the legislature, and then getting the legislature to act while we're certain that the Biden administration is still in position to approve it. So that's the other piece of this: getting the legislature the information it needs to make a timely decision to create that guaranteed healthcare system and to actually [00:21:00] set forward a process to move the Newsom administration and the legislature to a decision.

And that's what we haven't had before either.

How Can This Predatory Exploitation Be Considered Health Care - Thom Hartmann Program - Air Date 11-15-23

THOM HARTMANN - HOST, THOM HARTMANN PROGRAM: This is also the big thing that Republicans are using to beat up President Biden. And again, the big companies are all in on this. Gas companies jacking up prices. Why? Because they can. Big retail stores jacking up price. Why? Because they can. Amazon did this test -- it had a code name even, where they just randomly jack -- or not randomly, they're very carefully organized -- jacked up prices on things to see what would happen. They made an extra billion dollars in profit, because they have basically monopoly control of the online marketplace. We've got five big insurance companies, too. And we've got five big hospital chains, maybe six or seven now across the United States, but basically we've seen consolidation in those areas as well.

To that, Congressman Ro Khanna, who's a regular on this program -- I'm assuming he'll be back with us on Friday this week most likely, Lord willing

and the crick don't rise, and Mike Johnson doesn't do something insane -- but[00:22:00] Congressman Khanna just introduced a state based, it's called the State Based Universal Health Care Act.

See, here's the problem: Vermont and California have both tried to do single payer health care. And in both cases, what stopped them was that Social Security, Medicare, and Medicaid, in order to prevent fraud, because these are federal programs, track the dollars as they go to the states, to make sure that those dollars are ending up paying for actual health care services for the individual citizens of those states.

If you're Vermont, for example, with 600,000 citizens, and you've got 70,000 people on Medicare, retired people on Medicare, if you go to a universal healthcare system in Vermont that is entirely paid for by the state, there is no provision for those 70,000 people on Medicare to have that state insurance.

Or, more importantly, Vermont probably has about 100,000 low income people on Medicaid. There's no provision [00:23:00] for Medicaid for that money to continue to come into the state. If you say, we're going to do it ourselves, suddenly the Medicaid money vanishes, the Medicare money vanishes. And the state can't afford to do it any longer.

So this waiver would be a waiver to those laws around Medicare, Medicaid and other health programs, WIC and all these other programs, that would say these programs can, instead of directing their money to the individuals in the states, they can direct it to the state itself, and the state can roll that into the money that they are using to pay for the healthcare for those individuals.

We need this. So now might be a good time, if you're keeping a list, to call your representatives, this is in the House of Representatives right now. Obviously it's not going to pass with Republicans controlling the House, but still, we need to start building the pressure. Typically it takes a year, two years, three years, sometimes four or five years before a piece of legislation is ripe, before it's got enough support, before it's well known enough that it has enough support that politicians actually take it seriously.

So the phone [00:24:00] number is 202-224-3121, 202-224-3121. And that gets you to the switchboard in Washington, DC. And just say, Congressman Khanna has introduced the State Based Universal Health Care Act that provides waivers for states that want to go single payer. Please support it. It's that simple. He said, "Our failing healthcare system, where millions are burdened by debt and nearly half of all Americans report struggling to afford the care they need, has

increased the demand for state and federal action. We must empower states, including those such as California and New York that are working to create state based, single payer healthcare systems to guarantee that their residents can get the care they need when they need it." Great stuff. Important stuff. This is what we need to be doing.

And, this is how Canada got single payer healthcare all across the nation. The province of Saskatchewan, their equivalent of a state, Saskatchewan did it first, Tommy Douglas was the governor, the premier, and he put into place single payer healthcare system in [00:25:00] Saskatchewan back in the 1960s, and pretty soon, next door, Alberta said, hey, that's kinda cool, we want that, and then Ottawa said, hey, we want that, and then British Columbia, oh no, we want that, and then, Ontario said, we want that, and pretty soon the whole country had it.

This is how you do it.

Biden vs. Big Pharma Medicare to Begin Negotiations to Lower Price of 10 Costly Drugs & Insulin - Democracy Now! - Air Date 8-30-23

AMY GOODMAN - HOST, DEMOCRACY NOW!: The Biden administration has taken a step to rein in the soaring costs of prescription drugs in the United States. On Tuesday, the White House released a list of the first 10 prescription drugs Medicare can negotiate lower prices for. The list includes medication used to treat diabetes, cancer and heart disease. The Biden administration also added some insulin products, which surprised many. The White House says the price negotiations could lead to a savings of some $100 billion over the next decade. The move is seen as a major blow to Big Pharma, which has been fighting the plan in courts, filing at least eight lawsuit [00:26:00] since the passage of the Inflation Reduction Act last year, which gave Medicare the authority to negotiate drug prices. President Biden spoke Tuesday.

PRESIDENT JOE BIDEN: Big Pharma is charging Americans more than three times what they charge other countries, simply because they could. I think it’s outrageous. That’s why these negotiations matter. Reducing the cost of these 10 additional drugs alone will help more than 9 million Americans. And by

September 2024, HHS, Health and Human Services, is going to publish the prices it negotiated. In January of 2026, the new prices will go into effect.

AMY GOODMAN - HOST, DEMOCRACY NOW!: Independent Senator Bernie Sanders of Vermont responded to the news by saying much more needs to be done to stop Big Pharma from charging higher prices in the United States. Senator Sanders pointed out one diabetes drug made by Merck costs $547 [00:27:00] a month in the U.S. but just $16 in France.

Joining us now is Peter Maybarduk. He's director of Public Citizen's Access to Medicines Program.

Welcome to *Democracy Now!* So, talk about why this has taken so long, but also why this is such a landmark announcement from President Biden and Vice President Harris.

PETER MAYBARDUK: Well, it's obviously terrible that Medicare hasn't had the ability to negotiate prices until this point. It was a corrupt deal when the Medicare prescription drug benefit was created nearly 20 years ago. And Pharma was against the reform, until it was for it, because it was able to ride out the possibility of negotiation. And so, since that time, a generation of health advocates have been working to give the government the basic right to negotiate drug prices with the monopolists [00:28:00] that our laws create and support. Countries around the world have that right. And not negotiating makes, obviously, our drug prices high and our tax dollars not go as far.

So, this list, long-expected announcement coming shortly after the one-year anniversary of the Inflation Reduction Act, shows us where our government will begin negotiations, based on some of the most — the drugs that are most expensive to Medicare. And we expect the savings to be quite substantial. It includes six very commonly used medications to support heart health and fight diabetes. My father-in-law takes four of these drugs. They're very important to seniors. It also includes three very expensive rare disease drugs, or drugs against arthritis and a blood cancer. But, as you mentioned, the inclusion of insulin is a welcome surprise — well, not just insulin, but six insulin products sold by Novo Nordisk, something that Insulin [00:29:00] for All activists have been fighting for for quite some time. One-point-three million Americans ration insulin. And this is another step toward breaking the back of the insulin cartel, that we're very glad to see.

JUAN GONZALEZ: But, Peter, why so few drugs in the first batch that are going to be negotiated, compared to the thousands of drugs that are out there?

And also, doesn't this take effect, people will only feel the impact, in 2028? Why so long a period of time?

PETER MAYBARDUK: So, there's a statutory mandate. They have to begin with 10 drugs, but they will add 15 drugs in the following year and another 15 drugs in the year after that. So the impact is going to grow substantially over a period of time. We, of course, would have liked to see the initial legislation be more aggressive and bring more drugs immediately into the negotiation portfolio. The VA negotiates on behalf of veterans already. They handle it with a large number of drugs. But this is the deal that was cut. But that [00:30:00] impact is going to grow.

The prices will take effect on January 1st of 2026, and it does take some time. There will be a negotiation. There will be an exchange of information this fall with the companies. CMS, the Center for Medicare and Medicaid Services, will sit down with patient groups and hear their perspective. And then there will be an initial price offer from the government in February and negotiations next summer.

But the Inflation Reduction Act, more broadly, already is having positive impacts on drug prices. Beyond the negotiation provisions, there are measures to curb price spikes — the "Pharma Bro" Martin Shkreli problem — that also is a standard industry practice, to increase the prices of their drugs that are already on the market year by year. In fact, AARP found that for the top 25 Medicare drugs, Pharma has tripled the price of those drugs since they came on market. Prices are going up, not down, after they put a drug on market. Anyhow, the Inflation Reduction Act also [00:31:00] includes, and has penalized so far — CMS, I believe, has penalized about 40 companies for taking price spikes, and ensuring that that practice stops. So, IRA is already holding prices in place for some drugs, and over time we will see price reductions through the negotiation. But, as Senator Sanders mentioned, there is quite a bit left to do and more that needs to be done outside of IRA

Inequality Undermines Health & Healthcare in the U.S. - Economic Update with Richard D. Wolff - Air Date 11-14-23

RICHARD D WOLFF - HOST, ECONOMIC UPDATE: Here's a question that has come at us, I don't know, for the last two to three years, at least once every other week. And it goes something like this. The United States health system, being the health system of one of the richest countries on the planet,

seems to have done really poorly in dealing with COVID, and everybody wants to know why, given the number of people who died, the number of people who got ill, the number of people suffering long COVID, and all of that. Was it the president, Mr. [00:32:00] Trump, at the time? Was it the government that had the bad, wrong policy? Or was it part of an older and larger problem of poor health in the United States? What does your research suggest is the explanation for the poor performance of the United States?

STEPHEN BEZRUCHKA: Let's begin by looking at the term you used, "U.S. health system". That implies that there's some structure in the country designed to produce health. Now, health is different than healthcare. So, I tell my students every time, when you use the word health, do you really mean healthcare? So we should be speaking about the U.S. healthcare system, and was it responsible for our shameful COVID outcomes? And that word change makes you realize we conflate the terms health and healthcare in this country all the [00:33:00] time. Just think, we pay for health, access health, get health, insure health. We do nothing of the kind. We pay for healthcare, insure healthcare, get healthcare. So, I always ask the question, do you want health or healthcare? Because most people can't distinguish the two.

So, then we have to ask, how much does healthcare do for improving health? What is the evidence there? And the evidence is very strong that at best, in terms of averting death, healthcare accounts for at most 10 percent of the ability to avert death. And, uh, you know, since we spend, well, in 2021, 4.2 trillion on healthcare, a sixth of our total economy, and which ends up being about [00:34:00] half of the world's healthcare bill, we're consuming healthcare, and there's no reason that should provide health, 10 percent at best.

So, what about the COVID outcomes? Well, there are many studies linking COVID outcomes to economic inequality. Among the U.S. States, in a study in 2020, death rates were higher in the states that had higher income inequality. Among 84 countries, the same relationship was seen. There's something about inequality that produces conditions that lead to worse health. And that's, uh, you know, the reason for the title of my book, *Inequality Kills Us All*. The "kills us all" implies there's none of us that can escape the toxic effects of inequality.

RICHARD D WOLFF - HOST, ECONOMIC UPDATE: Yeah, it sort of, it reminds me, because historically there's a mountain of [00:35:00] evidence of that. That's why we know about, you know, great plagues and great other moments of collapsed health in the world, because it affected everybody. If you let the poorer part of your people be sick, have bad health, you can't prevent the spread of that, there is no effective way really to do that, so it becomes self

destructive even for the rich to allow poverty because it will come back to bite them in the proverbial rear end.

Big Pharma Explained Why Are Meds So Expensive [& The Solution] - The Laura Flanders Show - Air Date 6-12-23

LAUREN FLANDERS - HOST, THE LAURA FLANDERS SHOW: Dana, to you. Can you just underscore for people here who perhaps are unfamiliar or less familiar than they should be with the whole concept of public ownership, what makes that structure different?

DANA BROWN: So what's happening in California is categorically different, because there's no profit motive here, there aren't shareholders, there's not a CEO in some other country who's making a lot of money for this. The public sector is going to be producing or entering into contracts to produce insulin [00:36:00] at cost or at a little bit more than cost to begin with. So no one's paying this extra amount of money to satisfy Eli Lilly or Sanofi or another corporation, and we as a society benefit.

I'd also just like to underline that there are huge benefits for everyone. It's not only important to me as an American that Kevin, because he's a great person, gets his insulin, but it's actually important as a taxpayer and a human that millions of people get to participate in the workforce.

And that's also helpful. They pay taxes, right? People get to go to school and participate in their communities. This has economic and social benefits for all of us.

And last thing, having the public sector take a bigger role in the production and distribution of medicine categorically starts to shift the balance of power.

With some of the examples that Luis brought up earlier, governments are often reluctant to take any action to regulate Big Pharma, for fear that they're [00:37:00] just not going to bring new drugs to market, or they're not going to cooperate with us. And the only reason that works is because they're the only game in town. If Big Pharma are the only folks making drugs, then they have all the leverage. Once the public sector is also making drugs, it starts to rebalance things and erode some of the regulatory capture and open up policy space for other reforms like price transparency and negotiating prices and all of those things.

LAUREN FLANDERS - HOST, THE LAURA FLANDERS SHOW: How common is this outside of the United States, Luis?

LUIS GIL ABINADER: We have seen a number of different public pharma initiatives in countries like Brazil, Sweden, Cuba, and several others. In Cuba, they have the ability not just to manufacture things like vaccines, but also to do the research and the development. And we saw that during the COVID-19 pandemic, where the Finlay Institute and the Center For Engineering and Biotechnology in Cuba, both of them, each of them [00:38:00] launched their own COVID-19 vaccines.

And so because of what we saw during the COVID-19 pandemic with vaccine inequity, what we're seeing is an increase in this type of initiatives where governments say we're not going to just rely on Big Pharma to get our vaccines and treatment. We're going to produce it ourselves with public funding and with sovereignty.

And so for example, now Columbia, which 20 years ago had the ability to manufacture vaccines, but stop ped making those investments, stopped sustaining those public manufacturing capabilities because of neoliberal policies. They have realized that not sustaining that manufacturing capacity was a mistake. And so now they are creating, in the city of Bogota, the facilities to manufacture vaccines and other treatment now with the support of the federal government.

LAUREN FLANDERS - HOST, THE LAURA FLANDERS SHOW: Has the IMF that imposed a lot of those neoliberal structural adjustment programs on countries like Colombia changed? Is it singing a different tune, Luis?

LUIS GIL ABINADER: [00:39:00] Many international organizations are now realizing that the idea that developing countries should do like agriculture or textiles, and rich countries should control the technology, I think across the board, we're seeing international organizations realizing that was a mistake. And also governments in the global South are realizing that not sustaining their manufacturing capacity for things like vaccines is a mistake because you must have access to this type of products, and especially during health emergency, you cannot rely on big pharmaceutical companies that are driven by profit and governed by shareholders.

LAUREN FLANDERS - HOST, THE LAURA FLANDERS SHOW: Kevin, coming to you. Luis conveniently mentioned Cuba, which reminded all of us, I'm sure, of the backlash that's likely to come knocking at Gavin Newsom's

reelection campaign. "It's socialism, it's anti the private profit motive, and it's, of course, stepping on the private rights and and freedoms of private corporations." How important is this moment to that [00:40:00] confrontation?

KEVIN WREN: I think the opposition is purely free market capitalists that are just cutthroat and want to exploit the system. When this bill originally passed in 2020, it passed 31 to 8, so this is a bipartisan effort. In Washington state, where I'm from, we passed insulin copay caps almost unanimously. There was one abstention. This is a bipartisan issue and an apolitical issue, too. These are drugs that need to be regulated like a utility because they offer so much utility to people like me. Roughly 10 percent of the population has a chronic illness and they're exploiting and extorting our need for this drug and it's coming to an end.

LAUREN FLANDERS - HOST, THE LAURA FLANDERS SHOW: We produce this program with no money from private pharmaceutical companies. But boy, there's an awful lot of private pharmaceutical Big Pharma money in media these days. Dana, coming to you, you touched on the democracy questions early on, as did Luis. What's the Biden administration and what's Gavin Newsom up against?

DANA BROWN: You're right that it [00:41:00] makes sense to expect backlash in the current kind of political climate that we're in and also given the power of Big Pharma. But to echo Kevin, A, this is a pragmatic solution that I think is really bipartisan in nature. And the people that conveniently say, oh, it's California, therefore it's a radical thing. But you have to remember the state of Massachusetts has been producing vaccines and other biologics, biologic drugs in the public sector for over 125 years. The state of Michigan used to do it in the public sector; their lab was privatized in the nineties, but now there's a resurgence of interest from a Republican state senator who's been talking to the Democratic governor about reviving that tradition of producing drugs in the public sector.

A, this is a tradition in the United States. We've developed and produced medications in the public sector at various scales, from small public health labs at the municipal level to nationally under the Department of Defense, and this has been going on for [00:42:00] a century or a century and a half.

So really, we're actually just relearning how to do something that we already knew how to do as a country, and in terms of how can the public support, follow the Insulin for all folks on Twitter and social media, they will keep you focused on the prize. And really, I think, too, I, we just have to remember that we are "We the people" and the public sector belongs to all of us, and it's just our job to help remind it that it's supposed to work in our interest.

Bonus The Challenge of Caring for Our Elders Part 2 - The Brian Lehrer Show - Air Date 11-15-23

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: Reed, you found that in many instances that was part of what people had to do, that in order to qualify for Medicaid coverage, people needed to reduce their assets. Is that correct?

REED ABELSON: Yes that's very much correct.

And I think, what's very tough is sometimes you have a couple, and the question then becomes do we spend everything down, but then what happens to the surviving spouse or partner? And that's a truly [00:43:00] difficult decision. We came across some families where the decision was to keep someone at home, even though at times that they were at risk. And we found in other cases, the decision was yes, we'll spend down and hope for the best if the healthier spouse survives.

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: In your reporting, Reed, you note that the U. S., compared to other wealthy countries around the world, really lags when it comes to national response and investment in long term care. But just for our perspective, how far behind are we? How much does the U. S. not invest in these needs?

REED ABELSON: It's interesting. I think we truly don't invest, we're behind a lot of other European countries. And what's frustrating, obviously, is that there have been a series of attempts, but we've never had the political will, and maybe even the cultural will, to tackle this.

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: And, that's very much why we're [00:44:00] having this conversation, because obviously if we had better federal policies in place, we wouldn't be worried about the patchwork that doesn't seem to be holding together. But some policies have been proposed. What are some of the measures that Congress has considered, and what kind of political opposition have they faced?

REED ABELSON: I think there is an argument and, many Republicans argue this, that this is something where people really have a responsibility to save, or to take other planning steps trying to find a long term care insurance policy.

But Congress has tried to address this. President Biden tried to increase some funding so that caregivers were paid more, but that funding was dropped in the final legislation.

The difficulty is that this costs money. And so far, there just really hasn't been an appetite to fund this kind of care.

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: I want to go to Fred in Manhattan. Fred, thanks for calling [00:45:00] WNYC.

CALLER: Thank you for taking my call. I am a 67-year-old single son of someone who's about to turn 101. I took care of her sister, her brother, my father. I'm very good at it, and I get them through very old ages in pretty good shape. But it has entirely ruined my career and my earning potential.

And a very specific recommendation that I would make, among many, Is that social security benefits be provided, or the credits be made, for people who basically have given up their own work in order to care for others. If I were a paid caregiver, I would get social security benefits. As someone who cannot be paid because I'm a relative, I had to give up everything. And I do it out of love, and I am proud that I've gotten my relatives to such good ages and such good shape. But there's no awareness of the next generation. When COVID [00:46:00] came, we avoided COVID, but I had to basically lock down with my parent for four years. And she's still alive, and she's still managing, but cannot manage on her own even for five minutes. So it requires constant presence.

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: Fred, thank you so much for your call, and thank you for everything that you're doing for your family. They are very lucky to have you. Reed, what I think Fred is suggesting there in terms of a credit sounds similar to what you said President Biden had attempted to include in the Build Back Better. But it seems to be very hard to get the political will to support those kinds of policies.

REED ABELSON: Yes. I think it is possible that there could be specific changes to things like Social Security or trying to do tax credits, and I know under Medicaid, some Medicaid programs, family members who are caregivers can [00:47:00] get paid. But it's very difficult, and we don't take a sort of step back and think broadly about how to make lives better for people.

And I do want to echo that one of the true findings was that even when children managed to get their parents through, they were convinced -- and probably appropriately so -- that their own retirement years and older years would be

really much more challenging. That they had either spent a lot of money, that they didn't have a pension, that there were a lot of factors that were going to make it even more difficult for them.

BRIGID BERGEN - GUEST HOST, BRIAN LEHRER SHOW: Some of the other interesting -- there's so much that is in this series that we could talk for a very long time. But I wanted to spend a little bit of time seeing if we can offer some news or information people can use. One of the findings that I was struck by was that fewer than half of American adults have seriously discussed long term plans with a loved one. From your reporting, from everyone you spoke to, what kind of conversations do you think people should be having, and when should they be having them?

REED ABELSON: I think they should be having them early on, [00:48:00] before there's a crisis. And it's absolutely true that we spoke to a lot of families who were in a crisis mode with having never really talked to their parents about what their financial situation was, and even more importantly, what their wishes were. And so I think that's a conversation definitely worth having. Thinking about, are there steps that one can take now to make it easier later? And what can they do? How can they think about this?

So I agree with you. That was stunning to me that more people hadn't had that discussion.

Final comments on more good news from the fight against climate change

JAY TOMLINSON - HOST, BEST OF THE LEFT: We've just heard clips today, starting with *Democracy Now!* replaying an interview of theirs with Ady Barkan. *The Weeds* explained the origin of our private health care system. *Code WACK!* looked at California's efforts to implement universal health care. Thom Hartmann explained the process of achieving universal health care one state at a time. *Democracy Now!* reported on the [00:49:00] Biden administration's efforts to reign in the cost of prescription drugs. *Economic Update* described the difference between health and healthcare. And the *Laura Flanders Show* looked at the option of producing vaccines and other drugs as part of the public commons.

That's what everybody heard, but members also heard a bonus clip from the *Brian Lehrer Show*, looking at some of the challenges in longterm care for elders. To hear that and have all of our bonus content delivered seamlessly to

the new members-only podcast feed that you'll receive, sign up to support the show at bestoftheleft.com/support, or shoot me an email requesting a financial hardship membership because we don't let a lack of funds stand in the way of hearing more information.

Now to wrap up today. I just want to acknowledge that we've been a bit more positive than usual, which might feel a bit off-brand for us. I know you don't come to *Best of the Left* expecting to be uplifted. So, if that's been off putting for you, I apologize. Besides today's [00:50:00] episode looking at some progress being made toward a more just health system, we've recently been looking at positive visions beyond neo-liberalism, hopeful experiments to fight climate change, and, coming up, we're even going to look at some utopian visions to try to counteract all of the predictions of dystopia that we are practically swimming in right now. But not to worry: democracy is still on the brink in multiple countries around the world and, uh, I want to assure you that we will be panicking about that soon enough.

But for today, I am sorry to say that I have a little bit more positive news to share. Just a day or two after publishing our episode on new high-tech geothermal drilling techniques that have the potential to breathe new life into the geothermal industry and make clean energy from below ground available in vastly more places around the world, this story from the AP caught my eye. The headline is "New Google geothermal electricity project [00:51:00] could be a milestone for clean energy". And keep in mind, the *TED Talk* that we heard in our climate episode describing this exact new geothermal design was a couple of years ago, and it was talking about how we may be on the brink of implementation. Well, here, we all are already living in the future as this story describes this new power plant that has just come online. From the article, "An advanced geothermal project has begun pumping carbon free electricity on to the Nevada grid to power Google data centers there", Google announced Tuesday. And the CEO of Fervo Energy, that's the company that Google partnered with, says, " I think it will be big and we'll continue to vault geothermal into a lot more prominence than it has been". And this current project is basically just a pilot program to prove the concept. It's adding around 3.5 megawatts of energy onto the grid. And you don't need to know how much 3.5 [00:52:00] megawatts is to know that it's a lot less than 400 megawatts. From the article, "Fervo is using this first pilot to launch other projects that will deliver far more carbon free electricity to the grid. It's currently completing initial drilling in Southwest Utah for a 400 megawatt project. And then the article goes on looking at the bigger picture. It says, "Google announced back in 2020 that it would use carbon free energy every hour of every day wherever it operates by 2030. Many experts believe huge companies like Google can play a catalytic role in accelerating clean energy". And the head of decarbonisation for

Google noted that the company was also an early supporter of wind and solar projects, helping those markets take off.

But wait, there's more. The article continues talking about the governmental angle. "Last year, the Energy Department launched an effort to achieve aggressive cost reductions [00:53:00] in enhanced geothermal systems. This month, in announcing 44 million to advanced geothermal deployment nationwide, DOE said the United States has potential for 90 gigawatts of geothermal electricity, the equivalent of powering more than 65 million American homes by 2050". And then finally, it was discussed in Jamie Beard's *TED Talk* featured in our climate episode that as counterintuitive as it may be for environmentalists, it may actually be former oil and gas engineers who are needed to bring their drilling expertise to the geothermal industry if it's going to be able to scale up fast enough to make an impact. Well, it turns out, unsurprisingly, the CEO of Fervo Energy is a former drilling engineer in the oil and gas industry who's now helping transition away from coal, oil, and natural gas as quickly as possible to reduce carbon emissions, according to the article, and of course make money for his company, obviously. The [00:54:00] article doesn't mention that. And that fact, you know, may very well have been important in the actual working of the company, but it was definitely impactful in terms of the company being able to get funding to do its work. A partner with an investment firm that actually bought into the company, said that they invested "primarily because the company was really ready to start adding energy to the grid while others were lagging behind", and the that, referring to the CEO, "it's a plus that Latimer used to run a drilling rig. It was the right team who knew what kind of company that we're building". And I'll admit it does feel pretty weird to be cheering on oil and gas engineers because I never foresaw that there would be a path for them, not just ideologically, but like literally. I didn't foresee that there would be a path for them to be able to pivot away from fossil fuels. But here we are.

Oh, wait, there is one last thing. I'm not sure that the point was hit [00:55:00] hard enough in the climate episode - the importance of the fact that geothermal is a 24 7 clean energy source - solar and wind will still have their place undoubtedly, but the biggest criticism of them has always been that the sun doesn't always shine and the wind doesn't always blow. And that's true. But it's not just that they can't generate energy during those times, and so that's a bummer, it's that it means that there needs to be some other source of what's called base load power generation that is always partnered with solar and wind. And it's always been assumed that that would need to continue to be some version of fossil fuel or potentially nuclear. And advanced geothermal being a clean energy with the ability to provide base load power 24 hours a day is a real

game changer. Again, apologies for all the good news. I'm as surprised as anyone.

That is going to be it for today as always keep the comments coming in. I would love to hear your thoughts or questions [00:56:00] about this or anything else you can leave us a voicemail or send us a text 202-999-3991, or simply email me to jay@bestoftheleft.com. Thanks to everyone for listening. Thanks to Deon Clark and Erin Clayton for their research work for the show and participation in our bonus episodes. Thanks to our Transcriptionist Trio, Ken Brian, and LaWendy, their volunteer work helping put our transcripts together. Thanks to Amanda Hoffman for all of her work on our social media outlets, activism segments, graphic designing, web mastering, and bonus show co-hosting. And thanks to those who already support the show by becoming a member or purchasing gift memberships at bestoftheleft.com/support. You can join them by signing up today, and it would be greatly appreciated. You'll find that link in the show notes, along with the link to join our Discord community, where you can also continue the discussion.

So, coming to from far outside the conventional wisdom of Washington, DC, my name is Jay, and this has been the *Best of the Left* podcast coming to twice weekly, thanks entirely to the [00:57:00] members and donors to the show from bestoftheleft.com.