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Marianne O'Hare: Welcome to Conversations on Health Care. This week, we welcome Dr. Georges Benjamin, President of the American Public Health Association, on the pandemic, disparities, and the crisis in public health.

Dr. Georges Benjamin: Public health has been so undervalued and underfinanced for many years that the money that did go out built one-time capacity and not long-time capacity.

Marianne O'Hare: Lori Robertson joins us from FactCheck.org. And we end with a bright idea, improving health and wellbeing in everyday lives. Now, here are your hosts Mark Masselli and Margaret Flinter.

Mark Masselli: Our guest represents over 25,000 members, whose organization states it's the only one that has the ability to influence Federal policy to improve the public's health. He's a physician who's been leading the American Public Health Association for 20 years.

Margaret Flinter: Dr. Georges Benjamin oversees the push by APHA to make America the healthiest nation in one generation. But there are many challenges, COVID of course being one of the most devastating.

Mark Masselli: Dr. Benjamin, welcome back to Conversations on Health Care. And congratulations to you and your service and APHA's 150th anniversary.

Dr. Georges Benjamin: Yeah, it's a great birthday, a 150 years of age.

Mark Masselli: Oh my God! Well, I am feeling like a relative pop. We just turned 50, so I am feeling very youthful. But again, congratulations to you, and the entire membership. But let's start with the news that the Center for Disease Control and Prevention Director Dr. Rochelle Walensky says they are going to develop new systems and processes to deliver their science and programs to American people, along with the plan for how CDC should be structured to facilitate public health work. We know this is in the early stages, but share with us the advice that you have offered to CDC on the direction they should head.

Dr. Georges Benjamin: Well, you know, look, the CDC is an amazing organization, scientific organization, and they do extraordinarily good work. But if you think about it, they in many ways perform like academic institution, lots of thought, lots of science, and then it takes forever to get the information out. And what we really want them to function at, because they now need to do that in this modern world much more like an emergency preparedness

entity. They have got to do fast science that's accurate and timely. They have got to make rapid operational decisions, and they need to give good guidance to the public as they go forward. And so that means they have to think differently, and they have to maybe in many ways be organized differently. And so they are looking at whether or not they can do that as one way of trying to improve their performance overall.

Margaret Flinter: Well, Dr. Benjamin, another piece of big news is there is a deal in the Senate for an additional $10 billion for the COVID-19 response. But, you know, there is still pushback that public health departments need to be more accountable and maybe more transparent for how they have spent the money so far. Do you think this is a legitimate complaint, and is this something that health departments and health directors around the country are working to improve upon?

Dr. Georges Benjamin: Well, look, we always want to be transparent and responsible for taxpayer funds, and remind people that governmental public health has enormous accountability and enormous oversight. Every elected official, they meet legislative committees. They have mayors and governors and boards of health they have to be responsible to. So, it's not about accountability. Health departments are accountable. But, we have to recognize that a lot of money went out. But a lot of money went out in ways that are difficult to not account for, but the timing is everything.

And so people know where the money is, but public health has been so undervalued and under-supported, underfinanced for many years that the money that did go out built one-time capacity and not long-time capacity. And this new $10 billion agreement is going to help a little bit more, but in many ways, it's really a drop in the bucket on what's needed to give every community the capacity and supports that we need anytime a new health threat enters the community.

Mark Masselli: Well, I think you hit the right point there, the woeful underfunding that public health has had for decades. But I also want to talk about something else in that bill, or not in that bill, talking about underfunding, is that more money for international vaccine support also continues to be underfunded, and it is not in this compromise bill. Isn't it shocking that we are still arguing over the fact that COVID transcends national borders, and that it's in our country's best interest to make sure that people all over the globe are vaccinated?

Dr. Georges Benjamin: Yeah, you know, that's the real challenge we have here, is that we are going to take this $10 billion because we need it, and we need it urgently. But, we have to get the funding for the

international component of this because there is going to be another variant, and that variant is going to come from somewhere. It may come from out of the country, or it may come from somewhere in this country. But this pandemic is not over yet. It is transitioning, and we are going to need to make sure that we have the adequate resources to do this.

Margaret Flinter: And Dr. Benjamin, one of the things that we saw throughout this whole period of COVID, and that was so difficult to see, were some of the attacks and the confrontations, everybody from school board officials, to school teachers, to public officials. But I saw a study recently that as many as one-third of local and state public health officials who left their positions during that first and very tumultuous year of the pandemic, reported having been harassed. We haven't been suffering from an overabundance of talent out there in the field already, this has got to make recruiting for open public health positions even tougher. What are you hearing from the field from your membership and from your people out in the field about how much this has affected being able to bring people into public health?

Dr. Georges Benjamin: It's going to be a challenge. You know, there's a lot of people that hung on just because they had a need to help the public; they felt it was important to do this work. But, nobody wants to work in a hostile work environment. And quite frankly, many people now have found themselves in a hostile work environment, and the real tragedy in so many situations is their bosses didn't have their back. And so we have got to do several things. Number one, we absolutely have to reestablish the rule of law. No judge would tolerate the kind of behavior that occurred in some of these town halls in their courtroom. And security officials, police officials need to stand behind those public officials in those meetings.

The public needs to treat them with respect, and of course, we always have to treat the public with respect. So, we need to reestablish thoughtful debates. That doesn't mean people won't get mad. That doesn't mean people won't raise their voices, but, it still has to be done in a way that nobody feels threatened. And we have to do that very, very quickly, because if we don't do that the next time we have something really bad happen, the people that are best equipped, the smartest people in the room, they are not going to be there to help us. And I want to make sure that there is a good public health system for my grandkids.

Mark Masselli: Well, I want to pull the thread on the thought that we are a divided country, and yet the data suggests that there is a higher

mortality rate in counties that voted Republican in the 2020 Presidential election where the pandemic guidelines were less likely to be in place, compared to the counties that voted Democratic. Is this the case where only some parts of the United States have an issue of trusting public health? Perhaps we don't have a nationwide crisis, but we have one that's a little more segmented.

Dr. Georges Benjamin: Well, we have different views politically in this country, there is no doubt about that. But nobody wants to have the water not safe to drink, the air not safe to breathe, and the food not safe to eat. Nobody wants to get infected from an infectious disease. And we have to continue to speak truth to power, and the outcomes that you just talked about are the results that in some communities we had elected officials, as well as [inaudible 00:08:18] and other influencers who quite frankly gave a lot of misinformation and disinformation.

It certainly politically has, you know, tracked along red and blue lines, but I just have to say there are certainly some conservative communities, some Republican communities where those governors and elected officials did the right thing. My governor Hogan in Maryland, did the right thing. Governor Deval [PH] did the right thing. But, there are communities where people did not do the right thing, they did not follow the science, and we need to call them out when they do something that's wrong like that, and then we need to support people that are strongly in support of the evidence and science.

That doesn't mean we don't have to listen to the public. And I think far too often, people were saying, "I want to do the right thing, but I don't want the government to demand that I do the right thing." And so we just got to figure out how we incentivize people differently. But at the end of the day, sometimes we have to put in mandates, because if you don't do that people get sick and people die. And, you know, we have just got to come to some consensus about how to do that, and we just have to continue to push until we can get our nation back together on a reasonable pathway to improve the public's health.

Margaret Flinter: Well, I think Dr. Benjamin, we are all in agreement that we yearn for the country having kind of a unified voice. Doesn't all have to have the same opinions, but have, as an op-ed writer with the New York Times said recently, a healthy distance maybe between a group like the CDC and our political leaders that would give the agency a chance to very quickly and transparently communicate information so that public -- even when it may not be politically convenient. I wonder what your

thoughts are on that. Do you think there needs to be a sort of separating out of the CDC messaging from the rest of the administration?

Dr. Georges Benjamin: You know, the challenge we have is that CDC needs to continue to do the good science-based evidence that they do. But we have got to come to the grips with the fact that public health does most of what it does through change in policy. If you are going to change policy, you are going to be in a political arena. That doesn't mean that we need to be politicians per se, but I do think we need to understand political science, and I think we need to improve our risk communication. We need to build those trust relationships before we need the trusting relationships.

That means going in the community, with people that disagree with you, and talking with them and building that trust. You can't do that behind the desk. You can only do that by getting out and going in the communities, whether they are progressive or conservative, and getting trusted messengers, and we need to build a communications system so that when we see people saying really crazy stuff that has no evidence-base, we can push back. And quite frankly, the people that have the time to give the wrong information, are out there doing it each and every day for nefarious purposes. And we, as the public health community, need to have a better communications system. It needs to be funded and supported so that we can compete in that environment.

Mark Masselli: It's very interesting. I am thinking you have got many challenges in your role leading the APHA. The theme of the National Public Health Week this year is Public Health is Where You Are. But it seems that too many Americans don't see the connection or trust in public health, and I am wondering this is a little like I don't like Congress but I like my Congressmen and women, right?

Dr. Georges Benjamin: Yeah.

Mark Masselli: As you think about the challenge you have, is there somewhere else in the globe, another country that you think you could look to as an example of what they are doing right? Is there anything that as you think about your strategy that you blend in from other parts of the world?

Dr. Georges Benjamin: Well look, you know, Taiwan did this pandemic fairly well. They have got a very comprehensive public health system. South Korea has one. Canada and Britain, although they have done some things to undermine their system in the last several years,

we want American model system. We love our own stuff, you know. But, in the United States, we have a Federal-state-local partnership, and we need to invest in that partnership in a way that is going to improve the public's health. So that means we need to modernize the resources that we have. We need to bring our technology systems into the modern age.

Look, there's something called the fax machine. I know that many of your listeners don't know what a fax machine is, but that's how the old folks used to move paper over the wires from one point to another. And that's how public health was moving our data, using something called pens and pencils to write with. Now my children don't know what that stuff is, you know. My point is, you know, everybody is able to move data around the world much faster than the public health and health care system works, and we need to modernize that data system so that we can make decisions in real time rapidly, so we can make data-driven decisions.

We need to have the technology that is available now so that when we get a new microorganism that enters the community, we can look at its genetic structure very quickly to decide whether it's new and something we need to be worried about. Right now the technology is there, but it just takes us far too long to do it. Other nations like Britain were able to track their strains very, very quickly. Now we have built up that capacity in United States, but it's still not where it needs to be. And quite frankly, while this was happening, Congress was still debating over dollars for public health, which quite frankly the amount of money they want to put on the table is a rounding error in the Federal budget. So I just think that we need to -- if we are serious about this, we need to act like we are serious.

Margaret Flinter: Well, Dr. Benjamin, I know we can't say that COVID is in the rearview mirror yet. People have been telling us for the last couple of years that there will be other pandemics in the future that we will have to deal with. So we are all in learning mode about how we do things better. But we had scientist William Haseltine on the show in the past, and he argued for a much more aggressive top-down public health initiative that worked elsewhere to control COVID, would have worked better here, maybe would be better in the future. I am not sure if all of our listeners even have a good sense of how public health is organized around the country, but what's your thought about that focus on top-down approaches versus more state by state?

Dr. Georges Benjamin: Well, health care as you know in this country is very decentralized, whether it's public health or medical care. And

you know, we certainly would benefit from a more structured approach. Until we change this issue called Federalization, our system, where public health is actually governed at the local level, and the laws that allow you to do stuff at the local level, would have to be changed, and we would have to go through a national discussion to change that. Bill is right, that you can get a lot more guidance if you get a lot more consistency in what we do. But I got to tell you it's going to be a governance challenge.

Right now you saw the governors were really excited about support until it became politically untenable for some of the recommendations that came from the Federal level, and then they went off on their own. So I think that's the challenge we have to have, getting that consensus, keeping that consensus, and providing that support long term. But until we build, and everyone has agreement on what the public health system in United States of the future ought to look like, we are going to continue to be vulnerable to new health threats as they enter the community.

Mark Masselli: Well, you are down in Washington. At your Washington office, big day today in Washington, President Biden is going to host former President Barack Obama as they talk about the Affordable Care Act. Tell us, maybe underscore the benefit of the Affordable Care Act, its impact that's been on the health, and really focusing also on the equity lens of how it's helped transform, still work to be done, the lives of so many people throughout America.

Dr. Georges Benjamin: Well, you know, we are the only nation, industrialized nation, in the world that does not have a system for health care with everyone in and nobody out. The Affordable Care Act has gone a long way to making sure that everyone has quality affordable health care coverage. Having said that, it also has gone a long way in improving the health and wellbeing of Americans overall. In fact, in states which have not expanded the Medicaid coverage in their states, they are not doing as well from a health perspective as those states that have expanded Medicaid coverage.

President Biden has invited back President Obama to both celebrate the Affordable Care Act, but to also try to do some things to fix some of the glitches. So there is something called the family glitch, where people who're not eligible because of income. As an individual they are eligible, but their family isn't. And so they are going to try to fix that with tax credits, with a proposal on tax credits. And then they are going to go from one of the lessons that we learned during the COVID pandemic

where we enhanced the premium support for people in the health exchanges. We gave them more money and we reduced the cost of health care for those individuals. And they are going to be proposing that they expand that. So I am excited about that.

Mark Masselli: That's great.

Margaret Flinter: I don't want to miss this opportunity when we have you with us, to give you a chance to maybe just speak about health equity a bit more. Certainly right along with COVID over the last couple of years there has been a renewed focus on health equity, on what it means, and what we can do to assure that everybody in the country has access to health equity. What are you doing at the APHA to keep that front and center even as we are dealing with all of the other issues around COVID and various other threats?

Dr. Georges Benjamin: Well, we have certainly recognized the fact that health disparities exist, and tragically COVID has shown to the whole world the impact of not having a system with everyone in and nobody out, where people are treated differently based on race and ethnicity, socioeconomic status, based on gender, based on sexual orientation in many situations. Those tragic inequities in our system result in preventable illness and death, and COVID showed us very clearly how that happens. So the people that had to go to work, were much more likely to be exposed to COVID, and people with chronic diseases, disproportionately based on race and ethnicity, were much more likely to get really sick and die if they had COVID.

And Reverend Barber in the Poor People's Campaign just put out a report just the other day which shows that people who were uninsured, were much more likely to get sicker and die sooner if they had COVD. So, we know that socioeconomic status and these "social determinants of health" are important, and American Public Health Association is pushing on all of those. We are trying to adjust things like housing that impact health, education that impact health, economics that impact health, and now by the way voting is now becoming a social determinant of health.

So, we are encouraging people to get up and vote and be part of the process, because being part of the process determines who controls the purse strings in our country, and who controls your access to health care. So we are strongly pushing on that. We have declared racism as a public health problem. We particularly structured racism and try to do things to create systems and programs for people to address those policies that we know that

either help us become healthy, or impede our health.

Mark Masselli: That's great. You know, the APHA, as you know, does so many things, and one of the things it's very focused in on is tracking legislation at the state and Federal level. There are a number of bills that APHA has stated would directly harm transgender people, particularly transgender youth. Are all public health departments onboard with your position around that?

Dr. Georges Benjamin: Well, I don't know if all the departments are onboard, but I think from a moral perspective we have to treat everybody equally. We have to recognize that access to medical services and surgical services for all people is important, including people who are transgender, and that these efforts to, you know, really stigmatize people and take away their supports, is really foolhardy. And we need to leave medicine to the health providers.

I am very happy to be attorney general if you want me to be attorney general, but I don't think that I am the right person to be attorney general. And I absolutely am clear these lawyers don't need to be trying to practice medicine. They haven't gone to medical school, they don't understand the science, and while they are pretty smart people, they need to, as they say, stay in their lane.

Margaret Flinter: Well, thank you Dr. Benjamin for your time today, for your decades-long commitment to health and to public health. We are proud to be part of the public health sector as well. We are all trying to do what we can to improve health in this country. And thanks to our audience for joining us. You can learn more about Conversations on Health Care and sign up for our email updates at www.chcradio.com. Thank you so much Dr. Benjamin.

Dr. Georges Benjamin: Thank you.

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Mark Masselli: At Conversations on Health Care, we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. Politics. Lori, what have you got for us this week?

Lori Robertson: Senator Rick Scott went too far in claiming that Medicare will go bankrupt in four years, and Social Security in 12 years. Government trustees project that certain Medicare and Social

Security trust funds would become depleted by then, but payments would continue albeit at a reduced rate. Scott made his remarks on Fox News Sunday when host John Roberts asked the Florida Republican about his 11-point plan to rescue America. That's Scott's blueprint for a Republican-controlled Congress after the 2022 elections. Scott's plan calls for sunsetting all Federal legislation in five years, forcing Congress to act if it wants to keep Federal programs.

It also calls on Congress to "issue a report every year telling the public what they plan to do when Social Security and Medicare go bankrupt." Scott told Roberts, "No one that I know of wants to sunset Medicare or Social Security, but what we are doing is we don't even talk about it." He continued, "Medicare goes bankrupt in four years; Social Security goes bankrupt in 12 years." The long-term financing of Social Security and Medicare has been and remains a problem, but such bankruptcy claims could leave the wrong impression. Neither program is going out of business.

The two Social Security trust funds, the Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund combined, would be depleted by 2034 according to the most recent report by the Social Security Board of Trustees. But even if the trust funds are depleted, the program would still collect enough in annual tax revenues and interest payments to pay about three quarters of the benefits now promised. As for Medicare, the Hospital Insurance Trust Fund, which helps pay for inpatient hospital care under Medicare Part A, is expected to be depleted in four years, by 2026 according to the Medicare Board of Trustees. But the continuing income for Part A would be enough to pay 91% of total benefits, the trustees said.

The Hospital Insurance Trust Fund is financed largely through a payroll tax, which is currently 1.45% for the employer, and 1.45% for the employee on earnings up to $200,000. There is an additional Medicare payroll tax of 0.9% that individual employees must pay on earnings above $200,000. The trustees have been warning about the depletion of the Part A Trust Fund since 1970, but the trust fund has never been depleted.

And that's my fact check for this week. I'm Lori Robertson, Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players, and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com. We'll have FactCheck.org's Lori

Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Baltimore, Maryland has one of the highest emergency medical call volumes in the country, and it results in a significant number of patients being taken to the ER for conditions that could have been treated outside of the ER. The University of Maryland Medical Center and the Baltimore City Fire Department teamed up in the hopes of reducing unnecessary ambulance trips and hospitalizations.

Dr. David Marcozzi: How do we all start to address health issues more comprehensively than simply calling 911, being transported to an emergency department when that is not optimal care for patients?

Margaret Flinter: They created a new pilot program which pairs doctors and nurses at the hospital level with paramedics in the field, bringing medicine right into the patients' homes.

Dr. David Marcozzi: So then we co-dispatch a paramedic and either nurse practitioner or doctor to the scene of low acuity calls, ask the patient whether or not they would like to be treated at scene, and we then enroll them into our program, register them there just like a mobile urgent care center. We then treat them at scene, discharge them with the same exact paperwork we discharge them from the hospital.

Margaret Flinter: Dr. David Marcozzi of the University of Maryland Medical Center says that this mobile integrated health care community paramedicine program has a two-pronged goal, reducing unnecessary trips to the ER by delivering right care at the scene. The pilot also seeks another goal, to keep vulnerable patients being released from the hospital healthier with paramedics doing frequent follow ups over a 30-day period to ensure that patients are compliant with their medicines, are getting enough to eat, greatly reducing the risk of rehospitalization.

Dr. David Marcozzi: Once you understand the challenges when we discharge a patient, or when patients are seen for low acuity issues, people face just at home to navigate the insurance industry, the multiple providers they are supposed to follow up with, the challenges that individuals face certainly here in Baltimore, and we are exploring could we do this for longer, or is there a better way once we hopefully empower folks to transition to maybe a

lower resource intensive setting for THS Transitional Health Support, the 30-day follow-up program. Our data demonstrates that the patients who are followed in our program, utilize and are admitted to the hospital significantly less and utilize the health care primary care services significantly more. That translates into lower cost to the system from a physician billing construct, from a hospital construct, and oh by the way from an EMS construct. Because you know what happens, those patients typically call 911 to get to the hospital.

Margaret Flinter: But most importantly he says the patient outcomes are markedly improved. The mobile integrated health care community paramedicine program, rethinking how paramedicine is deployed in the field, reducing unnecessary emergency room trips, and by the way making sure that the emergency responders can respond that much more quickly to the true emergencies, now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care. I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Marianne O'Hare: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at www.chcradio.com, iTunes, or wherever you listen to podcasts. If you have comments, please e-mail us at chcradio@chc1.com, or find us on Facebook or Twitter. We love hearing from you. This show is brought to you by the Community Health Center.