

KHN's 'What the Health?'

Episode Title: Biden Declares the Pandemic 'Over'

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Julie Rovner: Hello and welcome back to KHN's "What the Health?" I'm Julie Rovner, chief Washington correspondent at Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Sept. 22, at 10 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today we are joined via video conference by Joanne Kenen of the Johns Hopkins Bloomberg School of Public Health and Politico.

Joanne Kenen: Hi, everybody.

Rovner: Anna Edney of Bloomberg News.

Edney: Good morning.

Rovner: And from St. Louis, my KHN colleague Lauren Weber.

Weber: Hello, hello.

Rovner: Lots of news this week, so we will jump right in. And we will not discuss NyQuil Chicken. Google it if you don't know what it is. Or, better, don't even bother.

Edney: Thank you. Thank you, Julie.

Rovner: So it appears that the pandemic is over, or at least it is according to President Biden in his "60 Minutes" interview last Sunday. But even though the president tried to contextualize his remarks to suggest that covid isn't quite over, it's still a problem, as he called it. That's not the way his remarks were taken. Among other things, this complicates the administration's efforts to get Congress to provide more funding for covid testing, treatments, and vaccines. And it has some Republicans demanding an immediate end to the public health emergency that's keeping millions of people around the country on Medicaid, among other things. How much of a flub was this? Or was it an actual effort by the president to start the process of winding down our perception of covid and what it's doing to our society?

Edney: Well, I don't know if it was anything intentional on his part. It felt like a flub in the sense that the administration is trying to still get more than \$20 billion from Congress for help with covid. I think it reflects an inability to talk about where we are right now. Like, I know a lot of people want to say it's over. And the president said, "Look, nobody's wearing masks at this auto show." But there is this maybe, you know, we're not seeing hospitals overflowing, but there are still 300 to 400 people a day dying — that's a huge number — from covid. And I think there's no way to talk about it without saying either "it's that bad" or "it's over," and there's no middle ground of "we got used to something really, really bad, and now it's just bad."

Rovner: That's actually as good a description as I've heard. Lauren?

Weber: Yeah. I just wanted to say, too, I think this is just very emblematic of the inability of officials to communicate properly about the gray of covid for almost the entirety of this pandemic. It's either black or white. "It's over" or "it's happening." And the reality is, as you pointed out, 300 to 400 people dying a day is a massive amount of people. But the way that crisis communications in this country appears to work around covid has been really flawed. And I think that the inability to speak to that gray really becomes a

problem for the president when you go and ask for money from Congress and so on, and we'll see how that continues to play out over the next couple of weeks.

Kenen: I mean, Biden has always been ... This is not the first time he's been called the "shoot from the lip" politician. And he's ... Whether he was trying to make a subtle point, that subtlety is not his strong point. Or whether he just blurted something out very inartful. None of us are in his head. But like my colleagues have said here, the way to talk about it is: "The covid pandemic is much less severe. We hope the worst is over. We have to still take steps to keep making progress and to keep making it manageable." And he didn't say anything remotely like that, even if he might have thought he did. So there are days it's still almost 500 dead. I mean, it's a lot of people dying every single day. There are a lot of people who, because of health issues, cannot resume a normal life. Many people can resume a modified version of normal life. Right now, you've just launched this new booster, the bivalent boosters. People don't understand what the word bivalent means. People are distrustful: "Well, why should it work against this variant if it didn't work with that variant. I've already had three [shots]. How do I know it lasts a year?" I mean, it couldn't have come really at a worse time, as we want uptake of these boosters and we want to be able to say ... We can't say they last a year because we don't know they last a year. We can say, "We have reason to believe that we may be entering the era where you can just do it once a year like you do your flu [shot], and we'll all be safer." But there's unknowns. So, yeah, in terms of both either the public response to boosters or the congressional response to budgetary needs, it was not useful.

Rovner: And my pet peeve on the communication tier is that now people are going out and getting their covid booster and their flu shot at the same time. And it's early to get your flu shot. And if we're going to have a bad flu season, you would like your flu shot to last not through February but through April or May. I personally am getting my flu shot in October, which is when I always get it. So that's my little public health service.

Kenen: They'd rather you get your flu shot than not get your flu shot.

Rovner: Than not get it at all. I get that. But you can go get your covid vaccine now and your flu shot in a month. Probably fewer side effects, too. All right. We will see how this progresses, both in terms of we're getting toward the end of the fiscal year, so Congress is going to have to put up or shut up or kick the can down the road in terms of money.

Kenen: I mean, we just haven't come up with the national equivalent of an adult lollipop.

Rovner: Yeah. That's what we need. So I wanted to actually spend some time this week talking about the business of health care because we haven't in a while and we've had a lot of news that sort of stacked up. So I want to start with good news and bad news on the health care inflation front. As we have talked about many, many times here on the podcast, the passage in August of the Inflation Reduction Act means that most premiums won't go up for people who buy their insurance through the Affordable Care Act. But the same can't be said for people with employer coverage because, like everything else, medical care is getting more expensive. And while employers don't want to raise costs for workers while we're having a labor shortage, at some point they're going to have no choice. So what does the return of medical inflation, which we haven't really had in a big way for as long as we haven't had high interest rates, mean both politically and substantively for people?

Edney: Well, I think what I've read about it is that what makes sense is typically these contracts that employers might make with insurers or anybody in the health care system, that they last a few years. And so, they were safe for a little bit, but these things are going to start expiring and needing to be renewed.

Rovner: It's also the contract between the insurers and the providers.

Edney: Exactly. Anybody in the system. Yeah.

Rovner: Yeah. Medical costs are a lagging indicator, as they like to say.

Edney: That's a good way to put it, I think. And employer-sponsored health insurance is not something that gets the same attention as anything that the government is more involved in, I guess.

Kenen: The interesting thing, and I don't understand this entirely — because I've been reading about it and I've been meaning to write about it and haven't had a chance yet. We're in an era of very historically high inflation, the highest in decades. All of us go to stores, and all of us see the prices. The health care components are actually lower than inflation, and that's unusual. Usually, health care is growing faster than the rest of the economy. Right now, drug prices, hospital prices, medical prices, their monthly reports have been lower than the rest of inflation, and yet the insurance contracts are coming in as quite high. So I don't entirely understand that yet. Is that because they can? Is that because they're all these messed-up things in the health care system accumulating because of covid and the related impact and that it's about to hit? Is it because worker shortages and wages are going up? I mean, I don't entirely understand.

Rovner: I think some of it, though ... There is no medical care other than covid given for like a year and a half. I mean, people just didn't go to the doctor.

Kenen: Yeah, but it has picked up again.

Rovner: And then, I would say, people started going again. So there's been this huge induced demand of people who missed all their cancer screenings in their checkups and their dental work and all the stuff that they were going to have done but didn't because they didn't want to go to a health care facility during covid. So you've got these kind of weird ebbs and flows.

Kenen: You're probably also anticipating the government is going to stop picking up some of the costs, so they haven't had a chance to unpack it. I mean, I've noticed this difference between relatively low inflation for health care services and an upcoming big insurance spike. I mean, I'm seeing it both in the national figures and also what I'm expecting at my own shop. There's connections I don't entirely understand yet.

Rovner: Yeah, I think we're waiting for health economists to explain all this stuff. I think they're trying to sort it out, too. So there's lots of things that are pushing medical spending up, but one is very clearly the increasing participation in the health sector by private equity. In other words, people getting into health care primarily for the profits that it can provide. Lauren, you have [a story](#) just this week about yet another specialty that's caught the eye of private equity. Tell us about it.

Weber: I love to see a pun from you, Julie. Yes. I wrote a story about the investment of private equity into the eye care space, and it's pretty vast. And over a decade, we went from about a handful of ophthalmologists being owned or invested in by private equity to now 8%. And the deal is there's a lucrative market in the aging U.S. workforce. I mean, a lot of people are getting older, a lot of people need some eye help. And the deal with eye surgery and cataract surgery is that it's kind of like buying a ticket on an airplane. You can upgrade to first class, with some little benefits. You can do laser instead of manual. You can have astigmatism fixes done while you do your cataracts. And a lot of these costs are out-of-pocket. So they're pretty lucrative. And so private equity sees that opportunity and is pouring literal billions into the space. And new JAMA research shows that after a private equity investment, costs go up. Costs have gone up for ophthalmologists, gastroenterologists, and so on. And so basically we see across the

country this coming consolidation that's already happening. And a couple of experts warned me they're concerned that ... When does the game end? I mean, how many times can you get 20% increase profit out of these practices? And then what happens after that?

Kenen: The private equity is like everywhere, and it's growing if not by the day, then by the week. Remember when many of us first became aware of private equity's increasing role was the whole surprise billing mess. I mean, they had a big role in the transition of how emergency doctors are employed and paid, pathology, traveling nurses. Which is now creating all sorts of other ripples. I mean, these have created economic disruption and extra costs and costs paid by consumers. Lauren's piece was really great. The study she's referring to — we're talking about the business of health today — and that was actually done by a program of my colleagues at Hopkins, on a program called the Hopkins Business of Health Initiative. And they've been looking a lot at private equity. And that was one of their studies. It's dermatology, gastroenterology, and hepatology. And those are all things where, like, dermatology is another one. Boy, can you add on there? Once my mother — this was not private equity, this was a regular doctor — went in for a skin screening, and they only did one side of her body. And they said she had to come back for the other side. They get two visits. She had something else being done, and they said that was it — they could only do two things, right. It's crazy.

Rovner: In the early '90s — I think, Joanne, that might even be before you started covering health care — when they revamped the way Medicare pays doctors, there was a big concern at the time that Medicare paid people who did things to people more than people who talk to people.

Kenen: It's still a concern.

Rovner: Right. Obviously. They didn't ... They addressed it, but they didn't fix it. So, basically, doctors who use technology — interventional radiologists, ophthalmologists. It's funny.

Kenen: It's cutting versus talking.

Rovner: Right. We're talking ... We're talking about all the people, I was going to say, who are using high tech. Everybody using high tech gets paid way more. And isn't it funny how that's where the private equity is going because they were already getting paid more. And now we're just expanding this differential between what doctors who do things to people, compared to doctors who sometimes cure people by talking to them. Let's not jump ahead of ourselves because I want to expand this a little bit. Meanwhile, this week, I want to talk about health insurers first. In this week in "Health Insurers Trying to Take Over the Actual Provision of Medical Care," Humana is expanding its partnership with the private equity firm of Welsh, Carson, Anderson & Stowe to build and operate primary care clinics for its Medicare Advantage members, of which Humana has many. Not to be outdone, UnitedHealthcare is finally being allowed to proceed to take over a data analytics firm in a merger that the Justice Department unsuccessfully tried to block. The Justice Department charged it would give United unfair access to competitors' payment data. United apparently argued that through its existing analytics firm Optum, it already basically has that access to competitors' data. I know all this sounds esoteric, but at some point shouldn't we be getting concerned that health care is just going to consist of three or four giant health care providers/payments/insurance companies? I mean, we're looking at an oligopoly here in health care.

Edney: Yeah, I think that that's definitely a concern when you see all of this going on. And I think, like, you know as well, too, when you see Amazon still trying to get its tentacles in health care.

Rovner: That's next.

Edney: You know, there is something to be said, I guess, as the consumer for maybe convenience. But when you're talking about insurance companies and the data, the technology they use, and things like that being monopolized by just one of them, and probably all of us have horror stories of dealing with insurance companies, and you wish there was better customer service and the ability to just walk away if you need to or go somewhere else. And that doesn't exist. And so, yeah, I think there's definitely a concern that ... And I think the Biden administration has made it clear that they're going to try to go after this, but they're not really having any luck, at least in recent days, given some [former President Donald] Trump-appointed judges out there and things like that.

Weber: Yeah. I just want to add, too. This consolidation all plays off of each other. I had experts in my private equity story say that in order to compete, ophthalmologists had to join private equity to compete with hospital systems and insurance giants and so on. And so you see this domino effect, where everyone feels like they're the smallest person in the room. So they either need to get bought up or be part of the larger system to be able to compete. And so we're going to continue to see the ramifications of that play out.

Kenen: I thought Lauren's story was really great. And just, like, think of yourself as a patient. You're going in, you're going to have somebody perform surgery, a procedure, on your eye. And they're asking you, "Do you want me to hold this thing by myself, or should I have the laser do it?" I mean, what are you going to say? And they are under these pressures. I mean, as they're owned by private equity, there's different incentives and expectations and targets. And, you know, how their own income is tied in ways that I don't know. But who owns you changes your behavior. So we're always upselling things, and it's happening after a 15-year period when we, supposedly, the whole health care system has been pointed toward greater value and quality rather than quantity. And it just seems to be, one of the fashionable phrases, an inflection point.

Rovner: Meanwhile, as Anna hinted, it is not just health insurance companies who are trying to take over the health care world. Amazon, as we know, is trying to get into primary care. CVS, which is already heavily into primary care — I'm sure everybody's been to a MinuteClinic — is extending into home care, and Walgreens is buying into the home care and the specialty pharmacy businesses. In other words, we've got traditional health care players and nontraditional health care players all trying to consolidate their stakes in health care. So maybe we're going to have non-health care companies driving the health care train. I've been rolling this around in my own head and I can't decide. I'm used to listening to futurists predict the future of health care. I honestly have no idea where we're headed right now, except for a lot of people wanting to make a lot of money.

Edney: I think we've seen Amazon try, and fail, a few times too, and so it's unclear if this is a space that can really be disrupted. I mean, Haven being the biggest point, when they tried to partner with JPMorgan and Berkshire Hathaway to do — I don't know what they were going to do exactly.

Kenen: Fix health care!

Rovner: Yeah. They were going to fix health care, and Atul Gawande went off into the government to head USAID [the U.S. Agency for International Development]. So we never really got a good debriefing on what happened or didn't happen at Haven.

Edney: That's a good point. You know, they've had their own pharmacy, but it's not becoming what we use Amazon for, everything else for. It's not really used as much, and so it's hard to know if that's going to be ... if those companies can do it. It seems to be that health care is just its own beast and it might not be

possible to take whatever Amazon knows really well about business and supply chain and transfer that over to the health care space.

Kenen: Or we'll have little doctors popping out of our ... coming up with our ... our Amazon Day delivery.

Rovner: Doctor by drone!

Weber: No, I was fascinated, too ... It's interesting if you notice that Walgreens deal had the same Welsh, Carson, Anderson & Stowe private equity company that Humana did at the top of the call. So it's kind of interesting to see the intersections, obviously, of private equity and these massive conglomerates as they continue to gobble up these smaller firms. And I also was interested by the move into, as you said, folks that come to your home. You know, it's interesting that CVS wants to invest in people not in their stores, but they're actually showing up to your doorstep. And I'm curious, as we kind of continue to go on, if we'll see more and more of that investment, especially in the era of telemedicine and in the middle of the pandemic. And as we move forward in the pandemic, like what that will look like.

Edney: I was just going to say that Joanne was joking, but when I read about the CVS deal getting into home health, I did really think, well, could you get a doctor to come see you, or a nurse, and did they pick up your prescription at CVS first, and then you also need some hairspray or something, and then they grab that for you and then they come ... like could not be a reality at some point? That's one way to sell things from CVS, I guess.

Kenen: I mean, home health is a good idea, that getting care to people's homes, particularly people with limited mobility, inability to drive, [who] live where there's lousy public transportation, all sorts of reasons, or infection, you know. I mean, there's all sorts of reasons. When I was really little, we had home calls, and that stopped. And they have been coming back in segmented niches, kinds of ways. But home care is probably a good thing — but in the right circumstances, with the right economic incentives. But I don't know that this is going to be the right model.

Rovner: It's sort of like we unbundled health care and now we're rebundling it.

Kenen: With Anna's hairspray.

Rovner: Yes, with Anna's hairspray! I'll also point out ...

Weber: Yeah, I mean it's like with Netflix ... all of the cord-cutting. I mean, who knows what's going to happen now?

Rovner: That Welsh, Carson, [et. al] and we should point this out that some of these private equity firms have a lot of health expertise. Welsh, Carson is where Tom Scully went after he left running Medicare and Medicaid. So there's not ... some of these firms are just getting into it because it's a place to make money. But some of [them] actually have always worked in this space. I mean there's always ...

Kenen: But some of them are buying everything. it's just like one more thing in the portfolio. So like, OK, I'm going to go buy a cardiology practice and a movie theater, you know, a movie theater chain today.

Rovner: Right. That's what I'm saying, there are different ones, which is a whole 'nother discussion that we will get into. All right. Meanwhile, I want to move on to the next segment, which I am calling "Things We Really Shouldn't Have to Pay For." There are [two separate studies](#) this week from husband-and-wife, single-payer advocates David Himmelstein and Steffie Woolhandler. David helmed a study that found nearly 10% of all people with private insurance nonetheless have medical debt, which is, not surprisingly, more

common for people with high-deductible health plans. But, more surprisingly, also more likely to have medical debt are people with Medicare Advantage plans, which are supposed to pick up the costs that Medicare doesn't. The study's authors theorize that's because Medicare Advantage often doesn't cover out-of-network benefits that its enrollees end up needing, and so they have to go out and pay for things themselves. Steffie Woolhandler, meanwhile, led a study in the *New England Journal of Medicine* showing that sexual assault survivors who sought emergency care were charged an average of more than \$3,600, despite the fact that they may not be charged for actual evidence-gathering by the federal Violence Against Women Act. Granted, both of these studies come from advocates of single-payer health care. But I have to say I was still pretty surprised, particularly by the finding that Medicare Advantage enrollees were more at risk for medical debt than people with other types of health insurance. And I think also that women who have been sexually assaulted and go to the emergency room end up with large bills.

Kenen: Yeah. And remember, there's a movement in this country, in many, many states, to make it extremely hard for a rape victim to get an abortion in states that are even going to allow it. It does require that you report. It does require that you get treatment. The state laws vary. But, first of all, if you're a rape victim, you probably should see a doctor. But you also have to jump through additional hoops, if you do get pregnant and want an abortion. In fact, I found that story shocking and disturbing — being a victim of any crime is traumatic; being a victim of a sexual assault is obviously deeply, deeply traumatic. And then having to go through the criminal justice system, if, in fact, you do need an abortion. I mean, if you go to the hospital, you get a Plan B and you reduce the risk of a pregnancy. I just found that one to be really disturbing and even more so given the political context of abortion right now and how rape victims are often treated, which they're subject to questioning and suspicion in a way that other crime victims are not often, not always the case. Things have obviously gotten better over the decades, but they're still not great. And thousands of dollars because you're a crime victim?

Rovner: And we should point out that the way they did the study, a lot of these bills were paid by insurance, if you had insurance. These were “this is what was billed,” not necessarily what the individuals paid. But still the idea that, you know ... you also wonder, should health insurance be basically footing the bill for victims of sexual assault? Because then everybody pays for it.

Weber: And we all know that whenever you're billed for anything, you're going to get envelopes in the mail about it. So every time you open that up, I mean, I just can't even imagine. Just horrifying ...

Kenen: And you haven't met your deductible and, you know, you have an out-of-network ... You know, there's all this stuff that I mean, some of the surprising bills deal with that, but it's just sort of like emblematic of so many things that are wrong right now.

Rovner: So. Well, as we've already said, abortion continues to roil the nation. Last week, West Virginia became the latest state to ban almost all abortions in the state. Meanwhile, [in Utah](#), where the state's trigger man is actually on hold in the courts, Republican state lawmakers sent cease-and-desist letters to abortion providers. They're threatening prosecution anyway, although then they tried to walk back that threat the next day. And [in Puerto Rico](#), which has other problems this week, a new political party has arisen to try to establish restrictions in one of the only U.S. jurisdictions that currently has no limits on abortion. Is the debate moving in one direction or another right now, or are we going to not really know anything for sure until after the midterms?

Edney: Yeah, I think it's hard to say. I mean, when you said one direction or another, for some reason I thought states or federal because they obviously a couple of weeks ago ...

Rovner: Last week! It was last week.

Edney: Oh, sorry. Last week, Lindsey Graham's legislation to ban it at 15 weeks. And I was kind of thinking that way, and I have no idea where it's going right now. And I think you're right. There has been so much talk that that is bringing a lot of women out to register to vote, particularly on the Democratic side. And we've got, I'm trying to do the math in my head, six or seven weeks, something like that, until the midterms. And it still seems to be an extremely important issue, which even with inflation and other things, that's often hard to do for an issue to last that long in the mind of the electorate.

Rovner: Yes, we have such short attention spans.

Kenen: But it's, like, built and built rather than ... I mean, I thought originally when we talked about it, I thought it would make a difference in certain states. I mean, I thought it'd make a difference in Pennsylvania. I thought it'd make a difference in states where youth vote might really matter. I thought in close some close races, in areas that are the few remaining swing district areas. And, actually, it's much more potent than we saw. Now, what we still don't know is people in the polls, they say this is my concern. Yes, I disagree with the Supreme Court. I mean, by large margins, we still don't know when someone goes into ... like, extrapolating the Kansas vote, which was only on abortion, we were all surprised by the strength of the pro-abortion rights vote in Kansas. It was way bigger than any of us expected, even in pretty red counties, but that ... you were only voting on abortion. How does that voter who voted in that referendum vote when there's also dealing with 500 other things, including inflation and crime and other issues that the Republicans said. We can't just say, OK, because we've had these polls and these cases votes that we know. But we do know it's a bigger deal in this election than we thought and that it is helping the Democrats and that things are going to be better for the Democrats than they would have been otherwise. But we don't know what that really looks like yet. I mean, they could still lose both the House and the Senate, but not by as much as they might have. You know, I mean, the Senate is very toss-up and there are races where they've suddenly gotten closer, like North Carolina is really, really close now. You know, is the Republican still favored? Yes, but that race is very, very close. And it's a pro-abortion-rights woman running for Senate, a Black woman running for Senate. There's a lot of dynamics.

Rovner: And the House is very gerrymandered. So, Lauren, you're in the middle of the country where this is really heating things up. I mean, obviously, Missouri has been trending redder over the last several elections.

Kenen: Beyond beet!

Weber: Yeah, I was going to say, I think we're pretty deep-red at this point, Julie. I don't know. I was fascinated by the Utah case that you brought up about the threatening letters by the legislators, because it reminded me a little bit of our attorney general. Missouri has sent quite a few legal letters, but it was interesting coming from legislators and not the attorney general of the state of Utah. And the fact that they actually walked it back, I was really surprised. It's a very interesting turn of events because you've seen, you know, usually letters like this that threaten legal action are not uncommon. But to see it from the legislative state itself is quite fascinating. And I think, you know, Joanne is exactly right. When people get into the ballot box, it's not just about abortion. And who the heck knows? I mean, considering what's going on in geopolitics these days, who knows what we're going to be voting on come November? So I think, you know, I do think that in very red states, this is already, you know, it's a states issue that's been pretty decided in those states. But then again, we did see what happened in Kansas. So, I mean, we'll see what happens come the next couple of months.

Rovner: I feel like as somebody, I say this a lot, who's been covering abortion for four decades now, I feel like the debate is kind of untethered in the sense that we just don't know where it's going. I mean, it's like a boat bobbing up and down on the waves and we've got currents coming from all directions and no idea where it's going to land. But we'll obviously see ...

Kenen: But we know that this issue was here to stay from the right for 50 years, and it is now here to stay from the left for unknown decades to come.

Rovner: At least the next six weeks.

Kenen: No, I don't think this goes away in six weeks.

Rovner: No, I don't either.

Kenen: This is a really volatile issue. And the pro-abortion rights people thought they were safe. They saw things being eroded. They saw things being weakened over the years quite a bit. I mean, there are places in the country where you couldn't get an abortion before the *Dobbs* decision, but there are places in the country where it's hard to get contraception. ... They're reproductive health deserts. But the intensity was on the side of trying to create change, which was the anti-abortion groups. And now the intensity is on the side trying to create change, which is now the abortion rights groups. So this is not going to stop. It'll ebb and flow, but it's not going to stop.

Rovner: And to put that another way, one of the things that's always been true about the abortion debate is that the losers are the ones who get more motivated, that whoever's playing defense tends to be more motivated. So for years and years and years, it was the anti-abortion groups on the defense because the status quo was that abortion was legal. And now all of a sudden this has shifted 180 degrees. And we will see how it all plays out.

All right. Well, that is the news for this week. Now it is time for our extra-credit segment where we each recommend a story we read that we think you should read, too. Don't worry if you miss it; we will post the links to these stories on the podcast page at khn.org and in our show notes on your phone or other mobile device. Anna, why don't you go first this week?

Edney: Mine was in The Guardian by Tom Perkins. It's "[Fury Over 'Forever Chemicals' as US States Spread Toxic Sewage Sludge](#)." So I hope no one's eating when I talk about this. But there's this growing movement to take sludge directly from wastewater companies that need to get rid of it and use it as fertilizer on our crops and the things we're eating ...

Rovner: Recycling!

Edney: Yeah. Yeah, exactly. And you know, it sounds disgusting and I wouldn't know much about it except that there's these forever chemicals. And that's the PFAS that we might all have been hearing about, because we all have them in our bodies. They're in everything pretty much. And the wastewater also has these, and then they're being spread on our food. There's just two states: Maine, and I'm blanking on the other one, that don't allow its use on the farmland, that's already ruined some farmland there. And there's other states which —sorry, Virginia residents? — that are just allowing it as much as people apply for it. So it's an interesting look at a really concerning topic.

Rovner: Awesome. Joanne.

Kenen: Yeah, I found a story from Capital B, which is a new — a couple of months old — startup, a nonprofit that's really covering, a heightened focus on Black America. And Margo Snipe wrote a story called — she's the health reporter — "[Clinicians Dismiss Black Women's Pain. The Consequences Are Dire.](#)" There is many years of research showing that Black people's symptoms are often undertreated, Black people's pain is undertreated, even in situations like appendicitis, kids with appendicitis. And also, you know, I think all of us can testify that women's health care concerns are often not listened to. So you got a double whammy if you're a Black woman. Now, you don't want to overtreat. White people's pain has been overtreated and we have an opioid crisis! But she really makes a real case about it. The anecdote that stuck with me was a woman who was asked to rate her pain on 1-to-10 [scale], which is something we're all asked. And the woman said 35,000 and she wasn't treated. And to the point that she was considering whether she wanted to even stay alive any longer. And it's a systemic part of anything still wrong with American health care in general and how Black Americans are treated by a system that doesn't trust them and they don't trust the system.

Rovner: Yet another example. Lauren.

Weber: I thought there was [a great piece](#) that my colleague Brett Kelman did for KHN about how a Supreme Court ruling from June, which I know is eons ago, *Ruan v. U.S.*, really has changed the game for opioid prosecutions against doctors. And he found that after that ruling, which was a unanimous Supreme Court decision that said that prosecutors must not only prove that the prescription for opioids was not medically justified, but that the prescriber knew as much. And by adding that extra layer that they knew and chose, what Brett found by researching court records is that in at least 15 cases across 10 states, it's altered their legal strategies and assumedly will alter legal strategies for years to come and could drastically change how doctors are prosecuted and how many of them actually are convicted with this kind of heightened legal deal. And so I think it's really fascinating to consider what we're looking at going forward when it comes to holding folks accountable for the opioid crisis and what it means legally.

Rovner: Yeah, we got all so excited about — as well we should have — about *Dobbs* and about the gun cases at the end of the term that we ... that a lot of people missed that important opioid case. I think it's going to come back and have some real ramifications down the road. Well, my story is from the Anchorage Daily News by Annie Berman and it's called "[Many Alaska Pharmacies Are Understaffed, Leading to Sporadic Hours and Patients Turned Away.](#)" And the headline pretty much says it. In the largest city in the state, people sometimes can't get their prescriptions because there aren't enough people to fill them. The dean of the University of Alaska's pharmacy program — and I quote from the story here — "went from begging employers to attend the fair to charging \$500 per booth due to increased demand." And lest you think it's just Alaska emergency rooms, in Canada — yes, a country with national health insurance — have been closing on a rolling basis because they don't have enough nurses. I fear that one of the big fallouts from the pandemic around the world is a burned-out health care workforce that could leave us all searching for care. I hope I'm wrong, but let's watch that space.

OK. That is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks, as always, to our producer, Francis Ying, who makes the weekly magic happen. As always, you can email us your comments or questions. We're at whatthehealth — all one word — at kff.org. Or you can tweet me. I'm [@jrovner](https://twitter.com/jrovner). Joanne.

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Rovner: Anna.

Edney: @annaedney

Rovner: Lauren.

Weber: @LaurenWeberHP

Rovner: We will be back in your feed next week. Until then, be healthy.