

U.S. Racial Health Inequities and Opportunities with Single Payer:
Susan Rogers, MD, President, Physicians for a National Health Plan

Janet Hoy: Moderator: I am going to kick off by introducing our speaker. We are super happy to have her.

Dr. Susan Rogers is the President of Physicians for a National Health Care Program. She has a particular interest in the topic of this session: Health Equity. She has held a faculty position in Internal Medicine at Cook County Hospital in Chicago and is the medical director of a community health center providing primary care to low income patients.

Dr. Rogers' talk will focus on the following questions:

What are the inequities in our health care system?

What changes are supported by the League's positions on Health Care, and on Diversity, Equity and Inclusion?

How can we achieve these positions?

What can we do as individual Leagues and as a statewide League to get closer to health care equality for all of us in this country?

A broad topic. We hope to cover a lot. We invite your questions.

One more thing, I would just like to do a quick shout out to Carol Moon Goldberg, who has just joined us. She is the President, as you know, of the League of Women Voters of California. Welcome Carol, we are so happy to have you as well.

With that, I will turn it over to Dr. Rogers.

Single Payer and Health Inequities
Susan Rogers, MD, FACP
Physicians for a National Health Plan

Dr. Susan Rogers:

Welcome Everyone. It is afternoon here in Chicago where I am. Thank you so much for asking me to speak to you today. I am excited to talk with you. As Janet said, this is a topic that I am quite interested in, and one of the reasons why I went into medicine and trained where I did.

Slide #1: World's Highest Standard of Living: There's no way like the American Way

I want to start with this particular slide. I don't know how many of you have seen this, but the picture in the background about the "World's Highest Standard of Living". There was a whole group of posters espousing the wonderful standard the United States has, and how it is just so great, and there is nothing like living in America because it is so wonderful. It didn't really talk about the whole country; it talked about part of the country. What this picture is, below this is a line of Black people who lived in Louisville, Kentucky who were made homeless because of the flooding. Here they are in line at the Red Cross in front of this billboard.

What this is saying is "There is no way like the American Way" and when you think about it, this is exactly what the American Way is. This American Way that we espouse is so wonderful has disenfranchised Black people from the very beginning. From the time we were violently brought from Africa and enslaved, to even after the end of the

Civil War, there has never been a sense of trying to equalize these two groups in this country.

I want to go through some of the things that have been done to perpetuate these inequities and how it shows up in health care.

Slide #2: Life Expectancy vs Health Expenditure per capita: US & US Black male vs 20 countries

I think this is a very interesting slide. If you look at this, it compares life expectancy and how much we spend on health care in this country, and actually in the world. On the left, the vertical graph, shows how long people live, and you can see all the wavy lines are mostly industrialized countries from Europe and Asia. You can see that they are much higher than the line for the United States.

The horizontal line shows how much money we spend per capita on health in this country. The United States is far and away spending more than anyone. So here we have this inequity: we have other countries spending much, much less, and getting much, much more than the United States. Even on the bottom part of this line, I have a line of Black Men and what their average life expectancy is: we are almost ten years younger than White Males in this country. So we are an outlier.

Why is it that we are spending three times as much as other countries, and getting nowhere near as much? Is that the American Way? Why are we espousing the American Way when what we are doing is so expensive and not getting anywhere what we should?

Slide #3: Age-adjusted Covid-19 Associated Hospitalization Rates by Race and Ethnicity, March 1 – July 18, 2020, KFF

Per 100,000: White 53; Black 247; Hispanic 243; Asian or Pacific Islander 67; American Indian or Alaska Native 281.

One of the things that Covid really laid bare was the inequities that are occurring in this country. People seem to be surprised at why are Black people getting so sick from this? Why are they the ones getting sick? Why are they the ones that are dying? This is some data from the early part of the pandemic. You can see that Black people were dying at 3, 4, 5 times the rate of White people in this country. Hispanics were faring just as bad.

There were questions about co-morbidities, but nobody asked why they have more co-morbidities. There is something genetic about the virus that it attacks Blacks and Hispanics more.

This question has come up. We have known about these inequities from the beginning, but we have ignored them. We have considered them to be normal. That is part of being part of this country. If you are Black, you are going to die earlier. That is just the way it is here, and it is not as if something were to be done to fix this.

This is interesting because that poster that I showed you in the beginning: this is the American Way.

Slide #4: Maternal Mortality: Deaths per 100,000 live births:
USA 26.4; France 8.7; Canada 6.6; UK 6.5, Germany 2.9, Australia 1.6

One of the things that I want to bring up is Maternal Mortality. This is separate from Covid inequities. Women in this country are dying at a rate – this is before Covid, this is not related to Covid - women are dying at a rate 5, 6, 7 times as high as some other industrialized countries.

The World Health Organization looks at Maternal and Infant Mortality rates almost as a surrogate for the health of a country. So what they are really saying is the health of America isn't very good. There are a lot of reasons for that. Two-thirds of these deaths are actually preventable. But in this country, we have a lack of midwives, we don't have any other staff to help with pregnant women in a lot of areas other than physicians – there are a lot of areas of this country where they don't even have an MD to provide obstetric care.

Let's be clear about Maternal Mortality. It is defined as "Death during childbirth or during pregnancy, related to a cause during pregnancy, up to a year after the birth of the child."

It is interesting that we look at mortality as a risk up to a year. However, most health insurance policies don't cover you for pregnancy for more than six to eight weeks after that childbirth. Let's say you have a complication that will remain a chronic problem – you won't be covered for the rest of the time. We are the only one out of 11 industrial countries that does not provide any maternal leave.

So we don't support women while they are pregnant, or support their baby. This is part of the reason why the rate is so high – we don't even track mortality. It wasn't until 2003, I think, that there was a box on the death certificate to even say if the woman was pregnant or not, so that you could go back and see if this was a pregnancy related death. Even Mongolia has more reliable data related to maternal mortality than this country.

We don't have a good way to track this. We are not giving support to women who are pregnant to provide them with the health care that they need, to provide them with other supports that they need. We don't acknowledge that many women are having careers along with families that need to be supported. It should be no surprise that we have this gap, that we have a worse maternal mortality than most countries.

Slide #5: Pregnancy-related mortality ratio per 100,000 live births: White, Black, Hispanic, Asian/Pacific Islander, American Indian/Alaska Native, All Women

This is how we break it down by race. Here Black women are suffering more deaths than White women. There is a condition called "weathering," I don't know if you have heard this term before, but what it describes is the stress of living Black in this country. It is described as a lot of hormonal changes, physiologic changes, biochemical changes that occur.

Some of this is normal. It's the flight or fight response when you get into a situation where you have to make an immediate decision, where you have to flight or fight. These hormones and changes come into play to help you respond to that situation.

But that should be short lived. It shouldn't be continuous. It shouldn't be part of your daily life, to go through these hormonal and physiological changes, to be able to function. So what happens is people age sooner, and that is what they found with Black women. They found that teenaged Black girls end up having healthier babies than Black women in their 20s and their 30s. This is the opposite of White women, where you get in your

20s and 30s, you are healthier to have a baby. But the feeling is that this is because of weathering, the physiological stress that Black women suffer from.

And it is not just socio-economic. Look at what happened to Serena Williams and Beyonce; it was a pediatrician who was the chief resident who died in childbirth. I mean, Serena could have bought the hospital she was at. But she still suffered a life threatening complication because she had to fight for herself and insist that she was really short of breath.

Part of it is the bias that has shown in this country that symptoms that Black people complain of are not taken seriously, their pain is not taken seriously, and Black women who are pregnant are not taken as seriously with their complaints. That again contributes to the increase in the mortality.

Slide #5: Infant Mortality: Deaths in first year of Life:
USA per 100,000 live births: number of pregnancy-related deaths, CDC
White 13%; Black 40%; Hispanic 12%; Asian Pacific Islander 14%; American Indian/Alaska Native 30%
ALL WOMEN 17%

And even the babies. The Infant Mortality is greater in this country with all babies, and even with minority babies.

Slide #6: Infant Mortality
Deaths in First Year of Life/1000 Live Births
USA 5.9; Canada 4.5; France 3.8; Germany 3.3, Australia 3.3; Italy 2.7; Sweden 2.4

Slide #7: Infant Mortality Rate by Maternal Race/Ethnicity KFF
Per 1,000 Live Births
White 4.6; Black 10.8; Hispanic 4.9; Asian 3.6; AIAN 8.2; NHOPI 9.4

Black babies die at over twice the rate of White babies of infant mortality. And Hispanics are not as bad as Black babies, but there are still more deaths in that group than with White babies. There is this gap here that persists.

Slide #8: Social and Economic Factors Drive Health Outcomes
Obstacles of Racism and Discrimination:

Economic Stability: Employment, Income, Expenses, Debt, Medical Bills, Support
Neighborhood and Physical Environment: Housing, Transportation, Safety, Parks, Playgrounds, Walkability, Zip code/geography
Education: Literacy, Language, Early childhood education, Vocational training, Higher education
Food: Food security, Access to healthy options
Community and Social Context: Social integration, Support Systems, Community engagement, Stress, Exposure to violence/trauma
Health Care System: Health coverage, Provider availability, Provider linguistic and cultural competency, Quality of Care

Health Outcomes: Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

We are all aware of what we call “the social determinants to health.” There are a lot of factors involved in being healthy and we all know about these, even if it is just casually if

it is not by that term. We all know that if we eat better we will be healthier. If we exercise more, we are healthier. If our finances are stable, we can be healthier. So all of these have a role to play, and one of which is health care. So whether we have access to health care is important as to how healthy we are.

Slide #9: Uninsured All Year, 1948-2018

This country provides health care by insurance. By insurance, we are talking about private companies that decide whether or not you can get the care that you and your doctor decide upon. Which if you think about it, is a very unusual situation because it shouldn't be the insurance company that decides what you need; that decision should be between you and your provider. So we have put the insurance company in the middle as a middleman who extorts billions of dollars a year out of this relationship; they get this money by not allowing you to get the care that you and your doctor say that you need.

Who is uninsured all year? Well, back in the 1960s, when Medicare and Medicaid became real entities, the uninsured rate dropped. People over 65 were now able to get covered by Medicare; people who were poor were able to get Medicaid. Keep in mind that when we talk about the federal poverty level in terms of who can get Medicaid, the federal poverty level really doesn't define who is poor and who isn't poor. It just creates a marker about who is eligible for this benefit and who isn't. There are a lot of people who make 2, 3, 4 times the federal poverty level who are still living in poverty, although they are not eligible for some of the benefits.

We can see here with this slide that after the Affordable Care Act, the uninsured started to go down again after it came into play. But now it is starting to go back up again.

Slide # 10: Percent of Adults ages 19-64 who are uninsured, 2010-2019, by Race

If we look here at how it has affected all racial groups in this country, we can see how the uninsured rates dropped with Latinx, Blacks, Whites, Everybody. The uninsured rate dropped, but there is still a big gap between who is insured and who is not. And especially when insurance is tied to your employment. Who is not mostly eligible for that? It is Blacks and People of Color. Most of the jobs that People of Color and Blacks have, they tend to be more front line workers, more low wage workers working at poverty levels. They are jobs that don't provide health insurance.

Even with health insurance, we should be clear that being insured doesn't assure that you have access to care. We will get into that more in a little bit.

Slide #11: Deductibles are rising even more than Premiums

One of the things that the Affordable Care Act was focused on was the cost of premiums, and there was all this talk about "people need to put skin in the game," they have to come out of their pocket for something so that they don't over-use.

I don't know anyone who decides, "well, I have nothing to do today, I think I will go to the Emergency Room." I mean, people don't over-use health care just because it would be quote FREE. Think of other things in their life. People go to the Emergency Room for real issues.

One of the things that has happened in this country is the Deductible. The Deductibles have risen way out of proportion to income. We can see what happens with Employer-Based Insurance. Employers pay about 67% of the premium, which means the Employee

is still paying money to pay for the premium. And they don't see that money because it doesn't go into what they bring home, but it is taken out of their salary. Rather than given to them as dollars for their salary, it is a benefit that they never see because it goes directly to the insurance company.

So the average Employee pays almost \$7,000 that is deducted from their paycheck towards the premium for their health insurance. \$7,000 a year would make a big difference to a lot of people who are working every day. It is also a very regressive way to pay, because that average cost per employee is not dependent on their salary. Every employee pays the same, whether you make \$30,000 a year, or \$60,000 a year, or \$600,000 a year, you still pay the same for your insurance. So it is a very regressive way to pay.

Having this Deductible means that you have to come out of pocket for a lot of dollars before your insurance even starts to pay. So think of how much this insurance company is getting before they pay a dime for your care. They are getting the employer's 67% of the premium, they are getting your \$7,000 a year to complete the payment for the premium, and they are getting this deductible...all of this before they spend a dime on you.

That sounds like a very lucrative plan to me. And that is what it is. So a lot of people never can pay down their deductible despite having health care needs and costs, so the insurance company never pays for any of their care, or they go into bankruptcy trying to cover their costs – I will get into that too, about the impact of the deductible on what people decide what to do and what to not do, in terms of getting health care.

Slide #12: The Affordable Care Act Coverage: Average Annual Deductible
Individual Coverage: \$4,574, 2018; \$4,320 2019;
Family: \$8,803, 2018; \$8,071, 2019

With the Affordable Care Act, Deductibles are an even bigger problem, because when the government decided to sponsor and subsidize premiums, they didn't think about the deductibles. And the deductibles are often higher for plans that people get through the Affordable Care Act exchange. If you are having your premium subsidized because you can't afford it, how are you supposed to come up with up to \$9,000 to pay for your deductible?

It doesn't make sense.

The numbers don't work out right. But that isn't how it is marketed. People don't see the deductible, so what they do is they get a plan that has a low premium but has a very, very high deductible, so they can't even have the benefit of having a low premium and having an insurance plan that they can use.

Slide #13: Medical Debt Leaves People with Lingering Financial Problems
Used all of savings: 37%;
Received a lower credit rating: 40%;
Took on credit card debt: 31%;
Unable to pay for basic necessities (food, rent, heat): 26%;
Delayed education or career plans: 20%;
Too out a mortgage against your home or took out a loan: 11%
Had to declare bankruptcy: 3%

So what happens is people have medical debt. It leaves them in financial despair. I mean, many people lose all of their savings, they take out another mortgage on their home. There are a lot of things that happen because people cannot pay their deductibles. They cannot pay the plan, they cannot pay the out of pocket expense, the co-pays, the pharmaceutical costs.

So that medical debt leaves people with lingering financial problems that devastate a lot of people.

Slide #14: Status of State Medicaid Expansion in 2021

Not expanded: Texas, Kansas, Wyoming, South Dakota, Wisconsin, Tennessee, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina

Now the Affordable Care Act financed Medicaid expansion did improve access. That was one of the things that was supposed to be for the entire country, but several states said “No we are not doing that.” Interestingly, a majority of those states are in the South. They chose not to expand Medicaid, even though a majority of poor people live in the South. But they chose not to expand.

I wonder if that is related to the fact that there are more Black people who live in Southern states than the rest of the country. They chose not to expand Medicaid. These states chose not to expand Medicaid, which leaves their hospitals having more unfunded patients to take care of. It provides the people who live there with less choices.

Or no choices of where to go for their health care.

Slide #15: Medicaid Managed Care Patients Can’t Get Appointments

Not participating: 43%

Won’t take new plan patient: 8%

Offered appointment within 2 weeks: 24%

Offered appointment longer than 2 weeks: 25%

And so what happens when people do get Medicaid, again? It doesn’t insure that you have access because privatization of Medicaid has so expanded that almost all Medicaid programs are now linked to a private insurance company. What happens is you have networks, you have restrictions on who you can see and where you can see them, what drugs you can get covered.

A lot of physicians don’t even take Medicaid patients because it is so grossly underfunded that it doesn’t even cover the costs by any means. Whether you are seeing a primary care doctor for a physical, or whether you are going for surgery or joint replacement. The payment reimbursement is so low that a lot of providers won’t see Medicaid patients. And this is an expression of how these patients are valued. I mean, we have a system that doesn’t even pretend about being able to provide them care.

We have a system with Medicaid where half the providers, half the physicians, won’t even see them. The ability to access this care is really restricted.

Slide #16: Number and Percentage of Rural Hospitals at High Risk of Financial Distress, 2019

One of the things that has happened because of the way that we finance hospitals with deductibles is that hospitals are closing. Hospitals need to get paid for what they do. This is what this country’s health care system does – it functions on profit. But a lot of

the hospitals can't even make a profit, especially in the rural districts where you have a lot of Medicaid patients. They end up going to hospitals, and the hospitals can't get reimbursed for their care. There have been a lot of hospital closures that have happened because of this lack of hospitals being able to be reimbursed.

One of the things that has happened is that since 2010 there have been about 180 rural hospitals that have closed. That is leaving gapping deserts of where there is no health care providers.

And this has really had an impact on obstetrical care. There are a lot of counties in the South that have no Obstetrician. None. You can't get your prenatal care, you can't get your care if you go into labor. They are deserts. And when you look at the most common reason for hospitalization? It is childbirth. And you have these areas with no hospital.

This is directly related to how we finance health care. It is through the insurance company that is made for profit. If you don't make a profit, then you close. This is happening in rural communities and it is also happening in urban areas.

Slide #17: Intensive care unit (ICU) bed availability by median household income
\$00,000 – \$34,999: 0 beds: 50%; 1-4 beds: 5%; 4-7 beds: 15%; 7 beds: 30%
\$35,000 - \$54,000: 0 beds: 42%; 1-4 beds: 11%; 4-7 beds: 24%; 7 beds: 23%
\$55,000 - \$89,000: 0 beds: 27%; 1-4 beds: 22%; 4-7 beds: 25%; 7 beds: 26%
\$90,000+: 0 beds: 4%; 1-4 beds: 38%; 4-7 beds: 27%; 7 beds: 31%

One of the things, too, a lot of hospitals in poorer communities don't have intensive care beds. This really came to light with the Covid pandemic, because so many more people need intensive care. What this graph is showing you, at the far left, communities where the average income is less than \$35,000, 50% of these communities have zero ICU beds. Zero. They may not even have a hospital. But they have zero ICU beds. You take a community where the average income is over \$90,000, less than 3% of those communities have zero beds; most of them have more than 7 beds.

The inequities come from the way we finance and who is able to get it is shown here. Covid made that very clear. If you look at some of the data from New York. New York was all in the press because they were hit so hard in the pandemic early. If you look at the hospitals in the Queens, and the Bronx and Brooklyn, they had the largest share of cases, but they had the smallest number of well-resourced beds to take care of these patients.

This is strictly because of the way we finance health care. If you can pay for it, you get it. If you can't pay for it, you don't get it.

Slide #18: Redlining

So why do we have these communities in the first place? Why are these inequities here? We hear about when Obama was President, as "post-racial." It's been 150 years since the Civil War ended, but there are a lot of policies and things that have perpetuated through that enable the inequities to persist.

One of the biggest is "Redlining." I am sure this is a term most of you have heard of. This is a graph taken from Chicago back in the 1930s when Redlining started. There was segregation way before Redlining started. But what Redlining was responding to was when the New Deal started enabling banks to insure mortgages. They decided that

communities that had any Black people in it were high risk, so they were not going to insure any mortgages where any homes were being sold or bought in Black communities. So those communities were Redlined.

But even before this took place, when the migration of many Black people, freed slaves from the South, moved to Northern cities, they were only allowed to live in certain areas. Back then, you could say “Blacks Only” “Whites Only.”

It is not politically correct to say that now, so there are different ways that it gets done. There were areas that were segregated legally in other cities.

What happens when you make a group of people have few choices, very limited choices on where they can live. You also eliminate the main way that families can accrue wealth which is through home ownership. What are you creating? You are creating poor communities. You are creating ghettos. They didn’t just happen. It is not like a bunch of people didn’t get together and say “Let’s all be poor.” It was created.

When we think about how where we live has such a big effect on our lives. Neighborhoods are where we have access to transportation, we get our education, our employment opportunities. This is where our health care is, this is where our grocery stores. This is what provides the infrastructure for people to grow and prosper.

When you have communities that are neglected, purposely not given those resources, what happens to them? They don’t thrive. They don’t prosper. This is what has happened.

Slide #19: Racial disparities in Concentrated Poverty

Percentage of poor Blacks and Whites living in concentrated poverty, by metro area

New York: White 18%; Black 27%;
Los Angeles: White 5%; Black 18%;
Chicago: White 4%; Black 35%;
Houston: White 4%; Black 18%;
Atlanta: White 3%; Black 17%;
Washington DC: White 3%; Black 16%;
Dallas: White 7%; Black 21%;
Riverside, CA: White 7%; Black 21%;
Phoenix: White 9%; Black 28%;
Philadelphia: White 11%; Black 34%;
Minneapolis/St Paul: White 18%; Black 23%;
San Diego: White 9%; Black 15%;
St Louis: White 2%; Black 29%;
Tampa: White 3%; Black 24%;
Baltimore: White 2%; Black 16%;
Seattle: White 3%; Black 4%;
Denver: White 2%; Black 9%;
Oakland: White 4%; Black 6%;

One of the things that we need to understand is that White poverty is not the same as Black poverty. If we look at areas of what is defined as concentrated poverty, and that is areas of communities where 30% of the people who live in that community are poor, that is they fall below the federal poverty line. That does not mean that people, like I mentioned before who fall above the federal poverty are poor too.

What happened? People end up living in concentrated poverty. Blacks have no choice about where to live. White people really can go wherever they want. And poor White people are readily accepted in other communities that a poor black person would not be.

If you look at what is happening in cities. I am here in Chicago. 35% of poor Blacks live in communities of concentrated poverty; Whites in Chicago is less than 5%. So who ends up getting un-educated? Who ends up living in violence? Who ends up not having a grocery store? Who ends up not having proper sanitation? Who ends up in crowded housing? Who ends up in a community that has no jobs?

This was all planned. This didn't just happen. This wasn't because Black people are this way genetically, that they want to live like this. This was forced. White people have always had choices in this country. Black people don't.

I look at myself. I am standing in front of you today because I was lucky. Yes, I worked hard. But I was lucky to be able to have the opportunity to work hard. I think that is one of the things that gets lost. Things are not the same for Black people and White people in this country. It is no different from the first slide that I showed, that showed the inequities of what is the American Way. That is the American Way. This concentrated poverty in the differences between Blacks and Whites is copied all over the country. It is not just one place.

Slide #20: Black Convicts: 1865 and Now

I wanted to show this slide because it is important that we see structural racism, which is what segregation is. It keeps Black people in their place, where White supremacists want them to stay, it controls them, the police are able to surveil poor Black people once you keep them confined. What happened after the Civil War and the 13th Amendment was signed, was when States started out with what we call "The Black Codes." The Black Codes were laws that only applied to Black men. They were things like you can't walk on the sidewalk, you can't play checkers, you can't walk along the railroad tracks. That was how people knew they were going the right way when they were following the railroad tracks.

It was not criminal behavior. It was just a reason to arrest Blacks. What happened was that they had to find a way to sustain the economy on the plantations in the South. They arrested Blacks, they went to prison, they were leased out as convict labor, and that's who worked the plantations. The North never did anything about this, because remember the North was just as dependent on the Southern economy as the South was. So this was a win for the entire country. That is why this persisted.

It made the business of arresting Blacks very lucrative. And who arrested them? The Police. This is how the police forces started arresting Blacks. It was a game. It was what they did. They saw nothing wrong with what they were doing. Their primary responsibility was to arrest these Blacks to supply the economy. Even children were leased, if their parents for whatever reason weren't around, they were leased to plantations. This was how the South prospered.

The picture on the left is from the 1860s, when convict leasing had just started.

Who is in the picture on the right? That's today.

This is what the war on drugs has done. It has repeated what was done in 1866. If you look at New York City: New York City is 43% White, 24% Black. However, People of

Color make up 94% of the marijuana arrests. Even though the data shows that Blacks and Whites use marijuana at the same rate. This is how with the Prison-Industrial Complex and many corporations now have factories, or they lease prisoners to work in their factories for pennies a day.

This is the same thing that is happening now. We don't call it convict leasing. It has a nicer word. I'm not sure what it is. This is what is happening today. It is Black men whose lives are destroyed, and the country gets rich off of their free labor.

And we know how the prisons are when we talk about health care. Covid was rampant in prisons because it was crowded, there was no way to control the spread of Covid during that time.

Slide #21: Improved Quality with Single Payer

- Single tiered system would foster quality by making it acceptable to everyone
- Help reduce racial health inequities with increased access and facilities where needed
- System would provide continuity of care
- Preventive care would be a priority
- It could make possible the creation of a unified, useful and confidential EHR (Electronic Health Records) like the Veterans' Administration already has
- Facilitates real health planning by putting resources where they are needed rather than where they make money.

Single Payer won't solve the police brutality against Black men. It is not going to solve a lot of the inequities that are such parts of the social structure in this country that it is considered "normal" now. These inequities are considered normal. You assume that a Black man who gets stopped by the police did something wrong. How do you stop somebody because they have an air freshener hanging down from their rear view mirror, and say that is obstructing their view, and he ends up killed?

How many people who are disabled, who have that thing hanging get stopped because that's obstructing their view? They can pick and choose who gets attacked and who doesn't.

One of the things that Single Payer can do is that it will foster quality by making it accessible to everyone. There is no question that people who have access to care do better. Whether they are able to pay for that access to care, it has been shown that with high deductibles, with high co-pays, with pharmacy costs, even with insurance they can't pay for their care. They can't pay the out of pocket expenditure.

To me, it is almost like if I give you a car, a brand new car, and its got all the bells and whistles, but I don't give you the key until you pay me \$9,000. You don't have a car. You have something that looks like a car in the front of your house, but you can't drive it. It is just like you have a card in your wallet that says Blue Cross Blue Shield or Signa, but you can't use it because you haven't paid the deductible.

With Single Payer, everyone would have access. It wouldn't be dependent on your having a job. It wouldn't be dependent on your paying for it. There would be small taxes with your employer, but it would clearly be less than what you are paying now.

This is a system that would be single tier, that would foster quality by making it acceptable to everyone. I have always said, "If it is acceptable to White people, then it will work." I am talking about all medically necessary services. If somebody wants to

pay for a single room with a view of the lake, if that's where their hospital is, they can do that, but they won't get better care just because they have more money.

It would help reduce inequities because we could put facilities where they are needed and not where they can make money. We wouldn't need to have rural deserts. We wouldn't need to have urban deserts. We wouldn't need to have hospitals in poor communities without resources, because that community cannot afford to sustain that hospital because too many are uninsured.

The system would provide continuity of care. You can keep going back to the doctor. You could get follow-up care, whatever your problems are.

Preventive care would be a priority. Right now, in this country, less than 10% of this country get all the preventive care that they should.

It would make possible a unified electronic medical record, like the Veteran's Administration has. If you are a Veteran and you see a doctor in New York, and then you see a doctor in California, they can both see your medical record.

It would facilitate real health planning by putting resources where they are needed, and not where they can make money. It is just putting things where they are needed. I work at Cook County Hospital. Within that one mile, there is Cook County Hospital, there is Rush University Hospital, there is University of Illinois Hospital, and there is the Jesse Brown VA Hospital. However, three or four miles away, absolutely nothing.

So we have all of these facilities together, but then farther away there is nothing. It is just like putting 4 fire stations at the four corners of an intersection. That doesn't make sense: you want the fire stations to be out in the city so that they are equidistant from where a fire may be. That should be the same with health care facilities, if we want to be able to treat everybody.

Slide #22: Reform Based on Private Insurance does not Solve ANYTHING

- Coupling of insurance to employment is a fragile and unstable relationship
- Insurers can change networks and increase premiums, deductibles and copays
- Providing more government money to insurance companies will not lower costs or improve care.

Part of the problem with the reform that is proposed now is so-called improving the Affordable Care Act or the Public Option and these improvements are based on private insurance – and that doesn't solve anything. For one, if we have learned nothing from the pandemic, we have learned how fragile employment is. So coupling insurance to your employment is really a fragile and unstable relationship. Your insurers can change your networks, increase your premiums and deductibles, they won't guarantee that you can see the same doctor. Providing more government to insurance companies doesn't lower costs or improve care. It just provides more money to the insurance companies. It doesn't do anything to improve your care. This is why we need MediCare for All.

Slide #23: The inequities that have been made obvious by Covid-19 are an extension of long-standing inequities that have been created in this country, and made worse by how we finance our healthcare system.

Universal coverage, publicly accountable, single-payer health coverage is an essential component to resolving these inequities and protecting the care for all of us.

The inequities that have been made obvious by Covid-19 have always been there. They were there, we just chose not to see them, to blame the victims for their own poor health. I have tried to show you some examples of how they were created in this country and then made worse by the way we finance our health care system.

Universal coverage, publicly accountable, single-payer health coverage is an essential component to resolving some of these inequities. And we will all be healthier. I think we all have to understand that we will all be healthier if everybody is healthier. When your children go to school, you want their teacher to be healthy. When you go to a restaurant, you want whoever cooked your food, and laid down your silverware, to be clean and healthy. Everybody benefits from that. We have to get over this thing that people who don't have money have no value. That is one of the crucial points that we have to change. We have to realize that whether you are entitled to health care or whether you are entitled to anything, it can't be based on money.

Slide #24: Shirley Chisholm for President: Unbought, Unbossed 1972

"We have never seen health as a right. It has been conceived as a privilege, available only to those who can afford it. This is the real reason the American health care system is in such a scandalous state."

I like this because Shirley Chisholm was the first Black African American woman who was elected to the federal Congress in the 60s. She said back then that health care was a right. It was felt to be a privilege as it still is now, available only to those who can pay. That is the real reason that the health care system that we have now just isn't working.

Slide #25: Insurance, Drug and Health Lobbyists: I'm just not seeing any good solutions (burying Single Payer with campaign contributions)

Slide #26: For more information... Health Policy Websites

- The Commonwealth Fund: www.commonwealthfund.org,
- Kaiser Family Foundation: www.kff.org,
- Health Affairs Blog: <http://healthaffairs.org/blog/>
- Physicians for a National Health Program: www.PNHP.org,
- Lown Institute: www.lowninstitute.org,

Janet Hoy: That was truly wonderful. Devastating and wonderful. I have not heard this kind of presentation before that had so many good graphics and statistics that was so devastating. I was looking around at people's faces, and this information is something we sort of knew but we never felt it in a compassionate way, so this was really impactful.

There are a few other people who are a part of this caucus who can answer questions. They are Pat Snyder, Janet Thomas and Hank Abrons. They have all been involved in health care for decades and involved in advocacy at the local level, the state level and the national level, so they are the people for questions as well.

I am going to start it off. Dr. Rogers, I think that one of the questions that many people often ask, in a knee-jerk way, it sounds great to have a single payer, we could get everybody covered with good, high quality accessible care, but how do you pay for it? High level, at 10,000 feet, what are the things that we need to be thinking about in terms of addressing this financially?

Dr. Rogers: What is kind of interesting is that question always gets asked, but we never ask about how all these other countries? How did they pay for it? And they got better care and outcomes. So there is a way. One of the ways is if we eliminate the private

health insurance company that is really just an administrator, an unnecessary middle man. We spend so much time and money on administration. Duke Hospital, for example, has more billing agents than they have nurses. So that they can bill, they are not paying for more nurses to provide care.

A lot of the dollars that we spend isn't going into health care. We could "global budget" hospitals so that they were providing the care needed, that needed to be done, rather than lucrative care. Right now, hospitals focus on procedures and things that make money because it is a for profit system. Whereas other countries with single payer/universal coverage focus on providing care.

Being able to provide some type of surgery is important, but it should not be at the expense of not being able to treat hypertension and diabetes in the majority of the country that needs it. If we taxed a small percentage of the people's income, this will be a progressive tax. It would be less than what they are paying now. They wouldn't be paying a deductible. They wouldn't be paying the balance of the insurance bill that their employer didn't pay. You wouldn't have these CEOs and the multi-million dollar salaries going to the insurance company. The money you would save from administration would more than pay for the care of people who haven't gotten care or people who aren't able to access care.

The Congressional Budget Office has shown that we can do this. This isn't magic. It has been done before.

We are a delusional country, thinking that we do everything better. When clearly the data shows that we don't. And why this country still keeps believing that we do everything better and this is the only way to do it, when everybody else is doing it another way. There is something very American that is very dysfunctional with this mindset.

One of the things I will say about the information in these slides: this stuff has never been taught. I had to learn it myself. And now, they are talking about eliminating all civil rights education in the schools, so things are going to get worse if we don't do something too about educating people.

Janet Hoy: Thank you. A follow up question to that. A number of parts of our health care system, private insurance is tied to public programs. For instance, as you know, the ACA program, Medicare Advantage, the VA and TriCare going out to civilian providers, workers' comp. etc. What would happen with Single Payer with those parts of the private-public partnership that is already in place? Have you thought about that, or is that a big part of what has to change?

Susan Rogers: That has to change. You won't need that partnership because that partnership is just a middleman. Health insurance doesn't provide care; they deny care. Your doctor tells you what you need to get, and then the insurance says well, that costs too much, or whatever – they are not going to allow you to get that. If you had a single payer system, where the doctor said this is what you need. OK, I will get my gall bladder out next Tuesday and the send the bill to government who pays for it, then it is done.

You don't need those other relationships. All they do is function as a middleman. They contribute to the administrative burden, and it fragments the system so that we don't work together. That is part of the problem with the pandemic. There was no cohesiveness. There was no sense that we need to work together to address this. Because every hospital was worried about them making money, every doctors' group was worried

about them keeping their jobs. Every other institution was worried about how they do they survive the pandemic. They weren't worried about the pandemic. They were worried about still making money.

The priority is money. It is not taking care of people.

Janet Hoy: I understand how that all fits in. This is kind of a more on the ground question, then I think we are going to move on to Hank and his close. Health care, like many other things in our current life have been really heavily politicized, starting with HillaryCare if not before, and on forward. It seems to be a trigger: we bring up health care discussions that we think can be productive and engaging. And there are so many red flags that go up for other people that it becomes a non-conversation.

Since you have done a lot of work in this single payer area, what do you suggest for Leagues that are interested in pursuing this. And having conversations in meaningful ways that can be productive and at least take a little bit of the pressure of the politicization of all this?

Dr. Rogers: Everything in this country is now politicized, unfortunately. I think we are going to have disagreements on whether the sky is blue or not. It is scary. Part of it is because of the problem with the politicization of things, that politicians are beholden to whomever gives them money. And who is giving them money? It is people who want to keep the status quo.

That is where grassroots has to come in. It has to be a grassroots effort and it has to be the people who are trying to move for change. It is going to be difficult. We have to break down the politicization. I am not sure how. That is a difficult one. It permeates all of society, everything that is being done.

Janet Hoy: Just one final question: what do you see as the role of the individual states in moving forward on a single payer initiative of some sort, versus a national approach? Do you see some practical advantage in states trying to pursue this more effectively and more quickly than we could ever get at a national level?

Dr. Rogers: What Canada did is they got a national single payer program going province by province. I think that would be more difficult here. We couldn't even expand Medicaid to the entire country because there are certain states that will never agree.

This country is divided. The South has never not been the pre-Civil War South. The South is still the pre-Civil War South. Now they are just a little more quiet about it. Now they are becoming loud.

What I am saying is that I don't know that we can get all of the states to ever agree to a single payer without a federal mandate. I think one of the things too that doing it federally will eliminate the administrative burden that presents. It will also decrease the fragmentation, because one of a federal thing is that like with the VA, you can go from New York to California and you are still covered. That is what it is with traditional Medicare. You are covered everywhere. It is the same benefit everywhere. If you are getting a knee replaced, you can move to where your kids live so that you can recuperate with them in their house.

It gives you the liberty to make choices. By keeping it with states, can further divide, and that is what I am concerned about. It can further divide the movement.

It has to become national to get all the benefits of a single payer program.

Janet Hoy: I am just going to read what Michelle Famula said to everybody in response to a question: This is a great question. One important way to de-politicize this issue is for a non-partisan, like the League of Women Voters, to lead on health care reform. Now there, that is a great segway.

Thank you Dr. Rogers. I have been in health care my entire career, and I learned a ton from you in a way that is really memorable and impactful and meaningful. So thank you from all of us. It was wonderful.

I would like to transition to Hank Abrons. He is going to talk about how you can get connected in your own League to a statewide group that is going to be continuing to plug away at health care issues.

Hank Abrons: Thanks Janet.

Thank you very much, Susan, for a very informative presentation. Before I talk about what is on the slide, I just want to say that politicization can be taken in different ways. I think that there is a positive aspect which is democracy. That is that people have a voice in government. That type of politicization needs to be strengthened to counter balance the lobbying and influence peddling aspect of politicization. I very much agree with Dr. Famula's comment about the League taking a lead. I think there is a lot of evidence that the kind of health care reform that we are talking about which is consistent with the League's position on health care, and is also best described by the kind of single payer program that Dr Rogers described for us is highly popular. So if the voice of the people is going to be heard, we are going to end up with the kind of health system that meets the needs of the population rather than becoming a corporate welfare program, or remaining a corporate welfare program.

Let me talk about the wrap up to this caucus. The co-sponsoring Leagues put this caucus together because we felt it was highly relevant in that the League has had a compelling position on health care for 28 years. Inequities in health care and in health have grown more and more urgent. They demand action. They demand our involvement, and our leadership and our participation. We think the League should be advocating for equitable universal care. And we consider that working for that is an integral part of making democracy work. Democracy is a process, but it is a process that is designed to accomplish something that is socially constructive and we think that health care reform is an excellent example of how working on a specific topic is the essence of making democracy work.

We want to wrap up with some action items. The hope is as the result of your gathering here today that we can reactivate a statewide League of Women Voters Health Care Committee. There has been such a committee in the past; it has been inactive in recent years. This would be instrumental in getting our League to become more involved, and our League members and our local Leagues and our communities.

We want to expand participation of California League members in health care reform. You are part of that now, and we will be in touch with you, because we are hoping that all of the Leagues that exist around the state will eventually form their own local health care committees as a way of getting League members involved and raising the points that we want to make to our communities.

We are going to be in touch with you. We are going to set up a statewide zoom call quite

soon. In the meantime, if you want to contact us, we have two emails, one at the Berkeley Albany Emeryville League, healthcare@lwvbae.org, and one at the Diablo Valley League, healthcare@lwvdv.org,

You are going to be on our email list. If you want to be dropped from that list, simply let us know. We won't bother you. But we hope to stay in touch. And we hope to see you on a statewide zoom call to continue the reactivation of the work.

Thank you very much to the participants and the co-sponsors and the participating Leagues, to Dr Rogers and to all of you for participating.

Janet Hoy: Thank you Hank, and thanks to Dr. Rogers. We hope to see you virtually at many other sessions throughout this convention week. Thank you for participating in this. We had 80 people who attended, which is wonderful. We hope you enjoy your California Convention. Take good care.

Transcription:

June 14, 2021

Start: 9:00 am

Finish: 10:30 pm

Jon Li

Institute for Public Science & Art

