Georges Benjamin: Hello, everyone. I'm Dr. Georges Benjamin. I am the executive director at the American Public Health Association, and I'm very pleased to be with you here today. The APHA is celebrating its 150th anniversary this year, being founded in 1872. So today's is a topical discussion on access to care, something that APHA has been intimately involved with for many, many years. We really believe in APHA that health is a fundamental human right. And if anyone doesn't believe that, just look at what's happened over the last couple of years with the COVID-19 pandemic. It has clearly shown the importance of the need for healthcare. And we also know that during the passing of the Affordable Care Act, that health insurance coverage has demonstrated itself to be very, very important, not only for the health of communities, but for the economic wellbeing of communities.

So we have three extraordinary panelists with us here today. We have Dr. Ted Brown. Ted is the professor emeritus of history, professor emeritus of medical humanities at the University of Rochester. Dr. Carmen Rita Nevarez, who is the director of the Center for Health Leadership & Practice. She's also a past president of the American Public Health Association. And Dr. Walter Tsou. Walter is the adjunct professor of family medicine and community health at the University of Pennsylvania, and a past president of the American Public Health Association as well. So with that introduction, I'm going to ask each of them to give an opening statement, then we're going to have a conversation for the rest of this hour. And so the first person I'd like to talk with is Dr. Brown. Ted and I actually wrote a book together called The Quest for Health Reform, which is 100-year history of the nation's quest to get quality affordable healthcare coverage. He's a medical historian and really a good friend. Ted.

Theodore Brown: Well, I'd like to pick up where you just left off, Georges. It's been 100-year quest. That's one of the most important things to realize. Efforts to create a national health program in the United States began in the turn of the 20th century in part led by European countries, which served as models, but in a way as frustrating models because the conditions weren't quite the same in the United States. And for just broad brush strokes, we can see the first efforts to try to imitate European models, great pushback, political backlash, political backstepping, and an attempt again in the late 1920s and the 1930s to try to regain some of the ground that had been achieved briefly in the 1918s, and then pushing through the New Deal period, the post-war period, to try to create a national health program. But much of those efforts were just pushed aside and were undermined.

We can talk about if we have time, some of the specific dynamics of that. But only in the frustration of not being able to achieve a national health program for the most vulnerable, the elderly and those in the farm who needed the care most. Led to eventually in the 1950s and early 1960s for a new strategy to create a universal national health program for a particular age group, those over 65 who reached retirement age. And that resulted in the creation of Medicare and with it, Medicaid. So the first phase, that long first phase can be seen as efforts that led in many different directions with many alternatives and contradictions built in. Finally, eventuated in Medicare for a group of the population, and that program was seen by many as the model for universal healthcare program. So the second phase can be seen as from 1965 forward when Medicare is enacted, to try to create a Medicare for All universal healthcare program.

Also getting considerable pushback with reformers having to make a difficult decision of trying to push for an all-out Medicare for All program, which many thought was philosophically and otherwise ideal, but which would not be realized within the

American political system and trying out various other compromises to cover a larger and larger number of previously uncovered people. Though some still held out for the Medicare for All strategy, and that has led to some of the tensions between those who have advocated for particular measures like the Affordable Care Act, and those who would've preferred a Medicare for All universal coverage system based on a single-payer model. If you'd like me to elaborate any of that, I have some very, very broad overview, of course. And I can drill down on any piece of that that you might like to pursue.

Georges Benjamin: Thank you, Ted. Let me give Dr. Nevarez an opportunity to talk about her experience as APHA president. Carmen.

Carmen Nevarez: Yeah. Thank you, Georges. Well, all I can tell you is it was a real rollercoaster. I think starting out, right around the week of my election was around the time of the election of President Obama. And so within the public health quarters, there was a huge amount of anticipation and excitement about what that might mean for health reform for public health in general. 2009 was my actual president-elect year. And so I was party to a lot of conversations that we were having at APHA about what kinds of elements we wanted to see in any type of bill that was going to be put forth by the administration. And then towards the end of the year, the bill that was put forth and then later passed and actually signed during a visit that I was having to APHA. We had tremendous amount of optimism about what this might mean as well as a good share of skepticism about what this might mean.

When I went to visit the various states. I really found that there was a very large gradient in understanding of what was really contained in the Affordable Care Act. Depending on which state I was in, there was just such a huge gradient. My job was to really help everybody to understand that our basic healthcare reform principles at that time were universal coverage, and ensuring that social and economic conditions where everyone could be healthy was what APHA was sincerely and vigorously advocating for. So in some states that I went to, they had a great deal of knowledge on what was contained within the bill, and pretty good understanding of what was within the healthcare provisions. In some states, there was not even a real awareness that the ACA impacted public health significantly. And so we spent a lot of time discussing what those provisions were.

And there were a couple of states that I went to where the skepticism about the ACA and APHA's position in supporting it was really not... There was really not a positive general feel. I have to say that those were just a few of the states, but that was out there. And so our association, as we might suspect, if you know anything about our association, was everywhere from full out in support of to, "We don't like it. It's not enough. And we want something different and something better." I think anybody who's been in this association knows that that is just very often the case on many of the things that we stand for. Although, as an organization, we fully stand for and commit to the idea of a society in which everyone can be healthy. So that was my experience. My year was pretty exciting.

Georges Benjamin: Thank you. Dr. Tsou, you've been in this for quite a while and you have, obviously, a very, very important perspective on this through APHA and through another organization that you've been very, very active with. Can you tell us a little bit about that?

Walter H. Tsou: Well, thank you so much, Georges, and to APHA for this wonderful opportunity to talk about one of my favorite topics, and one of the reasons why I even got into public health, which is access to healthcare. So I should say that I'm most proud of introducing myself as a public health physician. I've also served, as you mentioned, as past president of APHA, and one of the greatest distinctions in my life, and former health commissioner of the city of Philadelphia. I also serve as a national board advisor for physicians for a national health program, which is an advocacy group that fights for a Medicare for All, single-payer national health insurance program, for this country. Then I've been fighting for a single-payer national health insurance program for the last 40 years and so far, as you all know, I have been... What should I say? We all have been unsuccessful.

And part of the problem is that we get mired into discussions of single-payer versus the ACA, versus Medicare, versus Medicaid, versus public option, et cetera, et cetera, all kinds of healthcare reforms, all to the infinite confusion of the American people. Let me suggest that our true discussion about access to healthcare needs to take a step backwards, one that the American people perhaps can have and more intuitively understand namely whether healthcare is a public good or is it a market commodity? Again, is healthcare a public good or market commodity? The answer to that question is the democratic with a small D way of figuring out which direction we should go with healthcare reform. Most Americans are totally baffled, frustrated, and even angry about how expensive the American healthcare system is. It costs too much, it covers too few, it hurts too many, and it's too complex for most of us to understand. We can and must do better. The medical industrial complex has taken advantage of this confusion and used their lobbying prowess to ensure that healthcare remains a market commodity.

Those of us in public health need to stand in opposition to this thinking. We can see, for example, how a market-based approach to healthcare has been devastating during the COVID pandemic. Just at a time when people most desperately need healthcare, the pandemic closed down most of the businesses in America and with that, not only losing their jobs, but their health insurance. Were it not for the intervention of government to facilitate PPE, testing, vaccine development and distribution, as well as assurances that free testing and hospitalizations would be covered, the already abysmal response of our country to COVID would've been far worse. I give this prelude about healthcare as a public good, because if we were to adopt that ethos, single-payer national health insurance would become a no-brainer. It would be the obvious solution to how to finance healthcare, and that we would emulate what the rest of the world does to make sure that everyone in their country has access to healthcare for far less costs than we pay in this country. Thanks.

Georges Benjamin: Well, thank you for those opening comments. So let's have a conversation. One of the things that happened when the Affordable Care Act was initially passed was that it was actually structured to achieve near-universality. And then the Supreme Court stepped in and allowed at least the Medicaid coverage provisions become optional to the states. I think most of us thought, "Well, it's money on the table. Why would anyone give it up?" Particularly since we know that having the ability to see a doctor can actually improve your health. And then of course, we know that there've been lots of studies that have shown that to be true. But improving health is certainly only one benefit of that. And, Ted, I know that the Medicare and Medicaid programs have had other real good benefits, including desegregation of hospitals and things like that. Can you really talk a little bit about some of the other benefits that we've had from a historical perspective by passing Medicare and even maybe the Medicaid program?

Theodore Brown: I think you've identified the single most important positive fallout of passing Medicare and that is the alliance with the civil rights movement during the 1960s. When Medicare was struggling to get majority support in Congress, even though there was a very strong push by then president, Johnson, there was still considerable resistance, especially from southern states and from states that didn't want to have a universalized system, but rather a segmented system, which they could control with quality and cost as they wanted to apportion it. The civil rights movement was put together with the leadership of the Medicare reform forces and pointed out that if Medicare came in as a program that would substantially fund hospital costs, it would be almost no hospital in the country, no matter what it's principles, that could resist that new input of resources that would be desperately needed For the hospital's functions. That would then be the carrot.

And the civil rights people convinced those in the Johnson administration that if we coupled the access to Medicare funding with a desegregation of deeply segregated hospitals, I'm afraid to say, not only in the south, but in other parts of the country as well, in major northern cities in some cases. If those were coupled, that is, this hospital could receive the Medicare funding for those who would be eligible for it. If the hospital came up with plans to demonstrate that it had in fact gotten past segregated wards and segregated services, then the monies would flow. And that provided the combination, the carrot and stick, that helped desegregated hospitals in a very significant and accelerated way as one of very important additional benefits of Medicare, in addition to covering people, of course, who were primarily eligible for it on these new provisions.

Georges Benjamin: Wow, wow.

Walter H. Tsou: That story of the desegregation of the hospitals in the south was chronicled by David Barton Smith in a book called The Power to Heal, which has been turned into a movie, which I should say, I first saw at APHA. So kudos to APHA for showcasing it. But I think that Ted's point that it was two huge social movements, one around healthcare reform, one around the civil rights, and the confluence happened during the Johnson administration. And he was a great champion for both those issues and were it not for that leadership, I think, and then this goes to show you the importance of governmental leadership, Medicare would not have existed the way it is today, nor would we have had the civil rights bill that was passed during the Johnson administration.

Theodore Brown: I would also say that the APHA should get credit for that too because some of the leaders of both movements really came together in major leadership positions within the APHA during the 1960s. It was the crucible in which these ideas were tested and developed, and then there were the national political forces that were able to put it into play on the national scale. But the APHA was very much a catalyst and a place of ferment and experimentation for these ideas, and had been that way, supporting a single-payer initiative, going well back into the 1920s and into the '30s and '40s in providing leadership with that. Whereas others in health reform would be a little more hesitant, the APHA stood up very strongly for that, and also some of the importance of the civil rights movement and its implications to healthcare more broadly and for public health very generally.

Georges Benjamin: Well, I remember when the Medicare was working to be passed, the American Medical Association, everyone knows, was vigorously and actively advocating against it.

Theodore Brown: Absolutely.

Georges Benjamin: APHA and the American Nurses Association as two exemplary organizations were strongly in support of Medicare's passage, to begin with. And we also get asked, what is APHA's impact? And, Carmen, when you were out on the road, how did you make that case about APHA's impact? Because there hasn't been anything that's happened in health in this nation that we haven't got our fingerprints on.

Carmen Nevarez: Yeah. I think that's a really important question. I don't think that most of the states that I visited had members that really understood how pervasive the prevention measures, how pervasive the titles within the act that were riveted on public health programs and public health funding. And also, I don't think that very many people understood how important it was going to be to take some of the principles of public health and to really vigorously apply them to our healthcare system so that we could understand what worked better, what didn't work. The whole PCORI is built into the ACA. The whole patient-centered outcomes initiative research approach was within the ACA and was very vigorously a part of what we were advocating for. So I don't think that very many people understood those finer implications of the influences, the deeper influences than just simply program funding.

It's not just putting more money into maternal child health programs. It's a much deeper analysis and really looking at how is our system structured? What does it pay for? What doesn't it pay for? What do the outcomes look like? Just building that into a system that really wasn't very self-reflective and didn't offer up the opportunities for looking at investment aligned with outcomes, or no outcome, or poor outcome. It was really nice to share that with people and see them realize that public health thinking was some of the fundamental undergirdings of what happened within the ACA.

Georges Benjamin: Well, I also think it's... Go ahead.

Walter H. Tsou: Well, I think it's also worth noting that something like $2 billion was actually set aside for public health fund out of the Affordable Care Act. And it was laudably stated that that was going to be helping us rebuild our public health infrastructure. The problem, unfortunately, as history has shown us, is that people used it as their own piggy bank and they diverted much of the money maybe to enhance primary care fee schedules, or they used it for other services. So essentially what should have been a huge financial boost to public health got attacked by some conservatives in Congress. I know that, Georges, you were very much involved with trying to help defend the public health trust fund that was created by the ACA and some of the battles that you had to go through to try to fend off the adversaries to that.

Georges Benjamin: Yeah. Well, the real challenge here is that I would love to pick on one part or the other. But actually at the end of the day, it turns out that both parts have been guilty of rating the prevention fund as a way of funding other priorities within health, but not necessarily to really put the prevention as far upstream as it needs to be. And I think that's one of our challenges. We spend only about 50% of our healthcare dollar, by the way, which is now $4 trillion, each and every year on public health.

And we really still don't have the public health system that we all deserve to have. That's one of the real challenges here. And, Carmen, in California, you folks have done a really great job of both expanding on the Affordable Care Act using the whole range of state options, and ensuring equity in the system. The ACA has actually fairly strong equity provisions in it, including requirements to get data collection, requirements to

reporting. A lot of that really isn't being followed or enforced, but you folks in California have done a pretty good job of really stepping up to the plate.

Carmen Nevarez: Well, and one of the real benefits of that, particularly in the data collection area, even though the data collection that proves or that shows unequal treatment is not perfect, it really is very imperfect. It's better than most. And we were able during COVID to use data collected about infections, about testing, and about vaccination to really pivot and turn and focus like a laser on the communities that were being unserved. And those communities were black communities, brown communities, Asian communities, communities that are not typically part of the mainstream healthcare coverage boat. The people who are serving in essential functions.

And you wouldn't be able to find them if you didn't have the data about them. You'd never know until they ended up in the hospital or in the morgue. So the really good thing was that Public Health Department's programs and community health centers could actually locate where were people who needed service, outreach, vaccination, education, and social help. And I'm really proud to say that's what California spent a lot of time doing during COVID, was really thinking about how do we make sure that everybody is at the table and will get what they need in order to survive this pandemic?

Georges Benjamin: Well, Dr. Tsou, you brought up this issue of whether healthcare is a public good or commodity to be sold. I guess a fundamental question, I know both you and Dr. Nevarez have both practiced clinical medicine, and of course I have as well. And the real challenge you have is that you know that if you're walking down the street and you suddenly fall over, in the United States of America, we pick you up, necessitate you and take you to the doctor as our first act. So we behave as though it's a fundamental human right. We don't do the wallet biopsy on the street. It might happen at the hospital or in some other further-down-the-line healthcare setting, but it certainly doesn't happen when we pick you up and take you to the doctor. How does the single-payer system align with those principles?

Walter H. Tsou: Well, actually, if you fall down in the street, they'll take you to the emergency room. And under the thing called EMTALA, the Emergency Medical Treatment, something Act, you are obligated as a hospital to take care of bonafide emergencies and Medicaid will cover those visits. The problem is that if it's not deemed a true emergency, then you could still get stuck with this bill. And there are a lot of people who use the ER as their primary care physician because frankly, they just don't know how to use our current system. A single-payer system, I think would transform that. First off, if you fell down the street, whether you was a true emergency or not, it would still be covered by the single-payer system.

But perhaps more importantly, I think it would be in the interest of a preventive model healthcare system to get people to see a primary care doctor to have, as the CMS would say, an accountable relationship with a health provider. And you could establish that regardless of who you are in our society. Joe, homeless, to Jeff Bezos, everyone would have accountable relationship with a health provider under a single-payer system. That I think would allow the guy who falls on the street to make a choice. He could go to the ER, or he can go to his primary care physician and have them take care of it. And I think ultimately if they avoid going to the ER and they have that relationship with a primary care doctor, our society saves money in the long run.

Georges Benjamin: Mm-hmm (affirmative).

Carmen Nevarez: But the other thing I'd like to underscore is that the ACA wasn't just about the healthcare side, the side that the three of us have had the deep many years relationship of providing care inside the office. It was also about making sure that we considered and provide technical assistance and thinking and organization around and in some case, funding for issues like transportation, how you're going to get to the doctor, education, how you're going to know what to do when you get sick, how you're going to know what's the food that's going to keep you nourished. So food systems, transportation, education, housing. Not one of us has been free of seeing patients whose health deteriorates because their housing is completely unacceptable. So those kinds of things are part of the Affordable Care Act, part of the consideration. They're part of the equation. And we can't afford to abandon those ideas in just thinking about how we finance healthcare. I just want to point that out since we're a public health organization, that we are also working on social determinants and as physicians, we have a responsibility to advocate for those social conditions.

Georges Benjamin: Thank you. Thank you, Carmen. Ted, one of the wraps on our system is that we obviously don't want to take anything from anybody else. Americans always want to build our own. It's American made, American made. That's really wonderful, but didn't we emulate our model for Medicare after another country?

Theodore Brown: Well, we obviously copied a lot of what was being done in other countries. But at the same time, we had a very ambivalent attitude towards it. If it wasn't American, then it wouldn't uniquely fit our conditions. And even though it was very clear that there were similar conditions in other countries that led those countries to define principles of solidarity, and of covering everyone who was in need into making sure there was a healthy workforce for a more productive country and so on, there were those in the United States who very strongly voiced opposition saying America is unique. It is not like those European collectivist countries. It has a very different individualistic mentality and style. And therefore, anything that even smacks of, or tastes of, or has the odor of socialism wouldn't be appropriate in this country, even if we can see arguments for the overall value of it to improve the health and ability of our workforce and so on.

And that very tension has been an important political force for those opposed to a universal healthcare system. Any kind of major reform have views to counter America's moving in that direction and that explains why it has taken us so long. Germany crossed the threshold to the real beginning of a national health system in the late 19th century. England did in the early 20th century. Other European countries came along very quickly in the '20s and '30s. And it took us a long, uphill, very, very vigorous battle to even get to Medicare for part of the population and Medicaid for another part of the population, rather than the universal system with the argument against it being that it would socialize America and was absolutely inimical to America's fundamental values. And I might point out there's an irony in this.

At the same time that there was strong support for universal systems of public education, and systems of access to literature and learning through public libraries and the like, healthcare was seen as a very different kind of thing with that argument taken up in a self-interested way by leaders of the medical profession who at the time feared that any government involvement would be a government takeover. So we have had this continuing battle by many people who want to resist a national system, asserting America's uniqueness, denying so many ways in which America had become like European countries, but not in this area where there were very strong professional and commercial voices in the insurance companies, in the pharmaceutical industry, who

were speaking out against it and trying to resist to preserve their own special areas of profit and advantage.

Walter H. Tsou: Yeah. I would like to mention that Wilbur Cohen who's considered the father of Medicare during the Johnson administration, after he's resigned himself, because he really wanted national health insurance for the country, but had to settle for the elderly, decided that he would use the salami approach. And he says that we're going to get national health insurance, but we're going to do it one slice at a time. And Medicare, as it was created in '65, was the first slice. I'm still waiting for the other slices to come into place.

Theodore Brown: Well, there's a very important principle that's been articulated by Paul Starr, who is a very significant scholar, about our history in attempting to get a national health program. And he calls it the protected public. It works in this very complicated way that once you get a group protected, those covered by Medicare, they become part of the resistance to universalization because they fear that in that extension, the cutting up of the salami, using that image, they might lose some of the benefits they've already gained. And instead of being the supporters and being those out in front of the leadership to the universalization of the program, want to make sure that their piece is protected.

And it was the same way with... We got health insurance in this country, first, by basing it on employment. Employment-based insurance provided often by commercial insurance companies in arrangements that were negotiated between labor and management. Those workers and even the unions that supported those workers, instead of saying, "Oh good, let's leave the fight for universalization," wanted to make sure, first and foremost, and you can understand their perspective, that their covered population didn't lose out in the process. As the salami was cut up, maybe they would have less of a robust meal themselves. And that's what Starr refers to as this strange backlash of the protected public acting as an impediment to reform rather than as a catalyst to reform.

Georges Benjamin: Ted, you just pointed out the fact that workplace coverage is really the predominant way in which people get covered under the age of 65, but that wasn't something that somebody set up and said, "Let's do this. This is a great idea." Wasn't that an accident of history?

Theodore Brown: Well, it was partly an accident of World War II. And when we were trying to gear up for war production as was required by the circumstances of World War II, one of the policies that the nation came up with is we can keep workers at their task. Many, of course, were already under arms, but the workers that remained needed to be encouraged to be as productive as possible by being given benefits as part of the employment arrangements. And those employment arrangements would allow for new benefits to be provided for those workers to keep them healthy and motivated. What then happened when the war ended is a great period of political ambiguity. Was these just special circumstances during the war? What happens? Do workers and their representatives and unions have the right to negotiate for those benefits as part of labor management negotiations? Are those benefits only the privilege of management to provide as they see fit to achieve any of their production goals?

These issues weren't settled until there were political battles and Supreme Court decisions that allowed collective bargaining in the late '40s and '50s over employment-provided or employment-based coverage, which again created a lot of special,

segmented, protected public. As these policies grew, as worker coverage increased, as workers and their families were covered, lots of people who weren't covered by those contracts were left out and labor unions were in difficult position of saying, "Do we push for a single-payer program?" Of course, we can see the principle of it, "Or do we make sure that we protect our own workers and hunker down protecting them and therefore, taking some of the political wind out of the sales towards a single-payer program?" And ironically, those people who were covered first on the Medicare, a universal system, were those who had retired from the workforce, so they would no longer be covered by their employment-based insurance.

And that provided really the political incentive beginning in the '50s to lead to a Medicare program, because unions couldn't cover those folks once they retired and they didn't have sufficient benefits in their retirement funds. That would be a good program for the government to step in to cover those formerly covered workers, who now reached an age when they were more likely to have various physical illnesses and other problems facing them at a time when their financial resources were at the least, and the unions couldn't support them because they were no longer part of the covered workforce. And that complicated set of dynamics was the civil rights movements and other sorts of things. And broad principles led to the coalescence of the Medicare strategy in the late '50s and early '60s implemented when John Kennedy was president and then followed from, of course, when Lyndon Johnson took over.

Georges Benjamin: Wow. Walter.

Walter H. Tsou: Well, I think that the story of Medicare, its being successful with senior citizens and taking the wind out of the sales for a single-payer plan, and the Taft-Hartley Act, which has allowed these health and welfare funds for many trade unions, those individuals are afraid of losing what they already have to maybe leap into the unknown, if you will, for a single-payer plan. The real issue I think is that we need a discussion about exactly what do we want to deliver in healthcare? And what do we want to finance? In America, the term "healthcare" actually has dual meaning. It can mean both financing, and it can be delivery. If this was Chinese, we would have two different characters and two different meanings to those terms. The insurance industry takes advantage of this duality by saying that we provide great healthcare to our covered lives.

Well, and they always have pictures of maybe a cute kid with their teddy bear getting great care or people actively in their lives, rather than showing people behind a cubicle with a TV screen, adjudicating whether these claims should be paid or not, which is what really happens behind the scenes. Well, I say this dichotomy between delivery and financing because what I really think we have to do in order to sell something like single-payer and to tell people in the Medicare and the unions why they should jump ship, is to describe what is it that we will deliver in a single-payer plan or actually, what do we want to deliver in healthcare? And then find the cheapest way of financing that delivery system. If we did that, I actually think people would say, "Yeah, I like the idea that you're offering those type of benefits, prevention services.

"Maybe you would integrate a more integrated social determinants of health with our healthcare system. I would like to have a system like that." And yes, it may turn out... In fact, it will turn out that the cheapest way to finance such a delivery system would be a single-payer plan rather than this Michigan Marketplace multi-payer system, which I think nobody can really fathom or figure out. And I think that's the kind of marketing that we in the single-payer movement need to do in order to convince people who are

in the unions, who are in Medicare, to explain the grass can be greener on the other side, and that you should think seriously about moving to a single-payer plan.

Carmen Nevarez: So one of the thoughts that I've been having as this conversation is evolving is there have been a number of progressive unions in this country that were very supportive of health reform and of universal coverage. I'm not going to say that they understood the mechanisms of single-payer, but I'm going to say that I think a number of them have understood that universal coverage and universal access is really important for our country's health. And I think one of the things that we need to spend a little bit of time doing is asking them how they got to that point. How did they get past the really complicated explanations of the economics that drive this very fragmented and nonsensical system that we all participate in? Because it takes us years to understand it.

And if it takes us a long time, how do you build a movement amongst people who don't really care about those kinds of details, but do care what they have to pay at the grocery store, and do care if there's somebody there who's going to provide them essential services, and who do care if their children are being educated by people that are healthy and able to take care of them? So how do we build a movement for better understanding of why having everyone in this country have unfettered access to the right kinds of healthcare, and to those conditions which would allow them to live healthier lives? How do we build that? How are we going to... Who has done that already? And what do they know in their arguments that we don't know? Or how do we amplify the arguments that they've had that have been very effective with their membership as they've come forward and been very supportive with the kinds of things that we're talking about here?

Georges Benjamin: At the end of the day, the goal, I assume, is to get a system with everyone in and no one out. Is single-payer the only way to get there?

Walter H. Tsou: In my mind, yes. But you're asking [inaudible 00:42:50]. I'm the converted. But, I mean, I know I'm being cynical about it, but it's the most cost effective way of getting there. You can get universal coverage through a multi-payer system, but then you have to deal with all the administrative complexities of adjudicating which part of the bill is paid by insurance plan A versus B, versus C. And that administrative complexity is what robs us from putting the money into actual care for people. So one of the reasons why single... Although we're denigrated as one-size-fits-all and all the other stuff, the truth is that most Americans don't care about who pays their bill. They care about the kind of services that are delivered to them. They want to be able to see the doctor of their choice or hospital of their choice.

They want to be able to know that when they pull out their card, whatever, it will cover them for their services. And whether that's a multi-payer system or a single-payer system, they don't really care. The truth though is that as taxpayers and as individuals, I think the most cost effective way of doing that is a single-payer plan because you automatically eliminate all this administrative complexity that is inherent in our current system with terms that are frankly foreign to any other nation in the world. Pre-authorizations, in network, out of network, all these copays, coinsurance, deductibles, all this stuff is uniquely American that I think is administratively wasteful.

Theodore Brown: I as a supporter of single-payer, Walter, I'd like to challenge you though that why has it been so difficult to get that message across? Why is it so easy to deflect people's attention from basic principles and that simple economics?

Walter H. Tsou: Yeah.

Theodore Brown: It's a very hard sell. It's been a very difficult uphill battle to get those messages clearly across to the people who would presumably be most strongly in support of them when they don't understand them.

Walter H. Tsou: Well, actually, most surveys suggest that something like 60% of the American people, even something like 30 or five or 40% of Republicans want something like a national health insurance plan. But the understanding of health policy and how healthcare works is only an inch deep and it's a mile wide.

Theodore Brown: Right.

Walter H. Tsou: So the real problem is that it's very easy to dissuade people by saying, "Oh, they're going to raise your taxes. Oh, you're going to lose your choices." You're going to have all kinds of things that they can throw at you. And then you who know very little about how health policy works, or understanding what the other side really could look like, or what are experiences in other countries, you crumple under that weight and simply say, "Oh, I guess I didn't think about that. And yes, I guess I don't really want that." And I think that's one of our problems, is that people need to understand much more about the advantages of single-payer because their intuition... I think the survey suggests that most Americans actually want it. The majority of Americans want something like a national health insurance plan.

The other thing that's really problematic in America, of course, is Citizens United and the lobbying firms. Because think about this, just the pharmaceutical industry alone has three lobbyists for every member of Congress. You're talking about over 1,000 lobbyists just for one industry, and no wonder it is so difficult for us to get our message across when none of us have the lobbying dollars that the pharmaceutical industry have. I could go on, but the point here is that we do need to strengthen our educational programs, but we also need to understand that the American people, I think, really do want this. They just need to have enough strong support by hopefully, organizations like APHA to back up their convictions.

Georges Benjamin: Well, thank you, Walter. You're in line now with... There's a question here from our listening audience that your comments align with. And the question, of course, is how do we dislodge the vested interest that just very tenaciously refuse to relinquish profits to save millions of people from a single-payer system? I mean, how do we go further? How do we vest those interests? How do we undermine those interests, compete with them?

Walter H. Tsou: Well, we're never going to have the dollars to compete with them. That's part of the reason why some politicians feel like we can never get single-payer. But we have the power of the vote. And frankly, there are people who are running right now for office who have a Medicare for All platform. And we, as people, should go out and say, "This is an important issue for me and I'm going to vote for that candidate." Even though the odds against them seem pretty high, we need to support people who have the courage to say, "Medicare for All would be better and if you elect me, that's the kind of program." If we get enough people who get elected because they ran a Medicare for All, we could see changes. It's going to be a slow, but it's going to be a steady process.

Georges Benjamin: Yeah. And to our listening audience, if you have additional questions, please type them in and get them to us. Ted, on Walter's point about this issue, and there are many

people who have profiled Democrats and Republicans in two separate camps. But I seem to remember from history that we've had presidents from both parties that have really promoted this idea of maybe not necessarily single-payer, but universal healthcare coverage.

Theodore Brown: Well, that's certainly true. And in fact, the first president to promote it at the turn of the 20th century was Teddy Roosevelt, who had been president as a Republican and then led the Progressive Party. And from that time forward, there have been bipartisan support. When Medicare passed, a significant number of Republicans voted for it. It's not like the polarized red/blue situation that we have now, because it was seen as a general benefit to their constituents, to the country at large, and we have to get back to that kind of conversation. One of the principles I'd like to return to though, and address this to Walter's comments, although it would be excellent if we had single-payer supporters, more of them in Congress, more of them in leadership positions, making the economic argument, I also think that we have to borrow the model of the civil rights movement when it was at its peak of power in the 1960s. Some fundamental basic principles of human rights and human dignity, one man, one person, one vote. And I think if we were interested in universal health coverage, a single-payer model would really return to that principle.

We would spend, I think, a little less time trying to articulate the economic arguments and the complexities there, and assert as often as possible that healthcare is a right. It is what a good society would provide. Just as public education is a right and voting is a right, so should healthcare be a right and the most efficient way to deliver that, that's where the efficiency and the economics comes in, is by a single-payer. But it's the right that I think needs to be a very important part of the advocacy and we shouldn't shy away from that. It was mentioned before some unions that have strongly supported single-payer. Well, interestingly and perhaps amusingly and paradoxically, one of the strongest unions supporting single-payer has been the California Nurses Union. And they, of course, understand the healthcare situation and deliver. They're also a strong union. They have been very strong in leading this battle and also articulating the fundamental principle of rights as the real foundation for their movement. I think that needs to paid attention to.

Walter H. Tsou: Yeah. I would love to see members of Congress who subscribe to the idea that healthcare is a human right. And in fact, it's easy for them to mouth those words. But to be honest with you, when it comes down to finally deciding to vote for a budget, they end up deciding that the price tag for a single-payer plan is beyond what they're willing to accept. So that is one of the dilemmas that we have as a country. The irony about that, though, is that if you look at all the total spending, as Georges said earlier, we spent over $4 trillion a year. We actually could spend less than $4 trillion a year, I believe, and still get universal coverage for all Americans, if we cut out all the administrative wastes that we have right now. And people would get much more comprehensive care for less money. We would get much better bank for our buck. And you could do that if we had a single-payer plan.

Georges Benjamin: Wow. Yeah. Carmen, you folks out in California, of course, have been promoting a single-player plan. Haven't quite gotten there, I know Vermont was going to do it, the issue of cost continues to come up. How do you pay for it? And I know that's been one of the issues in California. Do you have any insight into that?

Carmen Nevarez: Well, I wish I had a really good insight into it, but I'm sorry to say that I don't. I think that still the point that Walter brought up earlier in terms of how many lobbyists are

out there, countering what I think is on our side, well-thought-out and well-supported economic arguments, rights arguments, justice arguments for why universal healthcare is a major societal good, it gets drowned out by the people that are there with the contributions and that's just the truth of it. Bills that we think have a very good chance get watered down, and get watered down, and get watered down, and then get killed because they're bad bills. And it's unfortunate and we see it over and over again. But I think this is really some place where we're coming up against moneyed interest because, I mean, I think we're all saying in one way or another that insurance companies and pharmaceutical industry, the Big Pharma-type pharmaceutical industry, is making a lot of money out of things the way they are and they have more money to spend on lobbyists than we ever will.

So I can't say that I think it's going to happen in California in a really big way. It's going to continue to happen incrementally. We will continue incrementally to increase the number of people that are eligible for our Medicaid program, which is called Medi-Cal. We will continue to increase the classes of people that are entitled to access those programs, because we know that it's important to keep the California economy running, to make sure that people who are essential workers have coverage when in fact their workplace is never going to provide their coverage. But we are really pushing uphill against very significant financial interests that would have nothing of what we are talking about today.

Georges Benjamin: Well, I know that this whole thing is complex and we had a person who commented in the chat about the cost of the way we train physicians, the nurses, other people in the system. There's just so many different pieces of this trying to get everyone aligned and everyone interested in a much more functional system. Our nation is ranked 37th amongst all the industrialized nations in terms of health outcomes, and we're the only nation of the industrialized world without universal coverage for all of the citizens. We've got about four or five minutes left in our webinar today. If I could get a lightning round, maybe just a one minute of final thoughts from each of you. Let me start with you, Dr. Tsou, and then I'll go to Dr. Brown, and then Dr. Nevarez.

Walter H. Tsou: Well, as I said in my three minutes, our current healthcare system costs too much, covers too few, hurts too many, and it's too complicated. And I think actually there's value in making something much more straightforward and simple. We should differentiate that... We should simply say, "Let's come up with a delivery system that incorporates public health principles and prevention at its core, and then let's find the cheapest way of financing it."

Georges Benjamin: Thank you. Dr. Brown.

Theodore Brown: I agree with what Walter has said, but I still would like to see some sort of moral upsurge in our country. I don't know how to get there, but I think without that, we're going to be defeated again and again by the money interest of lobbyists and all the practical considerations. We somehow have to have a moral rebirth, and I come back to the model of civil rights movement. If we can have something that is truly grassroots, truly touches on the American soul in the most principled way, then we have a chance to move forward and these other pieces will fall into place. Without it, I'm not sure they will.

Georges Benjamin: Thank you. Dr. Nevarez, Madam President.

Carmen Nevarez: Well, I think that I'd like to just go back to something that Walter opened with and something that really resonates with me and always has, which is that health is really a public good. We can't run an efficient, just, well-rounded society without having health. We just can't. And I'm really hoping that part of what we've learned from COVID is what happens when we don't have that kind of access to care, to good working conditions, to prevention services. I'm hoping that we, as a public health community, will be able to draw the best stories and bring those stories into the public discussion, because we have to be able to prove that health is a valuable, important, essential public good. And if we can do that, if we can take advantage of what we've just been through for the last two years to do that, we'll be advancing the course of universal coverage, of universal health for everyone in this country. But if we can't do that, then we've just thrown away one of our best opportunities to make our case.

Georges Benjamin: Listen, let me thank you all for your conversation today. And again, just to remind you, this teleconference is here in celebration of the 150th anniversary year of the American Public Health Association. We have been fighting for a system that's equitable, accessible, of high quality for many, many years. And as we start and think about what we want to achieve for the rest of this celebratory, let me get all of us to pledge that it won't be another 50 years before our nation actually achieves the equity that we all deserve, the universality that we all deserve, the social justice that Dr. Brown has pointed out that healthcare should illustrate in our country. We've all got work to do, and I want to just encourage all of you to roll up our sleeves because we're on the move. We're impactful. And the American Public Health Association is here to make sure that every single person gets the healthcare that they deserve, and that our nation becomes amongst the healthiest nations on this planet very, very soon. I want to thank you all and have a wonderful, wonderful day.