Why Aren’t We There Yet?

HCAC 3/13/21

Rick Bieser, MD
Co-Chair, Colorado Chapter
Physicians for a National Health Program
“Follow the money.”
The World Economy
Gross Domestic Product (GDP) by Country 2019

- China: $14.34T, 16.34%
- United States: $21.43T, 24.42%
- Japan: $5.08T, 5.79%
- Germany: $3.85T, 4.38%
- India: $2.88T, 3.28%
- Brazil: $1.64T, 1.94%
- Russia: $1.37T, 1.59%
- France: $1.34T, 1.55%
- Italy: $1.27T, 1.49%
- Spain: $1.21T, 1.45%
- United Kingdom: $2.03T, 2.29%
- South Korea: $1.42T, 1.61%
- Vietnam: $0.87T, 1.00%
- Netherlands: $1.04T, 1.22%
- Canada: $1.04T, 1.22%
- Australia: $0.87T, 1.00%

Other countries and regions contribute to the remaining 9.8% of the world's GDP.

Article & Sources:
https://howmuch.net/articles/the-world-economy-2019
https://databank.worldbank.org
Health Care Spending as a Percent of GDP, 1980–2018

Percent (%) of GDP, adjusted for differences in cost of living

2018 data*:  
- US: 16.9%
- SWIZ: 12.2%
- GER: 11.2%
- FRA: 11.2%
- SWE: 11.0%
- CAN: 10.7%
- NOR: 10.2%
- NETH: 9.9%
- UK: 9.8%
- AUS: 9.3%
- NZ: 9.3%

OECD average: 8.8%

Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 36 OECD member countries, including ones not shown here. * 2018 data are provisional or estimated.


The world by income
Classified according to World Bank estimates of 2016 GNI per capita (current US dollars, Atlas method)

- Low income (less than $1,005)
- Lower middle income ($1,006–$3,955)
- Upper middle income ($3,956–$12,235)
- High income (more than $12,235)
- No data

Note: The World Bank classifies economies as low-income, lower-middle-income, upper-middle-income or high-income based on gross national income (GNI) per capita. For more information see https://datahelpdesk.worldbank.org/knowledgebase/articles/906595-world-bank-country-and-lending-groups.

### World Health Expenditures, 2016

<table>
<thead>
<tr>
<th>Category</th>
<th>% World population</th>
<th>% World health expenditures</th>
<th>Health spending per capita (US$)</th>
<th>Health spending (% GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>4.4</td>
<td>41.7</td>
<td>$10,271</td>
<td>17.1</td>
</tr>
<tr>
<td>Other High-Income Countries</td>
<td>12.2</td>
<td>39.3</td>
<td>$3491</td>
<td>7.8</td>
</tr>
<tr>
<td>Upper-Middle-Income Countries</td>
<td>34.5</td>
<td>15.7</td>
<td>$491</td>
<td>5.0</td>
</tr>
<tr>
<td>Lower-Middle-Income Countries</td>
<td>38.9</td>
<td>3.0</td>
<td>$81</td>
<td>3.2</td>
</tr>
<tr>
<td>Low-Income Countries</td>
<td>10.0</td>
<td>0.4</td>
<td>$40</td>
<td>5.1</td>
</tr>
<tr>
<td>World</td>
<td>100.0</td>
<td>100.0</td>
<td>$1,077</td>
<td>8.6</td>
</tr>
</tbody>
</table>

*SOURCE: Lancet. 2019; 393: 2233-2260*
NATIONAL HEALTH EXPENDITURES, 2019, BY SPONSOR

- Household: 28%
- Federal: 29%
- Private Business: 19%
- State and Local: 16%
- Other Private Revenues: 8%

NATIONAL HEALTH EXPENDITURES, 2019, BY SOURCE

- Private Health Insurance: 32%
- Medicare: 22%
- Medicaid: 17%
- VA, DOD, CHIP: 4%
- Other Third Party Payers and Programs: 6%
- Public Health Activity: 3%
- Out of pocket: 11%
- Investment: 5%

U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Spending</th>
<th>U.S. Public</th>
<th>U.S. Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.K.</td>
<td>$4650</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>$4820</td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>$5380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>$5420</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holland</td>
<td>$5770</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>$5780</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>$6650</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>$7730</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S.</td>
<td>$7,619</td>
<td>$11,600</td>
<td></td>
</tr>
</tbody>
</table>

$/capita

Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance
Source: OECD 2020; NCHS; AJPH 2016;106:449 (updated) - Data are for 2019
NATIONAL HEALTH EXPENDITURES, 2019, BY TYPE

- Hospital Care: 31%
- Physician and Clinical Services: 20%
- Other Professional Services: 3%
- Dental Services: 4%
- Other Health, Residential, and Personal Care: 5%
- Home Health Care: 3%
- Nursing Care Facilities and Continuing Care Retirement Communities: 5%
- Prescription Drugs: 10%
- Durable Medical Equipment: 2%
- Other Non-Durable Medical Products: 2%
- Government Public Health Activities: 3%
- Government Administration: 1%
- Investment: 5%
- Net Cost of Health Insurance: 6%

### Administration's Share of Expenditures in Each Health Care Sector in the United States and Canada, 2017

<table>
<thead>
<tr>
<th>Category of Expenditure</th>
<th>Administration’s Share of Expenditures for Sector, %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>United States</td>
</tr>
<tr>
<td>Insurance overhead and government administration of health programs*</td>
<td>7.9</td>
</tr>
<tr>
<td>Hospitals</td>
<td>26.6</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>26.7</td>
</tr>
<tr>
<td>Home care</td>
<td>39.6</td>
</tr>
<tr>
<td>Physicians and other clinical services</td>
<td>21.8</td>
</tr>
<tr>
<td>Total†</td>
<td>34.2</td>
</tr>
</tbody>
</table>

*Variable estimation
† = Combined

Source: Ann Intern Med. 2020; 172(2): 134-142
# Health Care Companies in the Top 100, Fortune 500

<table>
<thead>
<tr>
<th>Rank</th>
<th>Company</th>
<th>Revenues ($B)</th>
<th>Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>CVS Health</td>
<td>256.8</td>
<td>Pharmacy and Other Services</td>
</tr>
<tr>
<td>7</td>
<td>UnitedHealth Group</td>
<td>242.2</td>
<td>Insurance and Managed Care</td>
</tr>
<tr>
<td>8</td>
<td>McKesson</td>
<td>214.3</td>
<td>Wholesalers</td>
</tr>
<tr>
<td>10</td>
<td>AmerisourceBergen</td>
<td>179.6</td>
<td>Wholesalers</td>
</tr>
<tr>
<td>13</td>
<td>Cigna</td>
<td>153.6</td>
<td>Pharmacy and Other Services</td>
</tr>
<tr>
<td>16</td>
<td>Cardinal Health</td>
<td>145.5</td>
<td>Wholesalers</td>
</tr>
<tr>
<td>19</td>
<td>Walgreens Boots Alliance</td>
<td>136.9</td>
<td>Food and Drugstores</td>
</tr>
<tr>
<td>29</td>
<td>Anthem</td>
<td>104.2</td>
<td>Insurance and Managed Care</td>
</tr>
<tr>
<td>35</td>
<td>Johnson &amp; Johnson</td>
<td>82.1</td>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td>42</td>
<td>Centene</td>
<td>74.6</td>
<td>Insurance and Managed Care</td>
</tr>
<tr>
<td>52</td>
<td>Humana</td>
<td>64.9</td>
<td>Insurance and Managed Care</td>
</tr>
<tr>
<td>64</td>
<td>Pfizer</td>
<td>51.8</td>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td>65</td>
<td>HCA Healthcare</td>
<td>51.3</td>
<td>Medical Facilities</td>
</tr>
<tr>
<td>69</td>
<td>Merck</td>
<td>46.8</td>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td>99</td>
<td>AbbVie</td>
<td>33.3</td>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>1837.9</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Fortune 500, 2020
"Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible."

The Profits of "Non-Profit" Health Systems

<table>
<thead>
<tr>
<th>Health System</th>
<th>2018 Profit</th>
<th>2019 Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser</td>
<td>$1,891 mil.</td>
<td>$2,732 mil.</td>
</tr>
<tr>
<td>Mayo</td>
<td>$706 mil.</td>
<td>$1,063 mil.</td>
</tr>
<tr>
<td>AdventHealth</td>
<td>$784 mil.</td>
<td>$829 mil.</td>
</tr>
<tr>
<td>Baylor Scott &amp; White</td>
<td>$582 mil.</td>
<td>$725 mil.</td>
</tr>
<tr>
<td>Indiana U. Health</td>
<td>$612 mil.</td>
<td>$679 mil.</td>
</tr>
<tr>
<td>U. Colorado Health</td>
<td>$526 mil.</td>
<td>$657 mil.</td>
</tr>
<tr>
<td>Houston Methodist</td>
<td>$473 mil.</td>
<td>$651 mil.</td>
</tr>
<tr>
<td>NYU Langone</td>
<td>$198 mil.</td>
<td>$606 mil.</td>
</tr>
<tr>
<td>Mass General Brigham</td>
<td>$310 mil.</td>
<td>$485 mil.</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare October 19, 2020:34
The Usual Suspects
(United Healthcare, Anthem, Aetna, Cigna, Humana)
Health Insurance Coverage (millions): United States, 2019

Source: Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2019
125 Million Members, Big 5 Insurers, by Market Segment, 2016

Administrative Services Only (!) 60%
Medicaid 12%
Medicare 8%
Group Risk 17%
Individual 3%

Source: Health Affairs. 2017;36(12):2185-94
52% of Private Insurers' Revenues Come From Medicare and Medicaid

Source: AM Best 8/13/2018
COVID-19 Boosted Insurers' Profits

Overhead + Profits (% of Premiums)

<table>
<thead>
<tr>
<th>Company</th>
<th>Q2, 2019</th>
<th>Q2, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centene</td>
<td>13.3</td>
<td>17.9</td>
</tr>
<tr>
<td>Anthem</td>
<td>13.3</td>
<td>17.9</td>
</tr>
<tr>
<td>Humana</td>
<td>15.6</td>
<td>22.1</td>
</tr>
<tr>
<td>Cigna</td>
<td>18.4</td>
<td>29.5</td>
</tr>
<tr>
<td>Aetna</td>
<td>16.0</td>
<td>29.7</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>16.9</td>
<td>29.8</td>
</tr>
</tbody>
</table>

Source: SEC Filings
Number Uninsured, 1976-June, 2020

Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data
Figure for 2020 is estimated based on increase in unemployment
Figure 3. Percentage of People Without Health Insurance Coverage by Age: 2008 to 2019
(Civilian noninstitutionalized population)

Note: Estimates reflect the population as of July of the calendar year. For information on confidentiality protection, sampling error, nonsampling error, and definitions in the American Community Survey, see <https://www2.census.gov/programs-surveys/acs/tech_docs/accuracy/ACS_Accuracy_of_Data_2019.pdf>.
Source: U.S. Census Bureau, 2008 to 2019 American Community Surveys (ACS), 1-Year Estimates.
### Percentage of People Without Health Insurance Coverage by Selected Characteristics: 2019

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>8.0</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Under age 19</td>
<td>5.2</td>
</tr>
<tr>
<td>Aged 19 to 64</td>
<td>11.1</td>
</tr>
<tr>
<td>Aged 65 and older</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Race and Hispanic Origin</strong></td>
<td></td>
</tr>
<tr>
<td>White, not Hispanic</td>
<td>5.2</td>
</tr>
<tr>
<td>Black</td>
<td>9.6</td>
</tr>
<tr>
<td>Asian</td>
<td>6.2</td>
</tr>
<tr>
<td>Hispanic (any race)</td>
<td>16.7</td>
</tr>
</tbody>
</table>

**Source:** U.S. Census Bureau, Health Insurance Coverage in the United States: 2019, page 7, Figure 2.
Since the ACA, Fewer Adults Are Uninsured, but More Are Underinsured

**Percent of adults ages 19–64**

- Insured all year, not underinsured
- Insured all year, underinsured
- Insured now, had a coverage gap
- Uninsured now

Notes: “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. “Insured now, had a coverage gap” refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. “Uninsured now” refers to adults who reported being uninsured at the time of the survey.


EVERY SYSTEM IS PERFECTLY DESIGNED TO GET THE RESULTS IT GETS.
-W. EDWARDS DEMING
2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016

- Medical Bills Only: 22%
- Work Loss Only: 8%
- Bills + Work Loss: 36%
- No Medical Cause: 33%


Work loss = "work loss due to illness"
Get help with medical fundraising

With a GoFundMe, you can get immediate help with medical bills.

Start a GoFundMe

A friend raised $35k to help Cindy's children with their medical care.

We're the leader in online medical fundraising

250,000+ medical campaigns per year

$650 million+ raised per year
38,531 Deaths During 2019 Due to Uninsurance

<table>
<thead>
<tr>
<th>State</th>
<th>% Uninsured</th>
<th>Excess Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>18.4</td>
<td>6,804</td>
</tr>
<tr>
<td>California</td>
<td>7.7</td>
<td>3,903</td>
</tr>
<tr>
<td>Florida</td>
<td>13.2</td>
<td>3,619</td>
</tr>
<tr>
<td>Georgia</td>
<td>13.4</td>
<td>1,817</td>
</tr>
<tr>
<td>North Carolina</td>
<td>13.4</td>
<td>1,504</td>
</tr>
<tr>
<td>New York</td>
<td>5.2</td>
<td>1,309</td>
</tr>
<tr>
<td><strong>U.S.</strong></td>
<td><strong>9.2%</strong></td>
<td><strong>38,531</strong></td>
</tr>
</tbody>
</table>

Based on best estimate from multiple studies of 1 death per 769 uninsured/year, and # uninsured at time of survey.
Life Expectancy at Birth, 1980–2017

Note: OECD average reflects the average of 36 OECD member countries, including ones not shown here.

Estimated and projected life expectancy at age 50 for males and females born in 1930 and 1960, by income quintile

Excess mortality during COVID-19: Number of deaths from all causes compared to previous years, United States

Shown is how the number of weekly or monthly deaths in 2020–2021 differs from the number of deaths in the same period over the years 2015–2019. The reported number of deaths might not count all deaths that occurred due to incomplete coverage and delays in death reporting.
Excess deaths each year in the USA relative to other G7 countries average (1980–2018)

Source: https://doi.org/10.1016/S0140-6736(20)32545-9

461,000 deaths
Deaths and Mortality

Data are for the U.S.

- Number of deaths: 2,854,838
- Death rate: 869.7 deaths per 100,000 population


- Life expectancy: 78.8 years
- Infant Mortality rate: 5.58 deaths per 1,000 live births

Source: Mortality in the United States, 2019, data tables for figures 1.5

Number of deaths for leading causes of death:
- Heart disease: 659,041
- Cancer: 599,601
- Accidents (unintentional injuries): 173,040
- Chronic lower respiratory diseases: 156,979
- Stroke (cerebrovascular diseases): 150,005
- Alzheimer’s disease: 121,499
- Diabetes: 87,647
- Nephritis, nephrotic syndrome, and nephrosis: 51,565
- Influenza and Pneumonia: 49,783
- Intentional self-harm (suicide): 47,511

Source: Mortality in the United States, 2019, data table for figure 2

America’s Wars Total (1775 -1991)

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Military Service during Wartime</td>
<td>41,892,128</td>
</tr>
<tr>
<td>Battle Deaths</td>
<td>651,031</td>
</tr>
<tr>
<td>Other Deaths (In Theater)</td>
<td>308,800</td>
</tr>
<tr>
<td>Other Deaths in Service (Non-Theater)</td>
<td>230,254</td>
</tr>
<tr>
<td>Non-mortal Woundings</td>
<td>1,430,290</td>
</tr>
<tr>
<td>Living War Veterans</td>
<td>14,918,000</td>
</tr>
<tr>
<td>Living Veterans (Periods of War &amp; Peace)</td>
<td>19,210,000</td>
</tr>
</tbody>
</table>

Source: https://www.cdc.gov/nchs/fastats/deaths.htm
Source: https://www.va.gov/opa/publications/factsheets/fs_americas_wars.pdf
Excess mortality in the USA relative to other G7 countries by age and race (2017)

Source: https://doi.org/10.1016/S0140-6736(20)32545-9
Change in life expectancy at birth, by Hispanic origin and race and sex: United States, 2019 and 2020

“Pay no attention to that man behind the curtain.”
Issue advocacy ad spending by subject, 2019

- Health care: $65.3m
- Energy: $19.1m
- Tax: $5.9m
- Impeachment: $5.7m
- Education: $5.0m
- Misc: $3.8m
- Transportation: $2.3m
- Trade: $2.0m
- Money in politics: $1.2m
- Right to work: $837.5k
- Abortion: $494.6k
- Criminal justice reform: $469.6k

Data: Advertising Analytics; Chart: Axios Visuals
“Under a one-size-fits-all government-run health care scheme, Americans will pay more and wait longer for worse care.”
Objectives

1. Change the national conversation around single payer/Medicare for All
2. Minimize the potential for this option in health care from becoming part of a national political party’s platform in 2020

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Support from left health care thought leaders (inside the Beltway)</td>
<td>- Support only from the far left and minimal political support</td>
</tr>
<tr>
<td>- Strong support but a lack of understanding around why Medicare for All (and all other proposals) actually is</td>
<td>- A moderate and left of center voter base that understands what Medicare for All is and no longer supports it/supports building upon the current system and fixing what is broken</td>
</tr>
</tbody>
</table>
Partnership for America’s Health Care Future Action
Lobbyist Disclosure Report, March 2020
Expense total: $2,865,427.77
Opposing: Colorado Affordable Health Care Option (HB 20-1349)
President Johnson signing the Medicare program into law, July 30, 1965. Shown with the President (on the right in the photo) are (left to right) Mrs. Johnson; former President Harry Truman; Vice-President Hubert Humphrey; and Mrs. Truman. Photo courtesy of LBJ Presidential Library.

At the bill-signing ceremony President Johnson enrolled President Truman as the first Medicare beneficiary and presented him with the first Medicare card. This is President Truman's application for the optional Part B medical care coverage, which President Johnson signed as a witness. SSA History Archives.
REQUIREMENTS OF THE CANADA HEALTH ACT

The Canada Health Act contains nine requirements that the provinces and territories must fulfill in order to qualify for the full amount of their cash entitlement under the CHT.

They are:
- five program criteria that apply only to insured health services;
- two conditions that apply to insured health services and extended health care services; and
- extra-billing and user charges provisions that apply only to insured health services.

The Criteria

1. Public Administration (section 8)

The public administration criterion requires provincial and territorial health care insurance plans to be administered and operated on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited. However, the criterion does not prevent the public authority from contracting out the services necessary for the administration of the provincial and territorial health care insurance plans.

The public administration criterion pertains only to the administration of P/T health insurance plans and does not preclude private facilities or providers from supplying insured health services as long as no insured person is charged in relation to these services.

2. Comprehensiveness (section 9)

The comprehensiveness criterion of the Act requires that the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services that require a hospital setting).

3. Universality (section 10)

Under the universality criterion, all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions. Provinces and territories generally require that residents register with the plan to establish entitlement.

4. Portability (section 11)

Residents moving from one province or territory to another must continue to be covered for insured health services by the “home” jurisdiction during any waiting period (up to three months) imposed by the new province or territory of residence. It is the responsibility of residents to inform their province or territory’s health care insurance plan that they are leaving and to register with the health care insurance plan of their new province or territory.

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence. If insured persons are temporarily absent in another province or territory, the portability criterion requires that insured services be paid at the host province’s rate. If insured persons are temporarily out of the country, insured services are to be paid at the home province’s rate.

The portability criterion does not entitle a person to seek services in another province, territory or country, but is intended to permit a person to receive necessary services in relation to an urgent or emergent need when absent on a temporary basis, such as on business or vacation.

Prior approval by the health care insurance plan in a person’s home province or territory may be required before coverage is extended for elective (non-emergency) services to a resident who is temporarily absent from their province or territory.

5. Accessibility (section 12)

The intent of the accessibility criterion is to ensure that insured persons in a province or territory have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unprejudiced or unimpeded, either directly or indirectly, by charges (user charges or extra-billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).

Reasonable access in terms of physical availability of medically necessary services has been interpreted under the Canada Health Act using the “where and as available” rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting “where” the services are provided and “as” the services are available in that setting.

In addition, the health care insurance plans of the province or territory must provide:
- reasonable compensation to physicians and dentists for all the insured health services they provide; and
- payment to hospitals to cover the cost of insured health services.
Medicare for All Legislation

116th CONGRESS
1st Session

H. R. 1384

To establish an improved Medicare for All national health insurance program.

IN THE HOUSE OF REPRESENTATIVES

February 27, 2019
Ms. Jayapal (for herself, Mrs. Dingell, Ms. Adams, Ms. Barragan, Ms.

116th CONGRESS
1st Session

S. 1129

To establish a Medicare-for-all national health insurance program.

IN THE SENATE OF THE UNITED STATES

April 10, 2019
Mr. Sanders (for himself, Ms. Baldwin, Mr. Blumenthal, Mr. Booker,

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Democratic Presidential Primary Polling, Dec 2018 to Apr 2020

The following graph depicts the standing of each candidate in the poll aggregators from December 2018 to April 2020.

Polling aggregates
Active candidates
- Joe Biden
- Others/Uncertain
Withdrawn candidates
- Bernie Sanders
- Tulsi Gabbard
- Elizabeth Warren
- Michael Bloomberg
- Amy Klobuchar
- Pete Buttigieg
- Andrew Yang
- Cory Booker
- Kamala Harris
- Beto O’Rourke
Events
- Debates
- Caucuses and primaries
- COVID-19 pandemic
- National emergency declaration
“I believe the path to ‘health care for all’ is a path following the lead of the Affordable Care Act . . . Let’s use our energy to have health care for all Americans, and that involves over 150 million families that have it through the private sector.” -Nancy Pelosi

“The cost of [Medicare for All] . . . would be so huge, we’d be broke.”

-Chuck Schumer

Source: https://americashealthcarefuture.org/
[Image description: A man in a suit and tie, with the U.S. Capitol building in the background.]
WE HAVE MET THE ENEMY AND HE IS US.
"Racial inequity is when two or more racial groups are not standing on approximately equal footing."

"A racist policy is any measure that produces or sustains racial inequity between racial groups. By policy, I mean written and unwritten laws, rules, procedures, processes, regulations, and guidelines that govern people."
Global Inequality

Income inequality...

GINI co-efficient versus per capita GDP, 2014 or latest

Source: Goldman Sachs. Data from CIA World Factbook
“It’s tough to make predictions, especially about the future.”
“Only a crisis - actual or perceived - produces real change.  

“When that crisis occurs, the actions that are taken depend on the ideas that are lying around.  

“That, I believe, is our basic function: to develop alternatives to existing policies, to keep them alive and available until the politically impossible becomes the politically inevitable.”

— Milton Friedman