

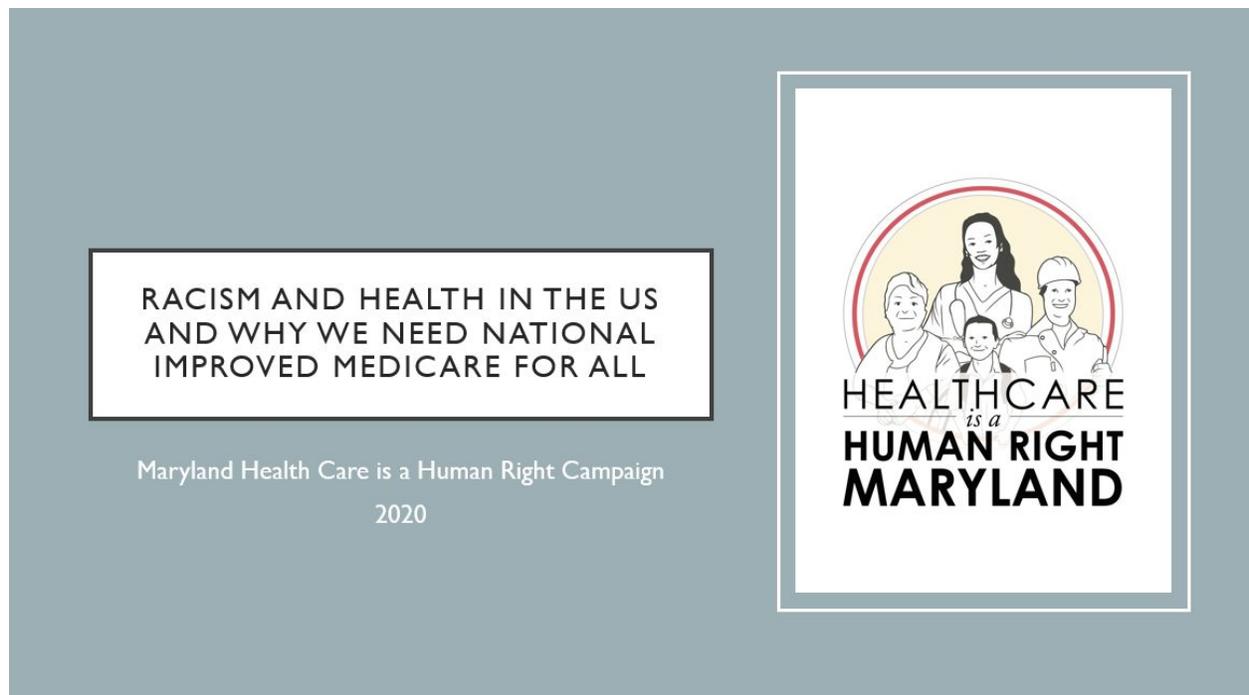
Presentation guide

Racism and health in the United States and why we need national improved Medicare for All

This toolkit is provided so you can give this presentation to your group or community. This is a big topic, so you can decide how much depth to provide in your presentation. You can choose which slides to use based on your audience. Information and resources are provided for each slide so that you can expand on what is presented visually.

You may want to give a summary as you present each slide and go into more depth during the question and answer session. Click here for a sample script. If you have questions or need training in using this presentation, contact margaretflowersmd@gmail.com.

SLIDE 1: Introduction



In this presentation, you will demonstrate some of the ways that racism targeting black people has been institutionalized in the healthcare system in the United States from the beginning and how it is manifested today. You will also describe features of a national improved Medicare for all (aka single payer) healthcare system that would serve to ameliorate some of the disparities in health outcomes between black and white people and what more needs to be done to end the impacts of racism on health.

SLIDE 2: Racism and health

RACISM AND HEALTH

- This presentation focuses on structural racism as it impacts black people in the United States.
- Discrimination against other groups of people based on race, ethnicity and country of origin also exists.
- Racism in the United States deeply impacts the treatment and health of Native American people.



The United States was founded as and continues to be a white supremacist country. White supremacy is defined as “the belief that white people are superior to those of all other races, especially the black race, and should therefore dominate society.” As a result, systemic racism and European norms are ingrained in every facet of society. Awareness is critical as a first step toward taking action to change the systems, practices and beliefs that perpetuate racism.

This presentation focuses on racism as it impacts black people, but discrimination exists in the treatment of all non-white people based on their race, ethnicity and country of origin.

In the United States, there is a long history of racism against Native American people that continues today. Native American people have worse health outcomes and a lower life expectancy than black people in the United States.

More reading: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2567901/>

SLIDE 3: Racism and Healthcare Reform

RACISM AS A FACTOR IN HEALTHCARE REFORM

- Racism is a significant factor in why the United States does not have a universal healthcare system today while all other wealthy nations do.
- Southern Democrats excluded black people from important New Deal Programs such as the Social Security Act of 1935.
- “Southern Strategy” = give states control over programs.
- The “three-layer cake” in Medicare and Medicaid.



There have been efforts to achieve a universal national healthcare system for more than 100 years but every attempt has been blocked.

Jill Quadagno, author of “The Color of Welfare,” writes, “The motor of American history has been the continual reconfiguration of racial inequality in the nation’s social, political and economic institutions. It is this characteristic that has impeded the development of a comprehensive welfare state.” For example, the original Social Security Act included all workers but the Southern Democrats in Congress changed it to exclude agricultural and domestic workers, which meant about 60% of African American workers.

Another tactic the Southern Democrats used was the “Southern Strategy,” giving control over welfare programs to the states so they had the power to discriminate. Black women, primarily, who were excluded from the Social Security Act received less generous benefits through the Aid to Families with Dependent Children (AFDC), which was run by the states. In the 1960s, there was an effort to create a more equal system through a national guaranteed income to provide support to all people regardless of race, but it was defeated, again because of the Southern Democrats, called the “Dixiecrats”, in Congress.

In 1965, Wilbur Mills, a powerful Dixiecrat and head of the House Ways and Means Committee, prevented health reform that could have potentially evolved into a national health insurance by adding what was considered a “poison pill.” It is referred to as a

“three layer cake.” Instead of one health program, Medicare was created as a federal program for people 65 years of age and older with two parts, Part A for hospital coverage and Part B for outpatient coverage, and Medicaid was created as a state program for the poor. This fragmented system could not be unified and gave states the power to discriminate in their Medicaid systems.

The photo: In 1948, Harry Truman ran for president on a platform supporting civil rights for blacks. The Southern Democrats were so enraged that they formed their own faction to oppose him, led by Strom Thurmond, the States Rights Party or the “Dixiecrats.” When Truman was nominated, they walked out of the Democratic Party Convention.

More reading: Race and Social Welfare Policy: The Social Security Act of 1935

<https://www.jstor.org/stable/2657939> and

<https://pnhp.org/news/race-as-a-barrier-to-universal-health-care/>

SLIDE 4: How is Systemic racism Manifested?



**HOW IS SYSTEMIC RACISM MANIFESTED
IN THE HEALTHCARE SYSTEM?**

Source: Medical Committee for Civil Rights at the March on Washington, 1963 National Library of Medicine

Now we will look at some of the specific ways that racism is embedded in the healthcare system and impacts the health of black people.

The photo: The Medical Committee for Civil Rights participated in the March on Washington and then became the Medical Committee for Human Rights the next year,

1964, during Freedom Summer to provide care to protesters, victims of police and KKK violence and black communities. It evolved into an organization that provided medics to march with protesters, deliver health care and advocate for desegregation in health.

SLIDE 5: Health Disparities are Systemic

RACE IS A SOCIAL, NOT
BIOLOGICAL, CONSTRUCT

- In the general population, black people are 2 to 3 times more likely to die of heart disease and have an overall shorter life span than white people.
- In a study of the Veterans Administration system, black people had a lower risk of heart disease and longer life expectancy compared to white people.



In 1790, Benjamin Rush, a founding father and professor of medicine, taught that being black was a form of disease, he called it a 'leprosy', that physicians would be able to someday cure.

Around the time of the civil war, in the mid 19th century, physicians believed that human races were different species and they responded differently to diseases. Thus, treatment depended on race.

It took until 1999 to dispel this belief when the Human Genome Project concluded that race has NO genetic basis. In fact, they found that using race as a factor in designing medical studies weakened them.

Racial disparities in health outcomes are not based on biological factors but on systemic ones - for example, the environment in which a person lives and their access to medical care.

A study of over 3 million veterans treated in the Veterans Health Administration (VHA) demonstrates this. While in the general population, black people have a lower life expectancy and are two to three times more likely to die of heart disease than white people, black veterans in the VHA have a lower death rate and less heart disease than white veterans. In the VHA

system, a type of single payer healthcare system, all people have the same access to care and it is provided for free.

More reading: No genetic basis for race -

<https://blog.oup.com/2017/09/racist-medicine-history-race-health/>, using race as a factor in studies should be stopped

<https://www.scientificamerican.com/article/race-is-a-social-construct-scientists-argue/>,

VA study - black people have a lower mortality rate and lower heart disease than white people, similar for strokes. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4618085/> [Note that in this 2015 study, the authors still promote the idea that there is a genetic difference between races. That is how ingrained the idea is in medicine.]

Overall, black people are 2 to 3 more times more likely to die of heart disease than white people <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367222/>

SLIDE 6: Health Disparities

BEING BLACK IN THE UNITED STATES IS BAD FOR YOUR HEALTH

- If black and white people had equal mortality rates, nearly 100,000 fewer black people would die EVERY YEAR.
- Black infants, mothers, children and adults are more likely to die than white infants, mothers, children and adults.
- “Blacks get sick at younger ages, have more severe illnesses and are aging, biologically, more rapidly than whites.”*

*Source: <https://www.usnews.com/opinion/blogs/policy-dose/articles/2016-04-14/theres-a-huge-health-equity-gap-between-whites-and-minorities>



Now, imagine if everyone in the United States had equal access to health care and equal risk of dying. Researchers found that if black and white people had the same death rate, almost 100,000 fewer black people would die each year. They also found that black people are sicker and die younger than white people even when they have similar education and wealth status.

The COVID-19 pandemic is a stark demonstration of racial health disparities. It is disproportionately impacting black people with higher incidence of infection, more

serious disease (black people are five times more likely to be hospitalized when they have COVID-19 than white people) and black people are two times more likely to die of COVID-19 when they are infected.

Racial disparities in death rates are found throughout life. Black babies are more than two times as likely to die in infancy as white babies. Black mothers are three to four times more likely to die during pregnancy and childbirth as white mothers. For children with asthma, black children are five times more likely to die as white children. And black adults with a variety of cancers are more likely to die than white adults with the same cancers.

A study looked at racial health disparities in Chicago over a 15 year period during which there were federal programs that focused specifically on ending racial health disparities. They found that for 15 different health outcomes they followed, disparities worsened or stayed the same for half of them and there was some improvement in the other half.

We have to ask ourselves - what is it about our society and healthcare system that creates these disparities? Why are they so persistent?

More reading:

<https://www.usnews.com/opinion/blogs/policy-dose/articles/2016-04-14/theres-a-huge-health-equity-gap-between-whites-and-minorities>

Infant mortality blacks 2.3 times higher than whites

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>

COVID-19 and racial disparities

<https://www.kff.org/disparities-policy/issue-brief/racial-disparities-covid-19-key-findings-a-vailable-data-analysis/>

Disparities persist even when there are attempts to end them

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804622/>

SLIDE 7: Endemic Racism in US Health Care

THE US HEALTHCARE SYSTEM WAS
FOUNDED ON RACISM AND WHITE
SUPREMACY

- Chattel slavery – black bodies were property and the medical establishment's role was to protect the interests of slaveholders.
- Racist medical theory was used to justify discrimination.
- Black people were subjected to unethical medical experiments.



We can begin at the beginning. The United States was founded and built on the displacement and genocide of Native Americans and chattel slavery of Africans. In 1772, around the time of the American Revolution, slavery was made illegal in England. Some historians believe the founding fathers feared England would make slavery illegal in the colonies too and that was a driving factor for seeking independence.

During slavery, physicians, who were mainly European, were hired to look after the slaveholders' property. They traveled on the slave ships to keep them alive and certified the health of slaves for sales transactions. Health care for black people was focused on them as property, not human beings. Black mothers were forced back to work shortly after giving birth and black people were forced to work long hours of hard physical labor in the hot sun because of the belief that they were genetically able to withstand it while whites were not.

In 1807, when the TransAtlantic Slave Trade was ended, slave owners started industrial breeding of enslaved girls to produce more slaves. This was also more profitable in some cases than growing crops, especially when the soil was depleted from years of farming.

In our own state of Maryland, there is a struggle going on over the property of one of the slave breeding camps in Bethesda. A cemetery that is part of a slave breeding plantation is being desecrated to build a self-storage facility despite the community

fighting to stop it. See the [Bethesda African Cemetery Coalition](#). (The photo is from one of the marches).

Medical research in the US also treated black people differently and in horrific and unethical ways. The “Father of Gynecological Surgery,” James Marion Sims, developed his techniques through experimentation on enslaved black women in the mid 19th century without using anesthesia. And in the mid 20th century, the famous Tuskegee syphilis experiments, in which black men were not told they had syphilis and were not treated for it, were conducted until they got public attention in the early 1970s and were forced to stop. Distrust of the medical system and medical research by black people continues to this day.

More reading: Doctors of European descent served the slaveholders

<https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305243>, Racism in health care from the start <https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305243>, Gynecological experiments

<https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves>, Tuskegee experiments

<https://www.history.com/news/the-infamous-40-year-tuskegee-study>, Did Infamous Tuskegee Study Cause Lasting Mistrust of Doctors Among Blacks?

<https://nyti.ms/24W1R7L>

SLIDE 8: Racial Bias in Medical Care

RACIAL BIAS IN MEDICAL CARE EXISTS TODAY

Racial bias in medicine has many root causes.

The ‘Medical Gaze’ – the lens through which health professionals view their patients contains racially-biased assumptions (implicit bias).

Racial bias exists in treatment protocols that result in less or lower quality care for black people.

Charity care versus universal care.



Distrust may exist because racial bias is still deeply ingrained in the healthcare system in the United States. Patients experience this bias when they come into contact with the healthcare system.

This bias is part of the 'Culture of Medicine' that medical students and doctors are trained to operate within. It is a high-pressure and hierarchical system that values knowledge, time and efficiency. There is little room for self-examination of interactions between patients and doctors nor is there room for critical examination of the medical culture and how it reinforces racial bias.

The 'medical gaze' is the term for how physicians view their patients. As medical students and physicians evaluate their patients, they work to fit patients into "what medicine considers to be important" rather than focusing on the individual patient and what their needs or situation require. The medical gaze reflects the biases that exist in the culture of the US including racial stereotypes.

For example, in one study, physicians were given descriptions of patients and asked to make a diagnosis. When the patient was identified as black, the physicians were more likely to "ascribe violence, suspiciousness, and dangerousness" to them than for the exact same description in which the patient was described as white.

On top of that, protocols for determining treatment for patients often include race as a factor. These protocols are designed so that race disadvantages black patients resulting in less or lower quality of care. For example, in the American Heart Association tool for determining risk of heart failure in hospitalized patients, patients get three points for being "non-black," which means black patients are viewed as being at a lower risk although there is no biological justification for this. Thus, a black patient may receive less aggressive care for heart failure.

In the culture of medicine, doctors who work in underserved communities are often viewed as "heroes" for doing so without questioning why there are underserved areas. This feeds the whole idea that inequality in healthcare is a given rather than something that is outrageous, shouldn't exist and needs to end. The wealthiest nation in the world has the capacity to end inequality in access to health care, housing, education, healthy food and more - something that countries like China and poorer countries such as Cuba and Venezuela have been able to accomplish.

More reading: Medical gaze, training and medical culture not examined itself nor is there time for health professionals to examine their own assumptions and interactions

with patients <https://www.ncbi.nlm.nih.gov/books/NBK220349/>, Implicit bias <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/> and <https://www.ncbi.nlm.nih.gov/books/NBK220347/>, Race-based algorithms for making treatment decisions <https://www.nejm.org/doi/full/10.1056/NEJMms2004740>.

SLIDE 9: Racial Discrimination within the Health Profession

RACIAL DISCRIMINATION WITHIN THE HEALTH PROFESSION CONTINUES TO EXIST

- Black people are under-represented in medical schools and over-represented in nursing, nursing assistant and home care professions.
- Black physicians are under-represented in medical and surgical specialties and are underpaid.



A new report found that when black infants are cared for by black doctors, they are roughly 40 to 60% less likely to die. But, there is a deficit of black doctors in the United States.

Black people who are interested in medical professions are more likely to become nurses than doctors. Although black people are 13% of the population, only 6% of graduates from medical school are black while 24% of nurses are black. Black people are also overrepresented as nursing assistants and home healthcare workers. Compared to white people in the same jobs, black nursing assistants and home healthcare workers are less educated and earn less.

Discrimination in medical training persisted for a long time. Black people were not initially allowed into medical schools in the United States and had to train abroad. During Reconstruction, black medical schools opened but most of them failed largely due to the Flexner Report in 1910 that imposed a high bar of requirements for

certification. Black physicians faced barriers to training and working in hospitals well into the Civil Rights Era.

When white and black physicians are compared today, white male doctors are more likely to be specialists and surgeons than black male doctors.

When adjusted for other factors such as hours worked and specialty, white male doctors earn much more than black male doctors. Interestingly, incomes for white and black female doctors are similar although substantially lower than male physicians and have been stagnant while income for male physicians has risen over time.

More reading: Black infants fare better when treated by black doctors

<https://www.nature.com/articles/d41586-020-02435-w>

Black medical schools

<https://guides.mclibrary.duke.edu/blackhistorymonth/education#:~:text=Seven%20medical%20schools%20for%20blacks,percent%20from%20white%20medical%20schools.>

Distribution of medical school graduates based on race

<https://www.aamc.org/data-reports/workforce/interactive-data/figure-13-percentage-us-medical-school-graduates-race/ethnicity-alone-academic-year-2018-2019>, White males

earn the most and most likely to be surgeons and specialists.

<https://www.bmj.com/content/353/bmj.i2923>,

Direct care workers are more likely to be black women and to be lower paid and less educated than whites and men

<https://phinational.org/wp-content/uploads/2017/11/Racial-and-Gender-Disparities-in-D-CW-PHI-2017.pdf>

SLIDE 10: Black Communities are Losing Hospitals

BLACK COMMUNITIES ARE LOSING HOSPITALS

- Hospitals are closing at a rate of 30 per year.
- Rural hospitals are a major source of jobs and healthcare for their communities.
- Rural hospitals are more likely to close in communities with a higher percentage of black and minority people.
- Gentrification is causing the closure of hospitals that serve black communities in cities.



Since 1975, while the U.S. population has risen from 216 million people to 331 million, the [total number of hospital beds has declined](#) from 1.5 million to 925,000. The US has about half as many hospital beds as European nations based on population (US has 2.8 beds per 1,000 people versus 5.4 for the EU).

Hospitals are closing down at a rate of about 30 per year. Rural hospitals are hardest hit. Since 2010, 120 rural hospitals have closed. The highest number of closures are occurring in the 17 states (many of them in the South) that did not expand Medicaid under the Affordable Care Act. 453 of the remaining 1,844 rural hospitals are at risk of closing. People living in rural areas travel twice as far as those in urban areas to get to the hospital. When a hospital closes, deaths in the community rise by about 6%.

In small towns, local hospitals can be the largest institution, which means it is the largest source of jobs. It may also be a place that offers other services that don't exist in the community such as an ATM or cafeteria. Losing a hospital also means losing investment in that community. Businesses consider health care when deciding where to locate.

Rural hospitals that are at risk for closure tend to be in areas that have a higher population of black people, higher unemployment and greater health needs than in areas where hospitals are financially secure.

Urban hospitals are also closing particularly in areas that are being gentrified, which tend to be black and poor communities. In this situation, it becomes more profitable to convert the hospital to condominiums, retail or business use.

More reading: Hospital closures

<https://truthout.org/articles/the-uss-wave-of-hospital-closures-left-us-ill-equipped-for-covid-19/>

and <https://qz.com/1866565/when-rural-hospitals-close-minorities-pay-the-price/>

SLIDE 11: Social Determinants of Health

RACISM WORSENS THE SOCIAL DETERMINANTS OF HEALTH

- Between 1983 and 2013, the median wealth of black households DECREASED by 75% while median white household wealth rose by 14%.
- Black people have the lowest rate of homeownership.
- Public schools are more racially segregated today than they were 40 years ago.
- Social stress shifts the body's biological resources toward a state that increases risk for disease.

A photograph showing three young Black men standing on a paved path outdoors. They are engaged in conversation. The man on the left is wearing a dark suit and holding a green folder. The man in the middle is wearing a grey and black patterned sweater. The man on the right is wearing a dark jacket and a backpack. In the background, there are trees and a tall, grey, cylindrical monument with a clock face at the top.

Access to care is more limited for black people than white people. Communities with higher percentages of black people are losing hospitals. The percentage of black people without health insurance (9.7%) is almost two times higher than white people without health insurance (5.4%).

You may be surprised to know that access to care is not the most important driver of good health. The biggest factors that determine our health are the social determinants such as wealth, education, housing, the environment, stress and more. Systemic racism has created conditions that worsen social determinants, and thus health outcomes, for black people.

The wealth gap between black and white people has gotten wider over the past few decades. From 1983 to 2013, the median wealth of black households fell 75% while the median wealth of white households rose by 14%. Note the large disparity: black households have a median wealth of \$1,700 and white households have a median wealth of \$116,800.

Black people earn less than white people, even working in the same jobs, so income is one reason for the disparity. A large factor is home ownership, an asset that is often passed down through generations. Home ownership by black people has fallen to just above 40% while 70% of white people own homes. Black people still face discrimination in bank lending practices and

home value appraisals. Currently, black homeowners are 80% less likely to be given a mortgage to refinance their home than white homeowners.

Despite the civil rights struggle for desegregation, schools have actually become more segregated over the past 40 years. Black students are more likely to attend a high poverty school (6 out of 10) than white students (1 out of 10). The results are lower standardized test scores in black students, thus limiting their opportunities. Black students in white majority schools perform better academically.

Another factor that impacts health is stress. Black people in the United States face racism everyday as they attend school or work or go about their daily activities. They are also disproportionately targeted by police and the legal system. This contributes to stress levels, which in turn have a biological impact on their health. Black people have more stressors than white people even when factors such as wealth and education are removed.

Photo: Students at Bowie State University, a historically black college or university (HBCU). Federal courts found that Maryland has not desegregated higher education and has disinvested in its HBCUs. Though Maryland has been ordered to rectify this, the state continues to fight it in the legal system.

More reading: The wealth gap

https://ips-dc.org/wp-content/uploads/2017/09/The-Road-to-Zero-Wealth_FINAL.pdf,

segregation in education

<https://www.epi.org/publication/schools-are-still-segregated-and-black-children-are-paying-a-price/>

Stress is a result of living in a racist society and causes earlier health deterioration in black people, “weathering” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470581/>

SLIDE 12: How National Improved Medicare for All would Decrease Racial Disparities



HOW WOULD NATIONAL IMPROVED MEDICARE FOR ALL DECREASE RACIAL DISPARITIES IN HEALTH?

Now that we've looked at some of the aspects of racism and health, let's discuss changes to our healthcare system that could decrease racial disparities in health. Specifically, we'll look at how a National Improved Medicare for All system could do that.

National Improved Medicare for All is a system in which every person living in the United States would have healthcare through a national, publicly-financed healthcare system that is lifelong, covers all necessary care and is paid for through taxes. It is called Medicare because it is similar to our national Medicare system, but better because it covers more and there are no out of pocket costs.

Slide 13: Equal Coverage for All



EQUAL COVERAGE FOR ALL

All people living in the United States would have the same the same comprehensive healthcare coverage from birth through death.

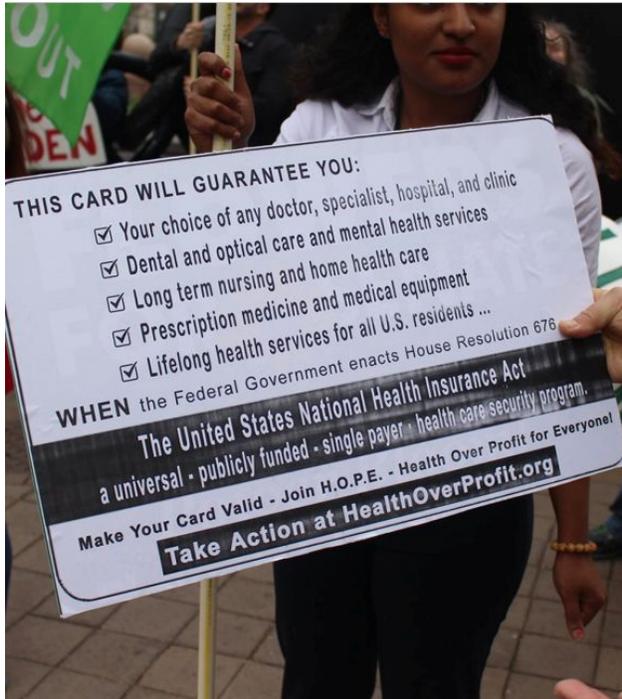
Benefits include all medically necessary inpatient and outpatient care, mental health, dental, vision and hearing, prescriptions, medical equipment, substance abuse treatment and more.

Healthcare coverage would be universal, lifelong and comprehensive.

In a National Improved Medicare for All healthcare system, every person in the United States would have a Medicare card from birth to death. The fear and hassle of losing health insurance when a person changes jobs or moves would end.

The program would cover all medically-necessary care. This includes care that is currently often not covered such as mental health, dental care, vision and hearing, all medications and medical equipment and substance abuse treatment, rehabilitation and long term care. Every person would have the same coverage just as veterans do in the Veterans Health Administration.

SLIDE 14: Choice of Where to Receive Care



CHOICE OF WHERE TO RECEIVE CARE

All health professionals would be in the healthcare system.

All people would choose where to seek treatment, including out of state facilities, without discrimination.

Hospitals would be safe from closures.

People would have free choice of where to receive healthcare.

In a national improved Medicare for all healthcare system, all health professionals would be part of the system and patients can choose where to seek care.

Health insurance networks that dictate where patients can be seen or where services will be covered would end. Under the current system, health insurance companies limit the number of primary care and specialist doctors in their networks, which can prevent people from getting the care they need or drive them to go out of network where they are not covered.

In national improved Medicare for all, no matter where a person is in the United States, at home or traveling, they are covered and can seek care. This also means that if a person needs to be seen at a specialty center out of state, they are covered.

Discrimination in health care would be illegal and there would be a way for people to report it if they are mistreated by the healthcare system.

Another benefit of national Improved Medicare for all is that all hospitals and health facilities would be funded by the government. This would end the drive to make a profit to keep the doors open and make it possible to not only keep hospitals open but to build new hospitals in communities that have lost them.

SLIDE 15: Elimination of Financial Barriers to Care



ELIMINATION OF FINANCIAL BARRIERS TO CARE

Healthcare is paid for through taxes based on ability to pay.

There are no co-pays or deductibles.

All medically necessary care is paid for.

There are NO medical bills.

Health care would be free at the point of service.

Under national improved Medicare for all, the system would be paid for through taxes based on income or ability to pay. There would not be any costs when patients seek services. Health professionals and facilities would bill the government and not the patient.

This would remove the financial barriers to care that currently exist for both uninsured and insured people. In the United States, people with health insurance often have to pay co-pays for doctor visits and prescriptions or meet deductibles of thousands of dollars before their health insurance coverage begins. This causes people to delay seeking care or getting treatments or prescriptions because they do not have the cash or have to choose between paying for health care or other necessities such as rent or food.

It would also end personal bankruptcies due to medical illness. This is the most common reason for personal bankruptcy in the United States, impacting about 500,000 families each year. When families go bankrupt, they may lose their home.

This would be an important step in reducing the wealth gap between black and white people by relieving the burden of healthcare costs and reducing personal bankruptcy and loss of homes.

SLIDE 16: Impact on Public Policy



IMPACT ON PUBLIC POLICY

Countries with national universal publicly-financed healthcare systems benefit from public policies that improve health, such as

- Not polluting air, soil or water
- Making consumer products safer
- Banning pesticides and GMO foods
- Providing walkable and bike-friendly cities
- Making housing affordable

Public policy would prioritize public health.

When governments are responsible for paying for the health care for their people, it changes public policy priorities to include impacts on health. It also incentivizes governments to take a more preventative approach to health. This is evident in nations with universal public healthcare systems around the world.

Polluting industries, and even cities that allow water systems to be polluted with lead and other heavy metal, cause significant disease and poor health outcomes in the United States. This happens more often in low income or communities of color. Once the government is fully liable for the cancers or long term impacts of disease caused by pollution, it will be less likely to allow this in places where people live.

A major reason that the European Union takes a precautionary approach for the licensing of consumer products is health. A company must prove that its product is safe before it is allowed in the market. The opposite happens right now in the United States, products are brought to market and consumers have to prove they are harmful if they are adversely affected.

Many countries with universal healthcare systems also ban genetically-modified foods, which are heavily sprayed with pesticides, and the use of certain pesticides in their food systems because of the harmful health effects.

Countries with high rates of diseases due to lack of exercise have built more bike and pedestrian friendly areas to encourage physical exercise.

Countries that treat health care as a public good also have a stronger safety net because they understand that social determinants such as access to affordable housing, high quality education, jobs with living wages and pensions are also necessary for good health and well being.

Moving to a national improved Medicare for all healthcare system will be a sea change in the United States that could drive the demand for stronger public systems that meet our basic rights and necessities as human beings.

SLIDE 17: What More is Needed Beyond National Improved Medicare for All?



WHAT MORE IS NEEDED?

- Transforming medical education
- Distribution of resources to every community
- End racial bias in medical care
- Give communities control over their health care

What would YOU add to this list?

Moving to a national improved medicare for all where everyone has access to the health care they need throughout their life is a simple first step that would address the current healthcare crisis but as we now know, the problem of racism in health care and systemic racism that drives inequality is long term and deeply ingrained.

Here are some other actions that are also necessary and should be next steps.

Medical education is increasingly expensive and thus less available to people without financial means or the courage to incur lifelong debt. Many wealthy countries provide free medical education. This would help address racial disparities in health professionals, but beyond that, more could be done to support black people from a young age who are interested in medical fields.

National improved Medicare for all would provide operating funds to hospitals and other health facilities. Communities must demand that they have the resources they need to access care in a timely way.

Medical bias in health care delivery must be deliberately addressed both in medical education and in medical institutions. It must be removed from treatment algorithms and protocols.

One way to reduce racially-biased practices is to give communities greater control over their local healthcare institutions including how the budget is used, who is hired and fired and what services are provided.
