HCFA WA

HEALTH CARE FOR ALL EDUCATION FUND

Accountable Communities of Health: Local, Integrated and Whole-Person Approach to "Better Bang for the Buck" Health and Health Care

By Elaine Cox, Policy Committee Co-Chair

How can our healthcare system achieve better, more equitable health outcomes at lower cost? One answer is in recognizing that traditional healthcare is only one piece of the health puzzle. 70-80% of a person's health can be attributed to factors outside of medicine, doctors and hospitals. Most of our health derives from Social Determinants of Health, (SDOH) such as where we live, whether we live in poverty, have access to healthy food, affordable, stable housing, are exposed to environmental hazards and our health behaviors. Greater and more cost-effective impact on health can only be achieved by multi-sector participation and collaboration, linking patients to services across sectors, with focus on prevention and equity.

Accountable Communities of Health (ACHs) are community-based collaborative organizations working to build system capacity and infrastructure to link social and health services to reduce costs, enhance quality of care and improve the health of a population at the community level.

Washington ACHs

ACHs in Washington state began in 2012, using a federally-funded State Innovation Model grant. Nine regional collaborative organizations were defined and began their efforts to pursue health system transformation in their communities. Each is governed by a backbone organization responsible for convening local leaders from multiple sectors that impact health to collaborate on projects that are testing new and innovative approaches to transform how we deliver health care.

In 2015 the ACHs increased their funding ($1.1 billion) with Medicaid Transformation Projects (MTP) and were able to build on their initial efforts. Washington is one of only a few states engaged in an MTP. With these grants they were able to build the foundational infrastructure for collaboration, developing regional health improvement plans, jointly advancing large scale health improvement and system transformation projects, and advising state agencies on how to best address health needs within their geographic areas. They have also been involved in legislative and policy advocacy, advancing the health care case for affordable, stable housing policy.

Some of the identified goals of these collaborations include:

- Integrate physical & behavioral health payment & service delivery
- Value-Based Payment to reward outcomes, instead of volume
- Respond to unique health concerns of their regions.
- Community-Based Whole Person Care
- Improve health equity & reduce health disparities

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SUMMER 2020

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Health Care for All - WA advocates for high quality, sustainable, affordable, publicly

Health Care is a **Human Right**

Health Care for All-WA Newsletter

Summer 2020

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From the President's Desk

by Marcia Stedman, President.

The Health Care Emergency Guarantee Act (HCEGA): An Immediate Step toward Health Justice

For many years, Health Care for All-Washington has focused on achieving state-based single-payer healthcare, and in the past few years, together with our allies, we have made important steps toward our goal. But that was before the COVID-19 pandemic decimated our health, our economy, and our state budget. We need action now! And, with Washington's predicted budget shortfall at $8.8 billion over the next two years, that means action at the Federal level.

While there are several healthcare proposals currently before Congress, **only the Health Care Emergency Guarantee Act (HCEGA) adequately responds to the COVID-19 public health crisis.** Sponsored in the House by Washington's own Rep. Pramila Jayapal, and in the Senate by Bernie Sanders, HR 6906 & S 3790 would

- Take effect immediately and continue until an effective vaccine is widely available
- Remove cost barriers to all health care regardless of income, employment, insurance status, or immigration status during the pandemic
- Leave existing private and public health plans in place during the pandemic, no need to enroll in a new plan or program

Statistics show that COVID-19 is disproportionately affecting Black, Indigenous and Hispanic people. In King County, the mid-May COVID-19 infection rate for Blacks was nearly 4 times that of Whites, and for Hispanics it was 9-fold that of Whites. Hispanics had nearly 6 times the COVID deaths as Whites, after adjusting for age differences in the populations.

As an immediate step toward health equity, the HCEGA would enable everybody to get the health care they need when they need it, and begin to heal our society as well.

So, while we continue working for state-based universal health care, Health Care for All-Washington also strongly supports the HCEGA. Together with our allies in the Health Care is a Human Right Campaign, and joined by 71 other grassroots, labor union, and community organizations who signed on to it, we recently sent a letter to the entire Washington Congressional delegation, urging them to support and co-sponsor the HCEGA. We also sent a copy of the letter to Gov. Jay Inslee, noting that the HCEGA would provide immediate health care access to everyone in the U.S. without further straining state budgets, and urging his support of the Act, both with our Congressional delegation and with other members of the National Governors Association.

We encourage individuals to also contact their Congresspeople and to urge their support of the HCEGA. Full details can be seen in the June 2020 e-bulletin, now available on our website: https://www.healthcareforallwa.org/

We need quick action now in order to safely reopen our economy and begin to address the shocking health care disparities in our state and nation. #####

Policy Committee Report

By Sarah K. Weinberg & Elaine Cox, Co-Chairs

After celebrating our accomplishments in the 2019-20 biennium, our committee has begun to look at the challenges ahead. Our communities, our state, our nation, and the whole world are in turmoil currently, rocked first by a swiftly moving coronavirus pandemic, and then by large demonstrations about the need for people everywhere to dismantle long-standing racist structures.

The first realization for us is that the future of the struggle for publicly funded universal health coverage may be dramatically different depending on the results of the U.S. national elections this fall. That makes long-term planning difficult, if not impossible.

The second realization is that, thanks to the pandemic, our state will be facing a large revenue deficit for each of the next 2 or 3 fiscal years (which start on July 1 each year). (See article by Cindi Laws in this newsletter.)
We do have some plans, however:

1. We have drafted a simple statement of HCFA-WA's mission, and one question, asking congressional and legislative candidates to promise to support the mission if elected. We will be asking our summer volunteer intern, Lily Lucas, to send it to candidates before the August primary election, and then to the two finalists for other state-wide offices after the primary.
2. If there is a special session of the legislature to deal with the revenue shortfall, we will need to be active to lobby to avoid drastic cuts to health care and the new laws we celebrated from the 2019-20 sessions.
3. We discussed how to educate the public about how universal coverage would make it much easier to improve our health care system's response to epidemics, social issues, mental health needs, and racial health disparities. One metaphor that may help: First bring everyone into the tent. Then, together, we can work to make a better tent.
4. We continue to monitor the progress of the Universal Health Care Work Group (UHCWG), and several HCFA-WA members have submitted public comments at each of the group's meetings. (See report on the UHCWG) in this newsletter.)

We continue to meet at least monthly. We would welcome new members who are interested in health reform policy. weinbergsk@msn.com

###

Outreach Committee Report

By Ronnie Shure, Chair

Ask Not What Your Outreach Committee Can Do For You…

Ronnie Shure, Erica Grall-Nealious, Stephanie Bennett, Rich Lague, Leah Vetter, and Leslie Zukor have been meeting monthly to build our grassroots network that will make universal healthcare coverage available to all Washingtonians. We are supported by our President, Marcia Stedman, and our Lobbyist, Cindi Laws – but we need your help too.

Ideas:

- If you are able to meet with a group that might become one of our natural allies… we need your help.
- If you are interested in speaking to a small group about our victories along the pathway to universal healthcare coverage… we need your help.
- If you are interested in being a Team Leader to help build the grassroots network in your Legislative District… we need your help.

We are reaching out to neighborhood groups, social justice groups, and political action groups. We are creating written and video content for our social media sites. We are contacting our legislators and advocates in each district of the state.

- If you have a skill or special interest in these areas… ask what you can do to help our Outreach Committee.

Contact Ronnie Shure at action@healthcareforallwa.org today.

###

Fundraising Committee Report

By Peter Lucas, MD, Co-Chair

We hit the ball out of the park this year with the response we got from the GiveBIG campaign in May. We put much effort into publicizing it and reaching out to previous donors. It certainly helped to have some generous matching funds. Our donations were up by about 1,000% compared to last year and there were quite a few first-time donors.

This summer we have many projects in the works in order to further boost our funds:

1. We have a list of Bernie supporters and health care donors of more than 100 people. We plan to send letters to all, and will schedule meetings with those showing high interest.
2. We are preparing for meetings with previous large donors. Our summer intern, Lily Lucas, and volunteers are checking backgrounds, and we are writing a Case Statement to present.
3. The possibility of applying to foundations and institutions remains in the future. We need a bigger donor base first.
4. Jointly with the Outreach Committee, we are working on reaching younger, more diverse groups.
5. Lily and Sydnie, our Communications Lead, are working on how best to use social media.
6. We are revisiting whether and how HCFA-WA should have different membership levels.
7. Cindi is also working on a follow-up letter with mention of matching funds to send to GiveBIG donors.

####

Book Review: "Long-Term Care in America: The crisis all of us will face in our lifetimes" By John Geyman, MD

Reviewed By Sarah K. Weinberg, MD, Editor

Dr. Geyman, a long-time author about the dysfunctional health care system in the U.S., has written a fine book about what happens to us as we age. He brings several different perspectives into his discussion: his career as a family physician; a caretaker for his first wife as she lived the last of her life with Alzheimer's dementia, and an aging senior himself, in addition to his deep knowledge about the US health care system's faults.

Parts I and II review the problems and history of what is out there in the world of long-term care and end-of-life care. Much of this is familiar to those of us who are involved in advocacy for universal health coverage in the U.S. However, many of us have not focused on the specific rat's nest that faces us as need for support in our later years arrives. As advocates for Medicare for All, we tend to assume that all will be well when we reach the magic age of 65. Tain't so!

Generations past provided most care for their family's elders. Families were larger and generations tended to be in the same geographic location, and the elders didn't live as long. Many of today's families find it impossible to take care of their elders themselves, but assisted living facilities, nursing homes, and home health aides are increasingly unaffordable, of poor quality, understaffed, or just unavailable.

What can we do? First, we need to shift financing of the health care system from private enterprise, whether technically "non-profit" or actually for-profit, to a public responsibility shared by all Americans – in other words a government responsibility. Second, we must re-value long-term care, and especially the hard-working people who provide it. They are currently paid poorly, have little training, and scant opportunity for career advancement – all leading to high turnover in these jobs. Lastly, we need to re-imagine what long-term care should (and could) be.

Dr. Geyman finishes the discussion by listing 9 characteristics of an improved long-term care system:

1. Public insurance coverage for patients regardless of age
2. Federal and state funding for LTC services
3. Fair wages and benefits
4. A large enough caregiver workforce to meet increasing demand
5. Get rid of the poverty industry
6. Training standards and certification
7. Late-in-life care
8. Aging in place
9. When a move becomes necessary

There is hope - Dr. Geyman still pilots his own airplane!

####

Accountable Communities of Health *Continued from p. 1*

Transformation projects focus on building health systems' capacity, care delivery redesign, prevention and health promotion, and increased use of value-based payment (VBP) models that reward providers for quality of care rather than the volume of services and procedures provided.

Project Portfolio

Objectives of Washington ACH projects include:

- Integration of physical & behavioral health using integrated provider networks
- Community-based care coordination/ integration with the health system for people with complex health needs such as asthma and diabetes
- Transitional care improvement to reduce avoidable hospitalizations: right care in the right place
- Diversion interventions to promote appropriate use of emergency care
- Addressing the opioid use public health crisis
- Reproductive & maternal/child health
- Access to oral health services

Example projects

Youth Behavioral Health Coordination Pilot Project (Cascade Pacific Action Alliance ACH)
Developed integrated/coordinated services from school districts, clinicians, behavioral health care providers to identify students with behavioral challenges as early as possible and connect children/ families to community-based treatment/services.

Whole Person Care (North Central ACH)
Integrating behavioral, physical health and social services at clinical sites and community-based organizations.

Three-County Coordinated Opioid Response Plan ***(***Olympic Community of Health)
A community response to the opioid crisis in Kitsap, Jefferson, and Clallam counties and eight Tribal nations. Brought together partners from the fields of primary care, mental/behavioral health, substance use disorder and dental health, as well as Tribal partners, public health, local government officials, law enforcement, fire/EMS, elected officials, and other community members from the region and across the state. Appears to have decreased fatal overdoses.

Community Health Fund (Greater Columbia ACH)
Community Health Fund set aside nearly $1.4 million of funding to address local needs such as housing, transportation, and food insecurity. The distribution method of these funds was designed to allow for more local collaboration and engagement in the ACH's work, and effectively target the CHF to reduce disparities based on local data, and the lived experience of community members.

Funding

Health Care Authority administers the grants, which are provided by Centers for Medicare and Medicaid Services. An independent assessor provides regular assessments of progress. The grants are intended to benefit Apple Health (Medicaid) clients, but benefits are expected to have system-wide impacts. Community participants are paid via an incentive structure: pay for planning, pay for reporting, pay for results.

Evaluation

The independent assessor completed a midpoint review of the MTP in January, 2020. Evaluations indicate that Washington has built considerable organizational capacity and projects have begun to be implemented. Concerns and challenges are around scalability and long-term sustainability. The report was published just as the COVID-19 pandemic was emerging and it is not yet known how that will impact the funding or progress.

ACHs and COVID

In March 2020 Washington received approval from CMS to obtain a Section 1135 budget neutrality waiver that provided supplemental funds for the state to respond to the COVID-19 emergency. With this supplemental funding, the state would empower local ACH grantees to develop regionwide and communitywide COVID-19 response plans to help "coordinate across clinical and community partners, including community engagement, education, provider relief, and alignment of response strategies around emerging best practices across communities and Local Health Jurisdictions."

ACHs and the Medicaid Transformation Project "demonstrate Medicaid's ability to transcend the normal bounds of insurance and can function as a core public health asset". We look forward to seeing outcomes of this promising healthcare innovation.

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https://www.hca.wa.gov/assets/program/ACH-101.pdf

https://www.hca.wa.gov/assets/program/dsrip-midpoint-assessment-report.pdf

https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/99456

https://www.hca.wa.gov/assets/WA-1135-waiver-request.pdf

https://www.commonwealthfund.org/blog/2020/medicaid-waivers-states-covid-19

#####

Universal Health Care Work Group: Progress Report

By Sarah K. Weinberg, MD, UHCWG Member

This work group was convened as a result of a state Budget Proviso passed in 2019. It has about 33 members, chosen from several different groups, or "stakeholders". Its charge is to come up with a recommendation to the legislature to attain universal coverage for health care for all residents of our state. The UHCWG is supposed to accomplish this by mid-November, 2020. Thanks to impressive lobbying by Cindi Laws, three members of HCFA-WA are among the 33. In addition to myself, Ronnie Shure and Kelly Powers are there. Two members of HCFA Spokane, former state representative Denny Dellwo and Lynnette Vehrs, President, Washington State Nurses Association, are included.

First Meeting, September 20, 2019: This meeting was mostly devoted to getting organized and setting the schedule for future meetings. The Portland-based support team from Health Management Associates (HMA) was introduced. Two presentations were made: "Health Coverage in Washington State" and "Single-Payer & Universal Health Care Systems", the latter from the Washington State Institute of Public Policy. (Both reports are available on the Health Care Authority's website, best accessed by searching for UHCWG (spelled out) Washington State.) The main action recommended was making some modifications to the charge to the work group.

Second Meeting, December 9, 2019: This meeting was held in the Capitol building in Olympia, with breakout groups scattered around the campus. In the larger group, there was some discussion of what "universal coverage" means; the difference between "access" and "coverage"; the need to capture other costs in the current system in addition to insurers' administration. The breakout groups spent most of their time discussing "root causes" of the problems of our current non-system. The meeting ended early, thanks to a bomb scare that emptied the Capitol building.

Third Meeting, February 7, 2020: This meeting was almost entirely devoted to discussing criteria for evaluating different models of health care systems. The categories considered were: population covered, benefits package, access to what?, quality, cost/ affordability, governance, feasibility and administration, and other. The HMA team will send out a survey to ask each work group member about elements that should be in the model plans that will be evaluated by the actuarial team.

Then COVID-19 hit, and everyone went into lockdown. The fourth meeting scheduled for April 22, 2020 was canceled. The survey was created, and extra time was allowed for answering it, yet only 21-22 people did so – around 60%.

Fourth Meeting, June 24, 2020: This meeting was supposed to be the 5th one, and it was supposed to be in Spokane. Instead, it was done via Zoom, with considerable technological success. Three general models were presented:

- ***Model A: Universal Coverage Administered by the State*** -.State government pays for all care, sets the benefits package, and contracts directly with all providers.
- ***Model B: Universal Coverage Administered by Multiple Private Plans*** - State government develops policy and benefits package, but delegates most financial risk, payer-related functions, and delivery system management to private insurers.
- ***Model C: "Fill in the Gaps" Coverage for People Without Affordable Access*** – This approach builds on the Cascade Care model, and would create one or more options that would be offered on our state's ACA Exchange.

These models were discussed in small groups. There was also discussion about the fact that the first two options would require federal cooperation in order to be able to include federal funds currently supporting programs (Medicare, Medicaid, the VA, etc.) in the funding for a truly universal system.

The general sense of the meeting was that the first two models could indeed be universal, provided that every state resident is to be included regardless of immigration status. The third model is probably most politically feasible, but won't lead to universal coverage.

What's next? First of all, we urge supporters of a public universal health care plan to submit a "Public Comment". I could put a very long link here, but easier is to use your online search method for "Universal Health Care Work Group Washington", which should take you directly to the page you need. There's a link there for "provide public comment". Let's make sure the work group and consultants know that the people want a plan that covers ALL Washingtonians!

For the August meeting, HMA and the actuarial team, Optumas, will flesh out the three models and compare their effectiveness and cost as compared with the current non-system. Studying their work should be the focus of the next work group meeting, currently scheduled for August 25, 2020. It's likely to be another Zoom meeting! An additional meeting may need to be added, and the final report may not be able to be completed by mid-November, 2020. We'll see….

#####

Health Care Professional Rally and March

By Dana Iorio, ARNP, HCFA-WA Treasurer

On Saturday, June 6, I marched with an estimated 7,000 other health care professionals on a march for justice to end police violence in the wake of the police killings of George Floyd in Minneapolis, Breonna Taylor in Louisville, and the vigilante killing of Arnaud Arbery in South Georgia. The march was organized by Estel l Williams, MD of Harborview Medical Center and her partner Edwin Lindo, lecturer on race relations at University of WA School of Medicine.

The march began at Harborview Medical Center and proceeded down James St, which was entirely filled with people all the way to the city hall plaza where a rally ensued. Along the way, various chants and signs relating to justice, public health, and racism were seen and heard. For example: "No justice, No peace", "black lives matter", "racism is a pandemic", "white coats for black lives", "police brutality is a public health emergency" and "defund SPD". The march was entirely peaceful without incident. The police were nowhere to be seen as the march had its own safety monitors (Is there a connection somewhere here?), until we arrived at the plaza in front of city hall where police had congregated.

I arrived a bit late to the rally due to the back log of people trying to get to the plaza. There were several speakers all tuned into the theme of the rally which was to demand justice and end police targeting of people of color. There was a list of demands (see below) that had been passed out previously. The main speakers were the co-sponsors of the march, Edwin Lindo and Estell Williams. Professor Lindo was essentially an MC and cheerleader to the large crowd that overflowed from the plaza onto James St, 4th Ave and Cherry St. Lindo started his oratory with "racism is a disease". Dr. Williams talked about the causes of police violence which she stated clearly were the disparities that exist between the 99% and the 1% in education, housing, pay, and health care. She stated, in order to effect change, we need to "equalize" wealth. Other speakers spoke about taking care of the planet, police reform, and the need to direct funding of child care, health care, education and away from the military budget.

The rally was totally peaceful without incident. People were nearly all wearing masks and social distancing as much as possible. I left a bit early, accompanied by my daughter who is a social worker at Harborview. On the walk back up the hill we saw groups of police gathered along the side of the road waving, smiling, and even a few took a knee. It was an inspiring display of what can be accomplished when protestors take charge in monitoring their constituents and the police presence is minimal and non-confrontational.

#BLACKLIVESMATTER DEMANDS

1. Eliminate legislative provisions that shield law enforcement officers from investigation and accountability.
2. Provide full public disclosure of all investigations of law enforcement officer brutality and excessive use of force as well as access to recordings of any incidents in question, which should be deemed public property. These materials could be made public through an online database.
3. Reverse the militarization of law enforcement, by eliminating acquisition and use of military equipment and reducing the number of SWAT teams and the frequency of their deployment.
4. Fund studies that explore the effectiveness of interventions that may decrease reliance on law enforcement, including decriminalization, increased investment in social determinants of health, and community-based alternatives that promote public safety, such as violence intervention and restorative justice.
5. Fund programs that meet human needs, promote healthy and strong communities, and reduce structural inequities (economic, racial, and social) — such as employment initiatives, educational opportunities, and affordable housing—including by using resources currently devoted to law enforcement.
6. Advance equity and justice by eliminating officer enforcement of regulations designed to oppress marginalized people, including but not limited to substance use and possession, sex work, loitering, sleeping in public, and minor traffic violations as well as targeting undocumented immigrants.
7. Engage in a review of law enforcement agencies' formal and informal policies and practices in order to eliminate disproportionate violence against specific populations. Examples of such policies and practices may include racial and identity profiling, stop and frisk, gang injunctions, and enforcement of laws that criminalize houselessness.

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"Medical Industrial Complex" & "Neoliberalism": What's This All About?

By Sarah K. Weinberg, MD, Editor

As advocates for a national health care system, or for a universal healthcare coverage system in Washington State, what are major impediments to attaining these goals? What special problems do we face in the U.S. in 2020 as compared with the rest of the developed world in the mid-20th century when they established their national systems? To answer these questions, we need to understand more about "neoliberalism" and the "medical industrial complex".

Neoliberalism

This term has been around for at least a century, but its common usage and meaning have evolved over time. Currently, the term refers to an economic ideology that favors free markets with minimal or no government regulation. The term is mostly used negatively by opponents of unregulated free markets. Modern free market ideology grew out of the writings of Frederick Hayek, Milton Friedman, and other economists who derided the Keynesian notion of a demand-based economy that grew out of the need for government spending to stimulate demand during the Great Depression. The neoliberal idea was that the economy should be based on supply, and that reduced taxes and government spending would liberate the economy to grow. These ideas really took hold during the governments of Margaret Thatcher in the United Kingdom and Ronald Reagan in the U.S. That said, both Republicans and Democrats since 1980 have acted to cut taxes, reduce social welfare spending, and reduce government regulation of businesses and financial institutions. In general, the result has been an expanding economy and a resulting enormous widening of the gap between the wealthy and the lower income groups. Within the last few years, criticism of this approach has increased, punctuated by Thomas Piketty's "Capital in the 21st Century".

Medical Industrial Complex

This term was first used in 1969 by Barbara and John Ehrenreich, probably building on President Eisenhower's famous warning as he left office about the threat of the "military industrial complex" accumulating too much power and influence over our government. The growing influence of big corporations in the field of medicine was much discussed during the 1970s, and the term was widely circulated as a result of a warning article in 1980 by Dr. Arnold S. Relman, then the Editor of the New England Journal of Medicine:

"The past decade has seen the rise of another kind of private 'industrial complex' with an equally great potential for influence on public policy – this time in health care…."

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Washington State Budget Shortfall

By Cindi Laws, Lobbyist

According to the latest state revenue forecast, state tax collections through 2023 will come in about $8.8 billion below previous estimates. The budget hole will continue to deepen in the coming months, as the economy continues to suffer with COVID-19 cases on the rise again.

The State Constitution grants the Governor sole authority to call a special session of the legislature. That said, the Governor works with legislative leaders to reach some consensus on the topics of a session. At this point, there is no consensus. While Republican legislative leaders have been advocating for a July session, Democratic legislative leaders are in no hurry. The state's fiscal year ends June 30th, and more accurate data will be presented to everyone.

Governor Inslee is taking action where he can, including canceling pay raises for some workers and furloughs for others that are expected to save about $55 million over the next year.

Following the legislative session that ended March 13th, Inslee vetoed nearly two dozen bills in their entirety on April 3rd, as the COVID-19 impact was coming in like a tidal wave. He also vetoed more than 140 separate budget items that will save the state $445 million. One of those vetoed bills was ours: SB 6088. It would have established a the prescription drug affordability board and required the board to identify prescription drugs priced above a certain threshold, and would have authorized the board to conduct cost reviews of drugs and set upper payment limits for state purchasers.

The veto of SB 6088 shows the challenge we face in trying to advance health care policy that fits our mission: high quality, sustainable, affordable, publicly funded health care for all Washington residents. In order to advance health policy that provides coverage, we need Boards and Work Groups that study costs, perform actuarial studies and run financial models to determine how to pay for that health care. With a $9B shortfall, every $250,000 work group and $500,000 study is on the chopping block.

While there are many calls for "more revenue", there is little consensus. Washington does not have a state income tax and previous State Supreme Court rulings declared a graduated tax on income is unconstitutional. A capital gains tax has been on the legislative negotiating table for several years and is supported by Laurie Jinkins (D-27), the Speaker of the House. Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Wyoming and Washington have no state capital gains tax. See: www.realized1031.com/capital-gains-tax-rate.

State Senator Reuven Carlyle (D-36) has previously introduced a bill to sunset tax loopholes. The legislature has, over decades, allowed about 700 tax exemptions for corporations, and hundreds more get tax credits. It is well past time to end those. Doing so will bring in several billion dollars. We can all remember when Boeing got an $8.7 Billion tax break if they stayed in Washington, but they opened factories in South Carolina and China anyway. It's just one example – the most glaring – of many that could provide vitally important revenue that the state needs to care for its citizens. #####

Join Now for 2020!
Health Care for All – Washington

Yes, I'll join to work for high quality, sustainable, affordable, publicly-funded health care for ALL Washington residents

Circle how you can help: Speaking/ Fundraising/ Phoning/ Demonstrations/ Writing/ Action Teams/ Meet with legislators/ Online & Social Media/Other_____

$_____Contributions to **HCFA Education Fund,** a 501(c)3, are tax deductible.

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Ways in which corporations have infiltrated medicine:

- Makers of medical devices and drugs fund medical education programs and pay physicians and hospitals directly to use their products.
- Business staff, instead of medical professionals, manage health care organizations like hospitals and medical practices
- Managers pressure professionals to generate profit from services, decreasing effort on creativity or innovation in medical research
- For-profit companies have increased their presence as stakeholders throughout the health care system
- Economic policies, both corporate and governmental, increasingly affect the practice of medicine

This definition of medical industrial complex doesn't include the health insurance industry, which adds another layer of private profiteering.

How these two concepts explain the difficulty attaining national or state publicly funded universal healthcare coverage

First, it's important to note that universal healthcare systems in European countries and Japan basically were established as these countries pulled themselves together following the wreckage of World War II. Even though Canada was not directly attacked during the war, the many Canadian troops killed in Allied battles meant that both the population and the economy were still recovering in 1947 when Tommy Douglas implemented provincial hospital coverage for all residents and got the process started that led to Canada's universal system by the early 1980s. There was no medical industrial complex then, and the ascendancy of privatization with denigration of the role of government that is neoliberalism had not yet displaced Keynesian ideas about using government to solve problems.

Now, in 2020, much of medical care is in the hands of mega-hospitals that have bought up physicians' practices. These goliaths "bargain" with huge insurance companies who pass the prices on to the hapless patients. Same deal with prescription drug and medical device prices. Moving to a publicly funded national or state healthcare coverage program will be fought tooth and nail by these powerful, wealthy corporations whose profits would be taken away by a public system. They spend millions (maybe billions) of dollars each year lobbying legislators in both Washingtons, and contribute generously to re-election campaigns.

Is there any hope of success?

The current combination of a scary pandemic stressing our healthcare system, an economic recession cutting into medical industrial corporations' profits, and a re-awakened racial justice movement spurred by extreme inequality may provide the pressure to move away from neoliberalism and toward government action for the good of all U.S. residents. Such a movement could well include finally treating our healthcare system as a public responsibility instead of a profit -seeking venture**.** ######

Health Care for All-Washington

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Ways in which corporations have infiltrated medicine:

- Makers of medical devices and drugs fund medical education programs and pay physicians and hospitals directly to use their products.
- Business staff, instead of medical professionals, manage health care organizations like hospitals and medical practices
- Managers pressure professionals to generate profit from services, decreasing effort on creativity or innovation in medical research
- For-profit companies have increased their presence as stakeholders throughout the health care system
- Economic policies, both corporate and governmental, increasingly affect the practice of medicine

This definition of medical industrial complex doesn't include the health insurance industry, which adds another layer of private profiteering.

How these two concepts explain the difficulty attaining national or state publicly funded universal healthcare coverage

First, it's important to note that universal healthcare systems in European countries and Japan basically were established as these countries pulled themselves together following the wreckage of World War II. Even though Canada was not directly attacked during the war, the many Canadian troops killed in Allied battles meant that both the population and the economy were still recovering in 1947 when Tommy Douglas implemented provincial hospital coverage for all residents and got the process started that led to Canada's universal system by the early 1980s. There was no medical industrial complex then, and the ascendancy of privatization with denigration of the role of government that is neoliberalism had not yet displaced Keynesian ideas about using government to solve problems.

Now, in 2020, much of medical care is in the hands of mega-hospitals that have bought up physicians' practices. These goliaths "bargain" with huge insurance companies who pass the prices on to the hapless patients. Same deal with prescription drug and medical device prices. Moving to a publicly funded national or state healthcare coverage program will be fought tooth and nail by these powerful, wealthy corporations whose profits would be taken away by a public system. They spend millions (maybe billions) of dollars each year lobbying legislators in both Washingtons, and contribute generously to re-election campaigns.

Is there any hope of success?

The current combination of a scary pandemic stressing our healthcare system, an economic recession cutting into medical industrial corporations' profits, and a re-awakened racial justice movement spurred by extreme inequality may provide the pressure to move away from neoliberalism and toward government action for the good of all U.S. residents. Such a movement could well include finally treating our healthcare system as a public responsibility instead of a profit -seeking venture**.** ######