Universal Health Care: An Idea Whose Time Has Come?

by Sarah K. Weinberg, MD, Editor

Three fairly recent articles caught my attention:

1. “The Conservative Case for Universal Health Care” by Chase Madar in The American Conservative. This article was reprinted from its original publication in July 2017

Taken together, these articles all point out the advantages when nations set up health care systems that provide health care to all their citizens or residents. Note that these three span the ideological spectrum from the right (American conservative) through right-of-center (free trade, British conservative) to the left (American social democrat). Maybe we’re going to get somewhere! A review of each article:

1. American Conservative View

Mr. Madar, a civil rights attorney in New York and the author of a book about Chelsea Manning and her leaks of classified information, wrote a great article about why the U.S. should socialize health care with the active support of Republicans and conservatives. He predicts: “…within 5 years, plenty of Republicans will be loudly supporting or quietly assenting to universal Medicare.” Why? “…because socializing healthcare is the only demonstrably effective way to control costs and cover everyone.” Not only do countries with socialized healthcare spend a lot less, but their populations are healthier than ours by several measures. “Why does socialized healthcare cost less? Getting rid of private insurers, which suck up a lot [of] money without adding any value, would result in a huge savings….”

“The barrier to universal healthcare is not economic but political. Is profligate spending on health care really a conservative value?” In other nations, conservative political parties support their popular universal healthcare systems.

Continued on p 5
From the President’s Desk

by Marcia Stedman, President.

Summer is the traditional season for vacations as we take a break from our customary activities to reconnect with family and friends, enjoy our favorite outdoor activities, or maybe relax in our own back yards. Just as our gardens thrive when we pay attention to them, so do people and organizations. Here at HCFA-WA, after a frenetic winter and spring of organization-building and political-action work, we have been taking time to evaluate our accomplishments over the past year as we engage in strategic planning for the coming year and continue to work with our allied organizations. But we’re not just sitting around, oh no!

In late June, HCFA-WA sent 4 members of the Board of Directors and our Program Director to the annual National Single-Payer Strategy Conference in Minneapolis, MN, where we shared strategies and tactics with representatives of state-based single payer organizations throughout the United States as well as folks working for a national single-payer health care system. Our Program Director Bevin McLeod shared creative organizing strategies while I reported on Washington’s accomplishments over the past year. Washington was well-represented as Eric Gonzalez, Legislative and Policy Director of the Washington State Labor Council, joined the panel presenting the workshop on assuring a just transition for workers displaced due to the implementation of single-payer health care.

Seattle’s own Congresswoman Pramila Jayapal addressed the group via video as she spoke about HR 6097, the State-Based Universal Health Care Act that she recently introduced into the U.S. Congress. When passed, this Act will smooth the way for states to get access to their portion of the Federal funds needed to help finance their own innovative health care plans and better serve their populations. We learned from each other about strategies that work, and made connections with powerful organizers from across the United States. At the end of the weekend, we were both exhausted and inspired, and came home with a wealth of new resources to share with our members and supporters in the coming months. Please look for the Conference reports elsewhere in this Newsletter for more details.

No sooner had we returned from Minneapolis than we immediately began the final preparations for our Summer Gala and Auction, to be held Saturday, July 28th, at 415 Westlake in Seattle.

We hope you can join us and help us put the “fun” in fundraising!

As always, thank you for your support and your commitment to assuring health security for all Washington residents. always for your work doing this!

###
Outreach Committee Report

By Jeannie Ernst, Chair

Health Care for All Blend Coffee: The East Side will continue with this and offer a pound of coffee for a donation of $20 at tabling events. The coffee labels are not ready yet, but the committee is working on it. Tabling events are scheduled in July. We expect to have coffee available at the July 28 fundraiser.

Volunteers: We can always use more volunteers! Spokane scheduled volunteer training: “Induction to the process of tabling” at the South Hill Library on July 10. We are working on a list of specific tasks for volunteers to sign up.

Meaningful Movies: Several HCFA-WA members have been featured speakers at Meaningful Movies events in the Seattle area and elsewhere. We’re working on scheduling an event at the Magic Lantern theater in Spokane.

Projecting HCFA-WA logo on buildings: This is a new and novel idea, and we are looking into the technical aspects of it.

Speaking opportunities: The new WSU School of Medicine is interested in having a HCFA-WA speaker, either in a classroom or a forum. This will likely occur in the fall sometime.

Messaging: We are working with the Writers Group to help with clear messaging around the phrases “universal health care” and “single payer”. We also are developing a good explanation of Rep. Pramila Jayapal’s bill (HR 6097) to enable state single payer plans to access federal ACA, Medicaid, and Medicare funds.

Want to get involved? Contact: outreach@healthcareforallwa.org.

Fundraising Committee Report

By Peter Lucas, MD, Chair

Horizon House meeting: Our committee held a brainstorming session with several Horizon House residents. Follow-up meetings are planned, as well as future efforts to keep these residents up to date with HCFA-WA’s activities and with single-payer developments.

Bainbridge House party: Dr. Lucas plans to hold a house party on Bainbridge Island in late summer/early fall.

Planning for the July 28 Gala: The committee members have been hard at work finding sponsorships and items for the auction. Remember to buy your ticket and come! It’s at 415 Westlake, an event venue, from 7-10 pm. Lots of entertainment and good speakers.

Other major donors: Committee members are continuing discussions with several individuals and organizations.

These and other activities will raise substantial funds that are needed to educate voters and lawmakers, support our contracted employees and day-to-day operations, and provide for an economic analysis of and polling about single payer healthcare in Washington State.

###
Health Care is the Real Issue in the 2018 Elections

Every candidate is talking about universal healthcare this year.

The 2019-20 sessions of our state legislature will be voting on a revised version of our bill for the Washington Health Security Trust, so let’s talk to every candidate for state office this year to make sure they are ready to approve our bill for universal healthcare for everyone in Washington state.

There are several bills in the US Senate and House, and national discussions have been spurred on by Representative Jayapal’s introduction of a new bill for State-Based Universal Health Care. Let’s make our US Senators and Representatives hear about universal healthcare.

Let’s keep health care in the forefront in our 2018 elections!

There are candidates for all 98 seats in the Washington State House of Representatives and for 25 seats in the Senate. Candidates recognize that the people of our state want everybody in and nobody left out of the basic human right to health care. In order to make sure that all candidates know about this, we asked each candidate to answer a survey.

There are candidates for all 10 seats in the US House of Representatives and for 1 seat in the US Senate. We have asked each candidate for these national offices to answer a survey too.

We will publish the results in time for primary elections on August 7th. Watch for the opinions of candidates in your district. If you agree with their opinion, let them know it. If you don’t agree with their opinion, motivate them to change their position. If we don’t get an opinion, ask them to let you know what they think about universal health care. Let’s show up at candidate forums in your district. Let’s make sure that each candidate is addressing the issue of universal health care.

Let’s keep it the real issue in our 2018 elections!

Watch for the results of our survey. Go and meet with candidates. Please share their response with us. Send an email to me at action@healthcareforallwa.org or contact the Field Director in your area of the state.

###

Report from HCFA Spokane

By DW Clark, Board member

The Spokane HCFA group met on July 10, with a good turnout of new volunteers. They will be involved with tabling at the following summer events:

- South Perry Street Fair
- Hillyard Festival
- Unity in the Community
- Pig Out in the Park
- Valleyfest

Spokane’s local Roast House Coffee has teamed up with HCFA to introduce our own HCFA blend. It will be available at the tabling events for a donation.

###

Bits and Pieces

Severely injured leg? “Don’t call an ambulance”

A Boston woman, 46, slipped getting onto a subway car, and got her thigh stuck between the platform and the car. She sustained a severe thigh laceration, exposing the bone. Although screaming with pain, and being extricated by fellow passengers, she wailed, “Don’t call an ambulance! It’s $3,000 and I can’t afford that!”

Emergency medical personnel arrived within minutes, and she was transported to Boston Medical Center for care. What bills she will actually face is unknown, but her instant reaction says it all about what’s wrong with our health care system.
Universal health care

Although none of these systems are perfect, all are subject to constant adjustments. However, their problems are minor compared with those in the U.S. “And virtually no one looks at our expensive American mess as a model.” A German friend of the author commented: “Yes, we are less free but security versus freedom is a classic balance! National healthcare makes for a more stable society, it’s a basic service that needs to be provided to secure an equal chance for living standards all over the country.”

Currently, “…GOP healthcare politics are…spectacularly incoherent.” Even GOP voters, talking to pollsters, say “…that they hate Obamacare but like the ACA.” It will fall on “reform conservatives” to realize that single-payer or some kind of universal care is perfectly keeping with conservative principles. As the ACA is undermined, the number of uninsured and underinsured increases, and medical bankruptcies increase, Republican governors (who actually have to govern) will be talking about single-payer for reasons of fiscal responsibility, community decency, and the obvious evidence that this is what works.

“The real obstacle may be the Democrats.” The Republicans may leap ahead of them in the enactment of single-payer. “…a civil war is raging within the Democrats with the National Nurses Union, the savvy practitioner-wonks of the Physicians for a National Health Program, and thousands of everyday Americans shouting at their congressional reps at town hall meetings are clamoring for single-payer against the party’s donor base of horrified Big Pharma executives and affluent doctors.”

“…even if there is some banshee GOP resistance at first, universal Medicare will swiftly become about as controversial as our government-run fire departments. … You read it here first, people: Within five years, the American Right will happily embrace socialized medicine.”

Editor’s note: It has already been one year since this article was published. Only 4 years to go?

2. Special Report: Universal Health Care

This major article in The Economist is global in its perspective. The disaster of the 2014 Ebola virus epidemic in west Africa has served as a wake-up call for major public (World Health Organization, World Bank) and private (Gates Foundation) sources of aid for impoverished countries. Previous aid targeted specific diseases, like TB, malaria, and HIV/AIDS, but the Ebola disaster highlighted the need for public health infrastructure in poor countries. Emphasis is now shifting to helping countries establish functional public health systems, and universal health care for the population based on good primary care. These systems should be more resilient in the face of various threats, and less reliant on outside aid. Interestingly, as of 2015, “All countries have committed themselves to getting there [universal healthcare] by 2030 as part of the UN’s ‘sustainable development goals [SDG].”

The World Bank, for example, now recognizes that better health leads to higher income, as well as the other way around. Its economists have shifted from regarding public spending on health care as a “social overhead” cost, to recognizing that such health spending actually leads to faster economic growth. There is accumulating evidence that better health leads to longer adult lifespans which lead to increasing Gross Domestic Product (GDP). Also, lower out-of-pocket spending for health care leads to increased consumer spending and better efficiency in health care purchasing.

Globally, while infectious diseases still kill millions each year, their rate is decreasing. Meanwhile, chronic diseases associated with longer lives and better economic circumstances are increasing – like diabetes, heart and artery disease, obesity, kidney disease, cancer, etc. Especially for this epidemiologic shift, primary care is an essential precondition for a decent health system.

As poorer countries find ways to increase the number of medical providers, ethical problems surface. For example, in India and China, medical providers (not all are physicians) are often required to see so many patients that too little time is spent to make accurate diagnoses, let alone do appropriate treatments. Without adequate accountability, wrong diagnoses, erroneous treatment, under-treatment, and over-treatment are common, especially when monetarily advantageous to the providers. Similar results were found in Paraguay, Senegal, and Tanzania. Costa Rica is an example of a well-functioning health care system, with a health ministry that holds doctors accountable for patients’ outcomes.
The article also points out that mental health care is abysmal or completely absent in many of the poorer nations. In general, policy makers and international donors ignore mental health. Access to essential surgery is also weak in all the world outside North America, parts of South America, Europe, and Australia. The most obviously missing surgical capability is in obstetrics: Ceasarean sections and post-delivery hysterectomies to control bleeding. In developing countries, 57% of operations are for emergencies, compared with 25% in rich ones. Also, surgery is much more likely to impoverish patients (and their families) in poorer countries.

A section of the article is set aside to describe the appalling situation in America, “the only large rich country without universal health care”. “America has a version of a problem seen the world over: voluntary insurance cannot ensure that everybody gets coverage.” Looking at the current Republican efforts to sabotage the ACA, the article states: “If health care turns into even more of a mess than it is now, Democrats might try to introduce more radical reforms should they regain the presidency in the 2020s. By then yet more developing countries may have achieved universal health care, making America even more of an outlier.”

The last part of the article is devoted to the road ahead, focusing mainly on low-income countries. Thailand provides a good example. It has put in a Universal Coverage Scheme that now covers 98% of Thais. Incentives encourage doctors to work in rural areas, and there are extra payments to hospitals to take on more patients. They also have a Health Intervention and Technology Assessment Programme that analyses the cost-effectiveness of treatments. Even so, Thailand is only spending 4% of its GDP of health (about $220/person/year).

Editor’s note: Think of the 13 people recently rescued from a Thai cave: all were hospitalized immediately, and likely none will be impoverished by huge bills afterward.

Three basic approaches to universal health care were discussed: 1) providing complete coverage for a small group to start, then adding more groups as resources increase; 2) providing some benefits to the entire population to start, then adding better benefits as resources increase; and 3) expanding the tax base – taxing extractive industries, sin taxes, reducing energy subsidies, for examples. Recent research by the Institute for Health Metrics and Evaluation (at the University of Washington) suggests that only about 20% of the health-related targets in the UN’s 2015 SDG document will be met on time (by 2030). “Poor countries will still need aid, but they will also have to step up their own efforts to bring about better health care for all.”

### 3. Medicare for All Is Now a Mainstream Position

Noting that 16 Democratic senators have co-sponsored his bill (S 1804), and that a majority of Democrats in the House have co-sponsored HR 676, Sen. Bernie Sanders makes the case that the time has come for supporters to mount a major campaign to pass some form of Medicare for All. He notes that polls show that at least 75% of Democrats support the idea, as does a substantial minority of Republicans, and that is probably the reason that so many Democrats in Congress are now signing on.

Not only that, but as Republicans and the current administration sabotage the ACA in various ways, increasing the financial burden on more Americans when they use health services, the pressure will grow for Medicare for All. After all, “…the function of a rational health care system in this country should be to provide quality care for everyone in a cost-effective way, not to make health industry CEOs richer or drive up stock prices on Wall Street.”

The main obstacle that Sen. Sanders sees is that those profiting now will spend billions to prevent change: insurance companies, Big Pharma, and mega-hospital corporations.

“This is a struggle not just about health care but about the heart and soul of our country, about what we stand for as a people.”

Conclusion

It’s impressive to see the whole world coalescing around universal health care as a necessary function of national governments. This fact can give those of us weary of the struggle to get there in the U.S. a new shot of f hope to carry us through the next few years.

###
A thoughtful, dense collection of chapters by several progressive authors (Howard Waitzkin and the Working Group on Health Beyond Capitalism), this book challenges readers on several concepts that have become received wisdom. Consulting Wikipedia for help with definitions:

**Neoliberalism**

This term is used throughout the book to refer to policies based on free trade, privatization, minimal government involvement in business, and fiscal austerity directed mainly at public safety net infrastructure. These policies are entrenched today in much of the world, but especially in the US.

**Capitalism**

This term denotes an economic system based on private ownership of wealth and the means of production of goods and services for profit to the owner(s). The system depends on competition among businesses. Without interference from government or if competition is inadequate, this system generates serious inequality in the population, with wealth accumulating to a very small number of people, and disregard for the plight of the workers or the poor.

**Back to the book: How did we get here?**

Most of the book (the first 4 parts) is descriptive of the evolution of the health care system in the U.S., emphasizing the effects of corporatization, de-valuation of health care workers, especially physicians, and pursuit of capital accumulation. Efforts at reform have been hamstrung by neoliberal insistence on maintaining privatization and for-profit market forces, both of which maintain the accumulation of capital among the very wealthy few. As a result, reforms such as the ACA have been inadequate in making access to health care truly universal.

Entrenched neoliberalism in much of the world has had the following effects on health care systems: 1) Austerity leads to underfunding the initially universal public system, 2) The system is forced to retreat from universalism, 3) Cost-sharing is instituted, leading to decreased benefits, and 4) Parts (or all) of the system are sold or contracted out to private businesses. The examples of Greece, Spain, and England are discussed.

**A road forward**

Part 5 consists of five chapters suggesting in various ways the need to move beyond capitalism, or at least its neoliberal expression now dominant in much of the world. In order to build a health system that works for everyone, much of the rest of social infrastructure also needs to change to support the needs of the many rather than generate huge profits for the very few. Yet, at least in the U.S., implementing a publicly funded single-payer health care system could be an important first major step.

This book will get you thinking in new ways!

###

Michael Lighty addressing a plenary session at the Minnesota conference June 23,
One theme of this year’s Conference was “assuring a just and equitable society,” and the above quote summarizes perfectly why Health Care for All-Washington members are so passionate about this issue. The conference consisted of several plenary sessions and two groups of breakout workshops. Our group split up to attend several different workshops.

Workshop Notes

“State of the State-Based Single-Payer Legislative & Ballot Campaigns”

Marcia’s main reason for attending the Single-Payer Strategy Conference this year was to find out if other states were planning to coalesce around bills or ballot measures in 2020 to coincide with the Presidential election. Of the 10 states that reported, only Oregon and Minnesota mentioned a definite timeline, although some of the states that are part of the “One Payer States Network” were not represented.

Oregon intends to convince their legislature to put a single-payer ballot measure on the 2020 ballot and is organizing and educating voters around this. They are also exploring a multi-state pharmacy-benefit management system in combination with CA and WA.

Tactics: ally with Nurses Assn, do tabling and house parties, seek local city council resolutions in support of single-payer.

Minnesota’s approach has a lot to offer:

- A simple plan name: The Minnesota Health Plan
- An inclusive name for their progressive coalition: “Our Minnesota Future”
- Multi-racial - make economy work for ALL MINNESOTANS
- Abundance for all, not scarcity
- Long-term, power-building coalition
- People-led agenda
- Tactics: Build capacity in allied organizations, get business owner input, engage farmers in canvassing—tie social determinants to health care, hold forums in conservative districts.

Timeline:

- 2018 - elect single-payer candidate Erin Murphy as governor;
- 2019 - transition – educate and mobilize on the MN Health Plan
- 2020 – get Democratic majority in state government
- 2021 – the MN Health Plan is in place

New Jersey’s plan is based on expanding traditional Medicare to cover all state residents, modelled after the carve-out that Sen. Max Baucus obtained from the ACA for the residents of asbestos-contaminated Libby, MT. They think this might be easier than depending on Pramila Jayapal’s SBUHC Act to move forward.

The New York Health Act passed their lower house for a 4th time, was 1 vote short in Senate

- Postcard campaign – 10,000 signatures
- Small biz endorsements – 400
- Endorsed by local gov’t officials – 16
- Katie Robbins, Nurses’ Union organizer – very important to involve Nurses
- Having consistent endorsements on record makes politicians accountable

Ohio activists collaborated with the Poor Peoples’ Campaign this spring

- Identical bills in House and Senate, with increased co-sponsors
- Considering a ballot initiative

In Pennsylvania, their House bill is in committee; Senate bill – trying to get hearing. Tactics: coalitions, resolutions in local govt., 13 of the 22 single-payer candidates won their primaries this season.

In Maine, they have a database of 25,000 and “complete data” on 15,000. Their staff includes a FT Executive Director and 2 FT field organizers. They are looking to other states for bill details to make their bill better.

California’s single-payer bill has faltered due to lack of a financing mechanism, despite their extensive prep work before even launching the bill: holding focus groups, doing strategic polling, and strong state-wide campaigning. With 70% of California’s health care dollars being spent by the state, CA has a lot to gain by switching to a single-payer financing system.

After the failure in 2016 of the Colorado Care single-payer ballot measure, the Health Care for All Colorado Foundation is now focused on research and education, and supporting other single-payer efforts, both state and national. They do candidate surveys, rating candidates on a 1-5 scale, where 5 = a ‘Champion of Health Care.’

“Taking on Big Pharma”

A. Why are drug costs so high?


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2. ‘Revolving door’ - of the 806 health care lobbyists in Congress, 502 used to work in Fed. Gov’t. Of the 600 Pharma lobbyists, 400 used to work in Fed. Gov’t

B. Physicians Proposal for Pharmaceutical Reform in the U.S. and Canada - Dr. Brian Yablon, PNHP

Minnesota - PowerPoint presentation covering ways to improve access to drugs in the U.S.
1. Regulate drug deductibles and co-pays
2. Develop a multi-state Pharmacy Benefits Management system for price negotiation
3. Include medical devices
4. End abuse of monopoly power by drug companies

C. Organizing tactics – same as those for single-payer plans, including
1. “Bird-dog” candidates/elected officials on Pharma issues
2. Engage in “Rapid Response” to Pharma price-gouging

“Building Solidarity: Bargaining Fights & Healthcare Justice”

How to bring single payer into union contract negotiations: Get the membership together before going in. For example, members might want to switch from paying a percent of the premium to paying a percent of their pay, which would be similar to how a single-payer plan would be financed. The difference between a HRA (funded only by the employer) and a HSA (funded by both employer and employee. Employees might want to bargain for a 100% funded HRA.

During strikes over health care, deploy 1/3 of striking workers on the picket line, and 2/3 demonstrating at the statehouse outside the governor’s office.

“Forging Partnerships with Workers’ Centers & Other Non-Union Workers’ Organizations”

Tactical relationships build deep trust for common causes of social and economic justice. Since only 18.8% of Washington workers are in unions, how do we get more workers on board? Try contacting worker education centers. The first step is to elicit their concerns, and keep on addressing their concerns to keep them engaged. Doing health surveys, making sure to use pointed questions, can help educate people and bring out critical thinking. Surveys can be done online, door-to-door, at street fairs, parenting groups, etc.

“All About Grassroots Lobbying”

Three asks:
1. Ask for public events from elected officials and candidates so that health care can be brought up;
2. Ask elected officials to sign a “Dear Colleague” letter to solicit support from other elected officials;
3. Ask elected officials to sign on to single-payer bills Be sure to cultivate staffers, who can be allies.

Politicians are people, too. Figure out what motivates them and why they hesitate. Check with staffers to see if different or better information should be given to them.

Don’t focus on people who strongly oppose (or even those who strongly agree)! Use most time and energy on educating those in the middle.

“Long Term Care, Disability Rights and the Single Payer Movement”

The need for long term care inclusion in single-payer plans is crucial, and not enough attention is being paid to it. There needs to be funding both for institutional care and for home or community care (up to 50% of LTC). A huge amount of home and community care is unpaid. Currently, Medicaid is a major payer of LTC (60%). Medicare only covers about 5% currently. Few people have adequate LTC insurance. Other OECD countries also only partially fund LTC. Scotland has a system that covers most LTC, and it turns out not to be as costly as feared. LTC is included in HR 676, but not in S 1804. The specifics need work.

Fears among those getting LTC now must be addressed. Many fear that if the government pays, it will force people into institutions.

Notes from the Plenary Sessions

“Creative Strategies for Winning State Single-payer Campaigns” – Sat. Night Session

Business Strategies:
• Hold monthly chapter meetings
• Contact business owners in your database
• Create a business endorsement form
• Show the Fix-It movie – great resource
• Join local Chamber of Commerce
• Maine has a business questionnaire
• 1-to-1 conversations
• Get 1 business to talk to counterparts, fellow board members

Get large business to influence other leaders – network. Contact info: David Steil, PA: djsteil@verizon.net
Lynn Cheney, ME: Lynncheney3@gmail.com

Business Initiative for Health Policy: http://businessinitiative.org/ Board of advisors includes Don Berwick, Wendell Potter, Gerry Friedman, Dr. Carol Paris of PNHP, Richard Master (the Fix-It suite of films), David Steil Business Alliance for a Healthy California: https://www.ba4hcal.org/ offered this:
• 15% of a company’s payroll goes to health care
• 57% of small biz supports single-payer

RESOURCES

Messaging Tips from Minnesota on the OPS De-brief podcast
https://drive.google.com/drive/u/2/folders/0B_zZqTcJjJNYtIjiYjRINTQitZWMzMC00MjViLWFiZTEtZDYyYjR1ODExMjdI

Rich Shannon – MN – about 25 minutes in
• Instead of “rural MN” say “greater MN”

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- County commissioners may be receptive to single-payer and going through them may be a better way to organize rural areas than going for individual voters. They are responsible for their own employees, jails, mental health services; they also contribute payroll taxes into Medicaid

Sen. John Marty – MN - Prime sponsor of the MN Health Plan – about 30 min. in
- MN has county purchasing coops – these are single-payer systems, although the county commissioners are actually conservatives
- The Regional Health Boards were able to increase reimbursements for Medicaid dental procedures as a result of administrative savings from their co-op management arrangements
- Re: ‘tax’ vs. ‘premium’ – call it what you want, it’s still what you pay for health care. This eliminates ‘freeloaders’ – you get health care, the $$ go only to health care – not the general fund.

Main Organizing Take-Aways
1. Nurses are key movement builders: They know the problems, have strong unions – work with them
2. Canvassing individual voters at their doorsteps builds the database
3. Practice active listening
4. Health care is a basic need: the correct answer to the question: ‘Is health care a right or a privilege’
5. Recruit single-payer candidates to run for public office
6. Develop a nationwide centralized database for the movement
7. Big Organizing – “Rules for Revolutionaries” developed for Bernie Sanders’ CA Campaign
8. A “just transition” – lessening the impact on workers displaced by the switch to a single-payer system
9. Clarify the difference between “social” insurance and “commercial” insurance

Archive of Videos and Presentations
Follow the links from the Agenda here: https://www.healthcare-now.org/strategy-conference/2018-minneapolis/agenda/#saturday

Zero in on the ‘State of Other States’ reports here: https://wiki.healthcare-now.org/State_of_the_States-Based_Single-Payer_Legislative_and_Ballot_Campaigns

Representative Keith Ellison gives the Keynote Address at the Single Payer Conference in Minneapolis, June 22, 2018
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Yes, I’ll join to work for high quality, sustainable, affordable, publicly-funded health care for ALL Washington residents

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$____ Contributions to **HCFA Education Fund**, a 501(c)3, are tax deductible.
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Thank you for your support.
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**Obituary: Rev. Paul F. Pruitt**

Rev. Paul Pruitt, with his wife, Mary Margaret Pruitt, was a long-time active member and supporter of Health Care for All – Washington, He passed away early on July 2, 2018 following a long illness. Paul was born February 3, 1922 in Nebraska, but moved to Washington during his school years. He graduated from Kirkland High School, the College of Puget Sound, and Yale Divinity School. Returning to Washington State, he worked for many years as an ordained minister in the United Church of Christ.

Paul was active in the civil rights movement in Tacoma, the Seattle Food Bank program, the King County Board of Ethics, the Church Council of Greater Seattle, Washington Association of Churches, and Fellowship of Reconciliation. He was elected to our state’s House of Representatives from the 34th LD in 1977, and served until 1985.

At HCFA-WA, we remember Paul best as a loyal member of our Board of Directors for about two decades until declining health caused him to resign. He is survived by Mary Margaret Pruitt (after almost 69 years of marriage!) and a large family. Mary Margaret has continued her support of HCFA-WA, especially by making conference rooms at Horizon House available for our meetings as she has done for 20 years.

All of us at HCFA-WA will miss Paul, and extend hugs and condolences to Mary Margaret.
Check your label for the date of your last contribution. Renew your membership now for 2018