The Cork In The Bottle:

THE ROAD TO SINGLE-PAYER HEALTH CARE GOES THROUGH NEW YORK

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Eleven states, including New York, have attempted to enact or implement single-payer healthcare plans since 1986, with the most recent California in 2019 and New York this year, 2021. All failed for the very same reason – fear. I'll explain below.

I'll also examine the barriers that tripped us up here in New York, from the systemic to the specific , and propose changes in strategy and tactics that might move us forward.

For the uninitiated, single payer health care is universal – every person gets it. It is comprehensive – primary to specialized care, emergency to long-term; plus pharmaceutical; dental & ocular. It's a right. And here's where the fear begins to get stirred up – with the government, as in Medicare, the sole payer of the costs for services incurred with non-profit treatment providers; with everything financed from three sources: income taxes; Federal waivers to integrate Medicare and Medicaid funds into a single-payer trust; and from savings accrued from reductions in administrative costs.

The latter currently account for 34.2% of all hospital/insurer expenditures (Annals of Internal Medicine, September, 2020); as compared to 17% In Canada's single payer system and 2-5 % in the U.S. for Medicare and Medicaid (Center for American Progress, April, 2019). How to reduce these costs? … Remove private, non-profit insurers from the equation. As spelled out in the NY Health Act, no private insurers can sell policies covering the benefits provided via NY Healthcare, essentially putting private health insurers out of business in New York. If enacted nationally, in Sanders' and Jayapal's Medicare for All proposal, that would mean all private, for-profit health insurers in the country, who netted $35 billion in profits during 2020, the first Covid year, will be done selling health insurance.

Health care is truly big business; in 2019, we spent $3.8 trillion, private and governmental monies, on health care representing 17.7% of our gross domestic product and rising. The US is the home of mega-capitalism, which is now thoroughly rooted in the belief that the government can't be trusted. Ever since Roosevelt died, the right wing has been preaching that the government is infested with Communists – the House Unamerican Activities Committee (HUAC) of the 1940's, the Army-McCarthy hearings of the 1950"; promoting the

notion, a la Reagan in the 1970's and into the present that the government is primarily invested in helping Black and Brown Americans and can't be trusted; and has demonstrated, along with Democratic neo-liberal connivance, that it really can't be, leading us into one war after the other, cementing income inequality and white privilege into the foundations of our economy.

Single-payer health care is truly a revolutionary program, intent on putting the bottom rail on top, ordinary Americans in a position to control their own health care … where and by whom it is provided – and to predict how much it will cost them. Fear reduced and perhaps eliminated, particularly the fear that you won't get treatment if you fall seriously ill or go bankrupt if you do and can't pay the bills. You will pay your share, on a sliding scale, of healthcare taxes, just like you pay now for Medicare and for your healthcare benefits assuming you're working; but your boss will still pay the larger share of those taxes and you won't be responsible for any co-pays or deductibles.

A cost analysis of Sanders' Medicare for All bill conducted by the Congressional Budget Office (CBO) in 2020 determined that single-payer would reduce annual healthcare costs by $400B, with most of the savings accruing from reduced administrative costs. Out of pocket expenses for Americans amounting to $406.5 billion annually in 2019 (Commission for Medicare/Medicaid Services (CMS) would be eliminated. All uninsured Americans – 9.2% or 30 million – and underinsured – 23% or 75 million – (Commonwealth Fund), 2018) would be fully covered; and medical debt -- burdening 19% or 62 million Americans in 2020– would be eliminated. In New York State, the Rand Corporation analysis of the NY Health Act in 2018 estimated annual savings for the State at 3.1% annually or $15B over the course of 10 years, and 1.2 million uninsured New Yorkers in 2020 fully covered.

What's to fear and what's not to like? Why hasn't one of the numerous single payer bills, first presented in the NYS legislature in 1992 and annually ever since and in the Federal Congress as early as 1943 by John Dingell, Sr., been enacted into law? The answer … money and power, with much of both at stake. In 2019, private health insurance expenditures amounted to $1,195B; hospital costs amounted to $1,192B; physician and clinical services $772B; prescription drug spending $370B. The largest share of health expenditures was made by the

Federal Government, with Medicare spending amounting to $799B and Medicaid to $613.5B. (All data courtesy CMS.)

To ensure that a large piece of the Federal pie would go to the private for-profit making sector, particularly Big Insurance and Big Pharma, Richard Nixon in the early 1970's resorted to the practice employed since the Civil War when Federal tax dollars went to private manufacturers to purchase shoddy uniforms and boots for the Union army. He promoted the development of Health Maintenance Organizations, profit-making ventures, and the utilization of managed care as the vehicle to facilitate the transfer of Federal payments for medical services to private for-profit entities, governed by standard capitalist practice: transactional in nature, i.e., services provided in return for payment; a zero sum game interaction, i.e., you don't or can't pay for the services you need, you don't get them or you incur debt if you do; ultimately, hierarchical and not relational, with all decisions regarding treatment, i.e., if, when, by whom and where you receive it decided primarily if not solely by the payer not the patient.

We've come to know this as "privatization," where Federal tax dollars primarily benefit the owner(s) of the HMOs and related organizations. Those of you reading this might well think, so what?; this is the way things are. And you'd be right, so accustomed have we become to these health care delivery systems. Simply recall how we've all been bombarded during and since the peak of Covid with robo calls from private insurance companies peddling Medicare Advantage programs. The use of "Medicare" might prove confusing, but MA programs are alternatives to Medicare run by for-profit insurance companies, which are paid by Medicare to take you of its rolls. At present, 3,550 MA programs are operating nationally, whose numbers are increasing at a 13% annual rate. Medicaid, thought of as a strictly Federal program, is currently managed by for-profit insurance companies in 40 states as managed care entities with all the limitations and exclusions of for-profit HMO's. And the health insurance you purchase via Accountable Care Act exchanges is provided by private, for-profit insurance companies and subsidized by Federal tax dollars. It's important to remember that upwards of 32% of all operational dollars expended by these for-profits are for administrative costs, including profits.

The *coup de grace* could well be struck by Wall Street, which has been plundering healthcare for investment opportunities since the advent of the ACA.

Predatory private equity firms have invested $580 billion in health care practices since 2010, peaking in 2019, at $79 billion. To quote from the Affordable Health Care Coalition (Aug.18, 2020), "The problem with private equity's profit-first goal is that the best health care and the biggest returns are often at odds with one another … Private equity firms expect greater than 20% return on investment … How do you secure 20% yearly return ….? You cut costs and raise prices …" running the risk of putting your investment property out of business. Witness Hahnemann Hospital's recent demise when it new owner's cost-cutting practices forced its closing in September, 2019, depriving a poor Philadelphia community of Black Americans of a health care provider whose mission was to serve and help them, a re-enactment of a growing national phenomenon.

So when you hear "cost-cutting", think cutting services and raising profits, the new mantras of all large health care systems in the US. Similarly, when you hear ruling class pundits lamenting the loss of jobs that will result from the single-payer revolution think loss of profits by big investors, individual and institutional, with health care workers' resulting predicaments used as hedges against approaching single-payer implementation.

(Please note that specific provisions of the Medicare for All bill and the NY Health Act directly address the issue of job loss occasioned in insurance companies by the transition to single payer by authorizing the long-term payment of unemployment benefits and preferential inclusion in health care training programs.)

In sum, so much money and power are at stake that the private for-profits will oppose single-payer fiercely much as they have for the past 30 and more years. The challenge for single payer advocates … how do we overcome this very determined opposition?

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New York is the cork in the bottle – if it pops, if the NY Health Act gets enacted, other states, and eventually the Federal Government, will do likewise. This was the scenario in Canada – first Saskatchewan then the entire country adopted single-payer health care. But I don't believe it will work here unless New York

has been acknowledged as the pathway to single payer, the vanguard of a coordinated national effort.

This has always been the conundrum for single-payer advocates – put maximum effort to establish a nation-wide program or piece it together state-by-state. This was the debate that split Physicians for a National Health Plan at the outset of its single-payer effort and caused a number of its activists to abandon their involvement. The compromise the PNHP appears to have reached is to split their effort and do a bit of both. The national PNHP supports the Sanders/jayapal effort to pass Medicare for All (M4A), first introduced as the Expanded and Improved Medicare for All Act in the House by John Conyers in 2003 and renewed annually into the present, and its NY Chapter is currently the principal sponsor of the single-payer NY Health Act (NYHA), introduced in the NYS Assembly in 1992 by Richard Gottfried and more recently co-sponsored by Gustavo Rivera in the Senate.

This approach has a certain logic to it but it's fragmented and comprises a flawed strategy. To quote from a recent article by Butcher (The Postulates in the Science of Unitary Human Beings,2021), "… Changes do not occur by local causes… it is the whole that influences the behavior of parts … [which] cannot be understood as isolated entities … but … can only be defined through their relations" with the whole. In short, a systems understanding of causality as an interconnected phenomenon.

We – single payer activists of the Campaign for NY Health -- just took a beating at the tail end of the past Legislative session in Albany, which I'll explain as we proceed. A rout was avoided and morale maintained as a consequence of the inspired leadership of the Campaign for NY Health's co-directors and the sheer obstinacy of Campaign activists. We not only had to contend with Big Insurance lobbyists but with suspicious union leaders, establishment Dems who echoed Biden's and Congressional neo-Liberals' single-payer opposition and, most disappointing, the about-face of several NY Senate Dems who had declared as NYHA co-sponsors only to renege once advised by a skittish Senate leadership that the bill lacked sufficient support. It would have been helpful and reassuring if we had received support and acknowledgement from the Congressional leaders of M4A in Washington, but it became clear the fight was ours alone to bear.

After you lose a battle, particularly if you intend to carry on and win, you're obliged to examine your strategy and change or discard it. We will never succeed in having the NYHA enacted so long as the NYHA and M4A remain isolated from one another and one another's struggles (which ultimately share one common goal, enactment of a national M4A). The opposition will continue to muster more resources than we're capable of matching; after all, we're in New York, the belly of Wall St. capitalism. We need a national organization or campaign of which we are considered an integral part (as should all states pursuing single-payer implementation.) Just imagine, the national M4A campaign is holding rallies across the country, three in New York, at the end of July and have failed to invite the Campaign for NY Health and our leaders to participate and address those in attendance.

And that's the other half of the equation, politicians, particularly those who've assumed leadership in purported mass movements for change, are not systems thinkers, not skilled at connecting the dots. A national mass movement cannot be built without local committed bases in each state. Equating legislative leadership with the capacity to build and sustain mass organizations, is another strategic error. It's a task better left to people on the ground who will not abandon the struggle once a law has been passed. Politicians in my experience have tunnel vision, focused on elections and passing legislation but ignoring or failing to understand that the struggle for change only begins once a law has been passed. It then has to be implemented in the face of unrelenting animosity, a situation which the NYHA and M4A are sure to face. In sum, the national single-payer leadership/organization and our NYHA Campaign must establish a working relationship or increase the likelihood that both will fail.

The Campaign for NY Health has to change our own local strategy as well, and cease focusing so much energy on NYS politicians, many of whom are unreliable in the crunch. More time and energy must be devoted to building a mass movement, an objective to which we pay lip service but have not made a key objective. More on this below. In short, we must abandon an approach we have been following for the past several years, beseeching elected reps for their support. Rather, we must advise those most likely to support the NYHA, Democrats by default, that we expect them to do so; that they will earn our gratitude and support if they do but our determination to remove them from

office should they not, particularly if they purport co-sponsorship of the legislation but fail to speak or vote for it.

None of this can be accomplished without a mass movement or base, which is the one resource we have within our reach and can assemble to offset the enormous power at our opponents' disposal. Building a mass movement is often referred to offhandedly as essential to promoting social change but is the most difficult task to accomplish. Accordingly, it rarely is. The Campaign for NY Health, year after year, has slowly involved an increasing number of activists, but its building strategy has been fragmented and too slow. We can't build a movement via periodic zoom meetings where the participants can't interact with and get to know one another. Further, there are too few Black and Brown Campaign activists in attendance at these meetings, especially egregious since we know these are the New Yorkers who've been systematically denied adequate health care. Similarly, there are too few mental health and child care activists, areas of health care that are readily ignored but whose involvement is key to the development of an holistic and patient-centered health care system. These folks who are missing must be actively recruited. Finally, relying on telephone banks to reach out to potential Campaign activists is too slow and uncertain, with the result that too few New Yorkers know what we are fighting for. I know it's not for want of trying but it speaks to the need to change our basic strategy and to begin to utilize the technology available on the internet to get out our message. Bottom line, no information to the many, no mass movement. And we have a plan.

The folks that I'm working with in the North Country Access to Health Care Committee are decided on building the movement via utilization of social media platforms, a tried and true strategy worldwide. We've had good experiences with zoom meetings as a way to keep us connected during Covid and plan to resume them come September on an every other week basis at the outset. We'll use them as an outreach tool to get the word out about the NYHA to Adirondack and northern New York communities, and to connect with other Campaign for NY Health affiliates throughout the State and diminish our fragmentation. We'll invite representatives of our sister groups to come and tell us what they're up to and discuss with them how we might coordinate our activities with one another. We'll do the same to solidify working relationships with actual and potential allies, including left wing, mental health and poor

people's advocacy organizations and the rank and file caucuses of local and NYC municipal unions. Most importantly, we'll connect the nationwide dots by inviting comrades from states that are pursuing single payer for their residents and from the M4A national leadership and demonstrating that yes, we are a national movement. Finally we plan on developing a Facebook streaming page, showcasing a feature story presented by one of our Committee activists initially monthly and then more frequently as we gain experience with the medium. An eventual expansion to YouTube seems possible but remote at the moment.

I've learned one thing over the many years I've been doing advocacy work – if I have an idea, many other folks invariably have had the same or similar idea. There are lots of talented comrades in the Campaign who've probably considered similar media strategies and who have the same or superior technical expertise. It is our expectation that our initiative will be replicated and improved upon by others. We will continually promote these ideas, sharing information about our experiences via our zoom and FB transmissions and encouraging others, particularly our co-Directors, to join with us. Our ultimate objective should be to create a State-wide communications network. Remember the mantras: No information to the many, no mass movement. No mass movement, no NYHA.

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In this final section, our focus shifts to the NYHA's implementation once it is passed into law, which could be as early as a year from now. We simply can't be caught unprepared since we know our opponents won't be, ready with lawsuits and a media barrage. Discussion of pertinent issues with comrades in the Campaign and with the bill's two principal co-sponsors, Assemblyman Gottfried and Senator Rivera, should help prepare us to defend the bill's integrity. Our planned social media platforms could well serve as venues

There are two issues that concern me most: can we implement the NYHA in a form true to its principal intent, to ensure NY residents' access to comprehensive healthcare as a human right -- as a resource that a community must have so that its members can lead healthy and productive lives? And second, can the NYHA stay true to its mission and withstand the onslaught of

lies and lawsuits from the right, broadcast all too willingly by the mainstream corporate media, that will ensue once it is enacted into law?

The NYHA's two principal sponsors surely had the foregoing in mind once their single-payer law was passed by the Legislature. It's also apparent they're determined not to have a repeat of the recent Vermont single-payer debacle, when the Legislature passed the bill but fears about tax increases to finance it pushed the Governor not to sign it. Or so the story goes.

Much of the latter part of the NYHA (A6058; S5474/2021) is taken up with the issue of implementation, getting the NY Healthcare system up and running while reassuring the political establishment that it is doable. Gottfried and Rivera are very much aware that this is key – it's loaded with checks and balances in the form of working committees, much of it described in mechanical boilerplate that feels as if Cuomo were looking over their shoulders as they and their staff transcribed it.

The bill spells out seven presumably representative oversight committees, all of whose members are appointed by the State's political leadership – the Governor and the political leaders of the Dems and Republicans in the Legislature. The first to be established as soon as the bill is signed is a Transitional Task Force, charged with developing the clinical protocols and financial/billing procedures that all NY health care providers will be obliged to adhere to. This is the most troubling of the lot. While absolutely vital for the new system, problems immediately emerge. First, the 15 politically appointed members of the Task Force are accountable to those who named them. Healthcare advocates and professionals, those who know what health care facilities need to function effectively, have been excluded. Can this be amended? More discussion is warranted. Most alarming, the Task Force is given two years to complete its tasks, leaving the entire enterprise exposed and at the mercy of the NYHA's opponents in and out of the Legislature. The NYHA won't be fully enacted and fully funded until the Task Force's recommendations are subjected to the same process the original bill had to undergo -- submitted to the Legislature for approval, after which to the Governor. *Déjà vu* all over again. What changes will be made to the original bill during this political gauntlet defy prediction.

The bill proceeds to specify a Board of Trustees to oversee the NY Health Trust Fund, as per State law. All 48 trustees are political appointees, among which will be presumed stakeholders – consumer advocates, health professionals, union members, business leaders – all named for four year terms. Finally, there will be six regional advisory committees, each composed of at least 27 members, all politically appointed, established to give counties a say of sorts in the operation of the new system. In sum, the bill establishes a mini-bureaucracy of uncertain function and power, leaving the new system under the oversight of the State's political leadership, principally the Governor's, whoever that might be, whatever her/his political ideology might be. Which uncertainty occasions more questions, particularly if the bill's implementation process remains unchanged. My cynicism keeps popping up.

Who will its advocates be? Who will protect its mission? Actually, what is its mission, what are its goals? The NYHA doesn't spell these out beyond a broad statement of purpose emphasizing comprehensive health care as the right of all New Yorkers. My concern is that if left unspecified and up for grabs, NY Healthcare's fundamental purpose will become a muddle; and healthcare's incumbent profits over people protocol will remain dominant or become an impediment to change in the new.

My own view is that single-payer health care must reject the current transactional model that reduces its patients to diagnoses and fragments them and their care among a range of specialized treatments In pursuit of profits. Single payer must become synonymous with its opposite, that views human beings, as per Dr. Martha Rogers, leading theoretician of modern American nursing, as "Irreducible, indivisible … energy fields identified by (unique) patterns and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts … [integral to and inseparable from which is their] Environmental field … irreducible, indivisible…" (Butcher, 2021).

> **In short, "Human beings are irreducible wholes who are more and different from the sum of parts … The environment is also understood as an irreducible unitary whole." (Butcher, 2021)**

Together they comprise an integrated system, with each not understandable without the other.

Social work has espoused a similar systemic viewpoint "the person in environment." Unfortunately , neither perspective gained pre-eminence in healthcare, both colonized by the medical profession and reduced to its handmaidens. Which suited the needs of all the insurance payers, including Medicare and the private for-profits, and enabled them to scale payments for services rendered by providers to specific diagnoses; which have served as short-handed identifiers not only for the illness being treated but for the person who is ill – e.g., John the Schizophrenic, Joan the Alcoholic, Pedro the Diabetic.

How do we get there, cut through and discard a treatment ideology rooted in a view of human beings reduced to commodities to be acted upon and consumers to receive the services provided and not as equal partners in a collaborative treatment relationship or system? The "Bigs" with all the resources and all the power, as I've detailed above, will not welcome the intrusion of a system that empowers its customers. The Federal government and NY State will not welcome it, and, in fact, are principal opponents of single-payer since it obliges them to resume full-bore the role of single-payer which they have been attempting to shed, via privatization, for the past 50 years. It's as if Reagan's mantra has become theirs, that "the government is the problem."

I would begin by having each NY Healthcare member institution enter the new system by developing a mission statement and a list of guiding principles or goals during its first 6-12 months of operation via staff discussion, a mechanism all but forbidden during the insurance companies' control -- allowing all staff members to meet in small departmental groups, in team meetings if you will, to discuss and develop a hospital-wide mission statement and set of goals, with the initial help of paid training consultants, in accordance with the following operating principles:

- **Beginning with a repudiation of the old principles, which are grounded In a radical capitalist, anti-humanist ideology, and promoted transactional, imbalanced relationships between provider and person seeking help, i.e., the powerful and the powerless, mirroring that between for-profit insurer**

and provider, with the former in both instances setting the terms of the relationship and exploiting it for self-gain;

- **Replaced by its opposite, a collaborative relationship, where both the provider and the person seeking help are regarded as equal partners in a unitary relationship which cannot succeed otherwise; one by-product – development by the person seeking help of a narrative belonging to the her/him alone of the problem being presented, key to effective treatment. (Research has shown that persons seeking help are much more likely to cooperate with treatment plans if they trust those helping them.)**
- **Trust is secured by listening to the helpseeker's description of her/his problem and its causes without judgment or correction, and by validating the help she/he is requesting, again neither judging nor correcting. Disagreement with or change to the her/his request is addressed through educative discussion if such proves warranted.**
- **In short, bottom rail on top, i.e., person seeking help responded to with courtesy and respect … perhaps best expressed by the metaphor of the "inverted hierarchy" , as illustrated by the "inverted triangle", first described by Dr. Charlie Rapp, a professor at the U. Of Kansas School of Social Work n the 1980's when I first met him:**
    - **Help seeker the focus of attention;**
    - **Followed by help giver, equipped with necessary resources;**
    - **Then by administrator, whose job is to ensure that the worker had all the resources and support she/he needed to help the help seeker**
    - **All working collaboratively in a unitary system**

  (the shorthand for which is "person-centered treatment.")

Yes, dear reader, I've been giving you a list of social work principles, which would not be unfamiliar to most nurses or anyone else that does hands-on work helping others. Physicians, administrators and those with power in healthcare systems or any other for that matter? Another unfortunate story. In hands-on work, experiencing others' pain and travail is demanding and draining, particularly without administrative support. Lack of mutual support at all levels is, in fact, a hallmark of all transactional for-profit capitalist systems,

which our health care systems have become. And which it will be our and others' mission to change.

Accordingly, a final and key operating principle … to function effectively, healthcare workers and their administrators need to develop a collaborative working relationship marked by mutual help and support. This is best accomplished via frequent meetings between workers and administrators and administrators with one another for clinical case discussions and administrative problem solving. Team meetings. The latter currently occurs periodically and is invariably top-down, transactional in nature, with little interaction between participants. The former, the clinical team meeting, currently not permissible by either administrators or insurers since the watchwords are always productivity and profits. The net result is worker fragmentation, designed to pre-empt opposition to administration/management procedures and control. The antidote – discussion, discussion, discussion, which then precipitates problem-solving and action and allows participants to experience first-hand systems thinking, connecting the dots.

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A few closing words. And a little about myself. I I spent about 7-8 years, from 1989 – 1996/7, as Director of Training & Curriculum Development at NYC's Hunter College School of Social Work, training several hundred case managers for the Intensive Case Management program of the State Office of Mental Health, including those on my staff. These principles are field-tested.

I essentially lived by them during the last twenty of my 40+ years as an administrator in the NYC mental health system, directing a large – 1000 persons needing help, 50 case managers – program whose task was to resettle folks, most of whom were men and women of color (as were members of my staff; my ethnicity is European-American), coming out of carceral institutions – jails, prisons, mental hospitals – back into their home communities with overall good success. To repeat,, these operating principles are field-tested. They worked. You can trust them.

The most fruitful experience of my almost 50-years long professional life, equal to the 8 years and more I spent as a community organizer working with Latinos

in East LA and Sunset Park, Brooklyn + my 3 years as an urban community action Peace Corps volunteer in Colombia.

One final note –Apologies for the personal endorsement/homily, but I felt constrained to give you a little of myself.

Comments, pro and con, most welcome. Let's keep the discussion going.

La lucha continua … the struggle goes on.

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