Healthcare and Racial Justice: Systemic Change Is Needed for a More Equitable Health System

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."
— Rev. Dr. Martin Luther King Jr., March 25, 1966

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CAMPAIGN FOR NEW YORK HEALTH

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Healthcare and Racial Justice: Systemic Change Is Needed for a More Equitable Health System

Introduction

This report compiles national and New York State level data to illustrate that healthcare access is a critical racial equity issue and how systemic solutions like a universal, single-payer health plan will improve healthcare access and health outcomes for everyone.

Key Findings

Black, Indigenous and People of Color (BIPOC) were disproportionately harmed by COVID-19 due to an unequal ability to access quality, affordable healthcare and long before the start of the pandemic, were more likely than white people to be uninsured and to struggle with medical costs.[1]

Black Americans are 10% less likely to hold employer-sponsored health coverage than their white counterparts. Having high-quality health insurance is directly related to whether patients seek care.

Many BIPOC work and live in environments that impose higher risks of exposure to COVID-19. Only 17% of Latinx workers and 20% of Black American workers have jobs that permit working remotely, while 30% of white workers can do so.[2]

The U.S. has the highest maternal mortality rate in the industrialized world. Black women are three times more likely – and in New York City, 12 times more likely – to die from a pregnancy-related cause than white women. 63% of these deaths are preventable.[3] Uninsurance and under-insurance are major drivers of the U.S. maternal and child mortality rate.

Public health insurance programs play a major role in providing affordable care and better outcomes, especially for Black Americans.[4]

Insurance coverage increases access to care, but being enrolled in an insurance plan does not guarantee timely care or affordability. Nearly half (46%) of insured adults report difficulty affording their out-of-pocket costs and one in four (27%) report difficulty affording their deductible.[5] About 6 in 10 Black and Hispanic adults (58% each) report delaying or skipping at least one type of medical care in the past year due to cost, compared to half (49%) of white adults.[6] Differences in reimbursement rates between private insurance and public insurance create a disincentive for providers to see lower income patients.[7]

Having health insurance lowers the likelihood of medical debt and the amount owed but even households with health insurance are at risk of incurring medical debt. 17.4% of households with insurance have medical debt compared to 27.9% of households without insurance. Among those with debt, households with health insurance have an average of $18,827.25, while households without health insurance have an average of $31,947.87.[8]

Black households are more likely to hold medical debt.[9] 27% of Black households hold medical debt compared to 16.8% of non-Black households. Medical debt can appear on a person's credit reports and lower their credit scores, reducing access to credit and making it harder to find a home or a job.

Communities with majority Black and Latinx residents experience provider shortages more than other communities all over the country. Unequal reimbursement rates lead to disparities in access to hospitals and providers.

Polling consistently shows that voters across race and party lines support systemic change to address shortcomings in the healthcare system. New York voters overwhelmingly see government as the key stakeholder that should act to address health system problems and support measures to make healthcare affordable and accessible.

Conclusion

A universal system of publicly-funded, guaranteed healthcare, often referred to as "single-payer healthcare," is the most equitable and affordable way to achieve comprehensive coverage for all. Universal single-payer healthcare will end the burden of medical debt that disproportionately harms BIPOC communities by eliminating cost-sharing – the out-of-pocket costs such as copays that act as financial barriers to care. Bringing all residents into a single public plan would eliminate the inequity in access that results from a fragmented system. Campaign for New York Health recommends universal single-payer healthcare as a policy intervention to create a health system that promotes racial equity and quality care for all.

www.nyhcampaign.org/report2022

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Introduction

Researchers, advocates, and the media have extensively documented that Black, Indigenous and people of color (BIPOC) in the United States experience worse health outcomes than white Americans. Throughout the COVID-19 pandemic, BIPOC communities have experienced stark inequities resulting in disproportionately high infection rates and death from the virus. For example, at the beginning of the pandemic, the death rate from COVID-19 for Black Americans and Latinx was quadruple that of white New Yorkers, according to the NYS Department of Health.[1] Asian Americans saw a death rate twice that of white New Yorkers. Black New Yorkers were hospitalized at a rate more than twice that of white residents during the Omicron surge, the New York Times reported.[2]

New York State officials have acknowledged the need to address deep systemic racial health inequities. "For far too long, communities of color in New York have been held back by systemic racism and inequitable treatment," said New York Governor Kathy Hochul on December 23, 2021 when signing a package of legislation to address racial injustice.[3] Governor Hochul appointed long-time racial justice advocate Dr. Mary Bassett as Commissioner of the Department of Health. **On the day of her appointment, Commissioner Mary Bassett stated, "The pandemic underscored the importance of public health, while also revealing inequities driven by structural racism. As we move to end the pandemic, we have a unique opportunity to create a state that is more equitable for all New Yorkers."**

Health Disparities: Population-level differences in health.

Health Inequities: Population-level differences in health that are avoidable, unnecessary, unfair, and unjust.

- From Dr. Rhea Boyd presentation, cites Whitehead, M. The Concepts and Principles of Equity in Health. 1992 [4]

The strong statements in support of racial equity from the highest levels of state Government indicate that health equity is a high priority for New York State. The data that follows show that healthcare access is a racial equity issue and that systemic solutions will improve healthcare access and health outcomes for all New Yorkers.

"In New York City, premature mortality - that's death before the age of 65 - is 50% higher for black men than white ones. A black woman in 2012 faced more than 10 times the risk of dying related to childbirth as a white woman. A black baby still faces nearly three times the risk of death in its first year of life as compared to a white baby...These statistics are paralleled by statistics found across the United States. And a lot of this is about racial disparities and institutionalized racism, things that we're not supposed to have in this country anymore, certainly not in the practice of medicine or public health. But we have them, and we pay for them in lives cut short."

- Dr. Mary Bassett, TED Talk, December 13, 2015 [5]

The Problem: *The healthcare system exacerbates racial disparities in health outcomes*

The COVID-19 pandemic illustrates how the existing health system leads to inequity

In the early months of the COVID pandemic, fatality and infection rates played out along lines of existing racial and structural inequities. Fatality rates among Black and Hispanic New Yorkers were more than double those of white New Yorkers in the first months of the pandemic due to higher risks of exposure and higher rates of pre-existing chronic health conditions that amplified the fatal impact of the virus, according to a June 2020 University of Albany report.[6] Asian American fatalities were also higher compared to white Americans and also underreported due to the lack of disaggregated data collection.[7] The inequality in fatality rates was even starker outside New York City, which reported a fatality rate per 100,000 individuals four times greater for Black residents and more than 3.5 times greater for Hispanic residents than white residents.

BIPOC were disproportionately harmed by COVID-19 due to an unequal ability to access quality, affordable healthcare. **Since long before the start of the pandemic, BIPOC were more likely than white people to not have health insurance and to struggle with medical costs.**[8]

Black Americans suffer far higher rates of many of the pre-existing conditions that make COVID-19 deadly, including asthma, diabetes, coronary heart disease, chronic obstructive pulmonary disease (COPD), and hypertension, according to data from the Centers for Disease Control and Prevention. For example, in Buffalo, rates of all five conditions spike dramatically east of Main Street, where roughly 85% of Black Buffalonians live.[9,10] A Buffalo News analysis of public health data found that in the first two months of the COVID-19

pandemic, per capita COVID case counts were 88% higher in Erie county's five majority-Black ZIP codes than they were in the rest of the county. Black patients accounted for nearly 19% of Erie County's COVID-19 deaths, though they make up less than 15% of its population.[11] In Onondaga County, Black Americans have been hospitalized from COVID at almost three times the rate of white residents.[12] The death rate for Black residents is more than 50% higher than for white residents.[13]

There are a number of reasons why COVID hits BIPOC communities harder, including: higher rates of pre-existing conditions that make COVID-19 deadly; lack of healthcare system capacity in low-income communities; a lower likelihood that BIPOC have jobs that can be done from home; poor housing conditions; high uninsurance and underinsurance rates - people with insurance who still cannot get the care the need due to costs or restrictive networks.

> "**Health Inequities** arise when certain populations are **made vulnerable** to illness or disease, often through the *inequitable* distribution of **protections** and **supports**."
>
> *- Dr. Rhea Boyd* [14]

A 2020 Brookings report found that Black essential workers are more likely to be uninsured than white essential workers.[15] Similarly, an Urban Institute analysis found that Black workers are more likely to be essential and frontline workers and they are more likely to be underinsured.[16]

Furthermore, high numbers of New Yorkers have lost health insurance coverage because of the pandemic. Black Americans in New York City reported losing health insurance twice as often as white New Yorkers (14% of all households compared to 6%). Latinx New Yorkers reported losing health insurance nearly four times as often as white New Yorkers (23% compared to 6%).[17]

Black maternal health is a strong indicator of health system equity

Maternal mortality is a hallmark of how well a country's healthcare system is doing. Prior to the COVID-19 pandemic, racial disparities in maternal health outcomes reflected the deep inequities in the U.S. health system. The rate of women who died during pregnancy or shortly after birth increased significantly during the COVID-19 pandemic, according to data from the National Center for Health Statistics.[18] The United States has the highest maternal mortality rate in the industrialized world, unconscionable racial disparities in maternal health access and outcomes, and nearly all regions of the country have seen declines in the availability of maternity care.[19, 20, 21]

Uninsurance and under-insurance are major drivers of the U.S.'s alarming maternal and child mortality rate. While Medicaid expansion has reduced both, Medicaid pays only about half what private insurers pay for birth costs.[22, 23, 24] This payment disparity sets up a two-tiered, unequal system of healthcare delivery under which Medicaid-insured patients have fewer options, receive care in (under-resourced and therefore) lower-performing hospitals, and are more likely to live in a maternity care "desert" with no access at all.[25,26, 27, 28, 29]

Black women in New York are three times more likely to die from a pregnancy-related cause than white women, and in New York City, Black mothers are 12 times more likely to die from pregnancy-related complications. According to the CDC, 63% of these deaths are preventable.[30] While there are many reasons why Black mothers and mothers-to-be experience poor treatment and access to care, the single largest contributing factor to racial health disparities in New York's infant and maternal outcome is the poorer quality of care provided at a 'concentrated set of "high minority-serving" hospitals'– where poor care quality is a direct result of racialized underfinancing (as outlined above).[31, 32]

The U.S. is the only Organization for Economic Cooperation and Development (OECD) country to not guarantee access to provider home visits or paid parental leave in the postpartum period.[33,34] In most other OECD countries, midwives outnumber OB-GYNs by several fold, and primary care plays a central role in the health system. In the U.S. there are fewer midwives and more higher-paid OB-GYNs. Low-risk birthing people under the care of midwives have had better outcomes than their contemporaries cared for by OB-GYNs at every point in western history.[35] The World Health Organization (WHO) recommends midwives as an evidence-based approach to reducing maternal mortality and has found that midwives – supported by a functional health system – can provide 87% of the essential care needed for women and newborns, and could potentially reduce maternal and newborn deaths by two thirds.

Researchers have found that for births assisted by a midwife, the C-section rate was 30% lower among first-time mothers and 40% lower among those who had previously given birth, compared to when women labored under the care of an OB-GYN.[36]

Amber Rose, a 26-year-old Bronx woman and mother-to-be died after extended medical neglect that led to an emergency c-section operation to bring her son Elias into the world. C-sections are more profitable to hospitals and doctors than natural births. Despite the tragic lapses in care which lead to the unplanned cesarean birth, Montefiore billed her family $2,000 after her death, which they were forced to pay.[37]

Disparities in insurance coverage cause health inequities

Nationally, 7.8% of white Americans are uninsured, while 11.4% of Black Americans, 20% of Hispanic Americans, and 21.7% of Native Americans are uninsured.[38] In New York, 3.9% of white Americans are uninsured, while the rates of uninsurance are significantly higher for Black New Yorkers (6.5%), Hispanic New Yorkers (11.3%), Asian New Yorkers (7.2%), and Native Americans (12.9%).

Percentage of Uninsured Rates for the Nonelderly by Race/Ethnicity:

	White	Black	Hispanic	Asian/Native Hawakkan and Pacific Islander	American Indian/Alaska Native	Multiple Races	Total
United States	7.8	11.4	20	7.4	21.7	8.2	10.9
New York	3.9	6.5	11.3	7.2	12.9	5.6	6.2

Kaiser Family Foundation, 2019

Coverage Matters: Insurance and Healthcare, published by the National Institutes of Health, explains, **"the voluntary, employment-based approach to insurance coverage in the United States functions less like a system and more like a sieve. There are many ways to slip through the holes."** [39]

Black Americans are 10% less likely to hold employer-sponsored health coverage than their white counterparts. On average, employers pay 82% of workers' health insurance premiums and 70% of workers' families' health insurance premiums.[40] But Black employees are more than 70% more likely (11.5% vs. 6.7%) to work for employers that do not contribute to their insurance premiums.

Having high-quality health insurance is directly related to whether patients seek healthcare. When insurance loss is a risk, instability affects patients' decision-making. They may choose short-term treatment options requiring fewer follow-up visits, postpone visits to health practitioners, or avoid medical care altogether in anticipation of future bills. **An ongoing relationship with a healthcare provider is a valuable piece of healthcare access.** That connection is facilitated by continuous health coverage.

BIPOC communities have fewer hospital beds

Communities with majority Black and Latinx residents experience provider shortages more than other communities all over the country. In New York, policymakers have made a number of decisions over the past 30 years that directed resources away from safety-net and community hospitals and the neighborhoods that they served. These decisions include the deregulation of hospital rates, the elimination of regional health planning agencies, and the diversion of Indigent Care Pool funds to wealthier hospitals and away from true safety-net providers. Safety-net hospitals in New York serve populations that are more diverse than the state average (32% of patients they discharged were white in 2016 compared to 51% of patients overall). Thus, decisions that take resources away from these safety-net providers disproportionately hurt BIPOC New Yorkers.

Unequal reimbursement rates in the wake of hospital rate deregulation and other state policies have led to disparities in access to hospitals. Safety-net hospitals that serve low-income people, BIPOC, and rural residents in particular struggle to remain open.[41] At the height of the first wave of COVID-19 in New York City, for example, the Bronx had 27 cases per 100,000 people but only 2.7 beds per 1,000 people, while Manhattan had only 12 cases per 100,000 people and 6.4 beds per 1,000 people.[42]

While it is widely believed that commercial insurers subsidize care for Medicaid and uninsured patients, research suggests that hospitals cannot fully shift increased costs onto commercially-insured patients.[43] Medicaid expansion appears to have helped hospitals; reductions in uncompensated care through state Medicaid expansions were associated with a substantially lower likelihood of hospital closures, especially in rural areas and in those with large numbers of uninsured patients.[44]

Social determinants of health impact health inequities

Social determinants of health are major drivers of the substantial racial inequities observed during the COVID-19 pandemic. These social determinants include: the nature of employment opportunities; the quality and cost of housing; the proximity to toxic environments; the prevalence of food insecurity; and the quality of educational opportunities.

For example, many BIPOC work and live in environments that impose higher risks of exposure to COVID-19. Many of these jobs were classified as "essential" during the pandemic and the workers who filled them risked their own health. In New York City, more than 75% of essential and frontline workers are BIPOC.[45] A recent study found that only 17% of Latinx workers and 20% of Black American workers have jobs that permit working remotely, while 30% of white workers can do so.[46]

Similarly, housing policies founded on racially-biased zoning and redlining policies leave BIPOC communities living in low-quality housing that engenders poor health.[47] Hypertension, obesity, chronic lung disease, diabetes, and cardiovascular disease—conditions that often lead to severe complications for COVID-19 cases—are more prevalent in non-white communities.[48] In the Bronx, which had some of the highest rates of COVID-19 in New York State, 68% of apartments have maintenance defects that impact health.[49]

Housing inequities also mean that BIPOC are more likely to live in crowded conditions—when one member of the household is exposed to COVID, the effect is multiplied because of the difficulty of social distancing.[50, 51, 52]

It is also important to recognize that before the pandemic, BIPOC communities of color were already experiencing significant health inequities and relying on an under-resourced and unequal healthcare system.

Racism is a devastating root of chronic, undertreated disease and preventable premature death. The physical and structural environment in which humans grow, learn, work and play shapes intergenerational population health.[53]

Hand-washing is one of the most important ways to limit exposure to and spread of infectious disease.

Race is the strongest predictor of water and sanitation access.

Black and Latinx populations are about twice as likely to lack access to clean water in their homes. Native Americans are 19 times more likely to lack access to clean water in their homes.[54]

Structural Racism, in this case, functions through residential segregation and public divestment in Indigenous and Black communities, to exclude populations from access to clean water and a critical public health intervention as simple as hand-washing which shapes the racial distribution of COVID-19 in the US.

From Dr. Rhea Boyd presentation, cites Closing the Water Access Gap: A National Plan. Nov 2019; Jones CP. Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health. 2000;90(8):1212-1215. Poverty; and Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. Annu Rev Public.[55]

Insurance Coverage Does Not Equal Quality Care

Insurance coverage increases access to care, but being enrolled in an insurance plan does not guarantee timely care or affordability

In 2019, the Campaign for New York Health published the People's Report on Healthcare in New York based on a statewide survey of 2,409 New Yorkers. Half of the respondents with insurance reported delaying or skipping care due to cost, and 1 in 3 respondents reported worsened health conditions as a result of skipping care. Other studies in the same time frame reported similar findings.[56] According to Kaiser Family Foundation, nearly half (46%) of insured adults report difficulty affording their out-of-pocket costs and one in four (27%) report difficulty affording their deductible.[57] About 6 in 10 Black and Hispanic adults (58% each) report delaying or skipping at least one type of medical care in the past year due to cost, compared to half (49%) of white adults.[58]

Compared to publicly-insured residents (those with Medicaid, Medicare, Tri-care and Veterans Administration coverage), New York adults with private insurance through an employer or purchased on the individual market report somewhat higher rates of worry and affordability burdens.[59]

Having health insurance lowers the likelihood of medical debt and lowers the amount owed, but even households with health insurance are at risk of incurring medical debt due to illness or injury. According to the Brookings Institute, 17.4% of households with insurance have medical debt compared to 27.9% of households without insurance. Among those with medical debt, households with health insurance have an average of $18,827.25, while households without health insurance have an average of $31,947.87.[60]

Medical debt is a leading cause of consumer bankruptcy.[61] A 2016 survey by the Kaiser Family Foundation found that most people with medical debt had health insurance.[62] In 2007, at least 62% of bankruptcies were at least partially attributable to medical debt. Even after the implementation of the Affordable Care Act in 2010, that number has not decreased significantly.[63]

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> *Americans are more afraid of the cost of medical coverage than their underlying illness, according to NORC at the University of Chicago. Seniors, particularly low-income seniors with chronic diseases, are more likely to become nonadherent to medical and medication prescriptions due to costs.*

Black households are more likely to hold medical debt.[64, 65] **27% of Black households hold medical debt compared to 16.8% of non-Black households.** These findings align with a 2020 Urban Institute report that found medical debt was also higher and more concentrated in BIPOC communities than in white communities.[66] Medical debt can appear on a person's credit reports and lower their credit scores. This can reduce their access to credit and make it harder to find a home or a job.

In many parts of New York, there are substantial racial disparities in who has incurred medical debt. In Onondaga County, 14% of residents in white communities had medical bills in collection, while in BIPOC communities, 41% of residents had medical bills put into collection.[67, 68] Similarly, large disparities are observed throughout the state. For example, in Monroe and Albany counties, the difference in the rate of medical debt for white communities and BIPOC communities is 19% and 16%, respectively.

Black households are more likely to have medical debt at every age, but this debt disparity is particularly acute for Black households past retirement age when households have access to Medicare.[69] Black households past retirement age still holding medical debt reflects how Black seniors have been denied the ability to build wealth. Americans are more afraid of the cost of medical coverage than their underlying illness, according to NORC at the University of Chicago.[70] **Seniors, particularly low-income seniors with chronic diseases, are more likely to become nonadherent to medical and medication prescriptions due to costs.**[71]

"A progressive economic agenda that seeks to raise the minimum wage, for example, will benefit Black Americans, but it will not change the fact that a dollar of income in Black hands buys less safety, less health, less wealth, and less education than a dollar in white hands." [72]

Reimbursement rates impact access to providers

More than half (61.1%) of Medicaid beneficiaries identify as Black, Hispanic, Asian American, or another non-white race or ethnicity.[73] Differences in reimbursement rates between private insurance and public insurance create a disincentive for providers to see lower income patients even though Medicaid provides crucial care to millions of beneficiaries.[74]

From 2010 to 2015, an estimated 35.2% of all children's visits to physicians were paid by Medicaid (approximately 53.5 million visits). Payments per child visit to office-based physicians were higher for privately-insured children than Medicaid-covered visits in 2014 and 2015. Mean total payments were $88 higher for

> *Increased Medicaid reimbursement for office visits is associated with an increased likelihood of a patient being screened for cancer.*

visits covered by private insurance ($214) than those covered by Medicaid ($126). **Given these generally lower reimbursement rates, children and families enrolled in Medicaid face greater difficulty gaining access to physicians, obtaining timely appointments, or getting referrals to specialists than their privately insured counterparts.**

A similar trend of lower reimbursement rates can be seen when comparing Medicare payments and private insurance payments.[75] Kaiser Family Foundation reviewed studies comparing private insurers' and Medicare's provider payment rates over the period from 2010 to 2017 and found that nationally, **private insurance reimbursements to hospitals and providers are on average significantly higher than Medicare reimbursements.**[76] Private insurers paid nearly double Medicare rates for all hospital services (199% of Medicare rates, on average), ranging from 141% to 259% of Medicare rates across the studies reviewed by KFF. The difference between private and Medicare rates was greater for outpatient than inpatient hospital services, which averaged 264% and 189% of Medicare rates overall, respectively. For physician services, private insurance paid 143% of Medicare rates, on average, ranging from 118% to 179% of Medicare rates across studies.

The 2017 study "Public And Private Payments For Physician Office Visits" found that for physician office visits of all types, total payments under Medicaid averaged 62.2% of the payment amounts under employer-sponsored insurance and total payments under Medicaid averaged 73.7% of those under Medicare. **Low Medicaid payments are associated with lower provider participation rates and thus, some access problems.**

Increased Medicaid reimbursement for office visits is associated with an increased likelihood of a patient being screened for cancer. Medicaid reimbursement is an important tool for increasing screening among the Medicaid-eligible population, who are currently less likely to be screened for cancer and more likely to present with advanced-stage cancer than those with other insurance. Higher primary care Medicaid reimbursement rates in 2013 and 2014 were associated with improved behavioral health outcomes, without a corresponding increase in behavioral health services utilization, and had a positive spillover effect on behavioral health outcomes: mental illness, substance use disorders, and tobacco product use.[77, 78]

Solutions: *New York can adopt health system changes that reduce racial disparities in health outcomes*

Expanding public health coverage reduces racial inequities and improves outcomes

The Affordable Care Act increased coverage rates for all racial and ethnic minorities. In 2014, Medicaid and marketplace coverage expansions resulted in the greatest rate of increase in insurance coverage. Prior to the implementation of the Affordable Care Act (ACA), nearly one in three Hispanic Americans and one in five Black Americans were uninsured, compared to about one in eight white Americans. Since the ACA's core coverage provisions came into effect in 2014, uninsured rates fell across all racial and ethnic groups, with the biggest coverage gains among Black and Hispanic Americans.

More comprehensive public health insurance programs play a major role in providing affordable healthcare and better outcomes, especially for Black Americans. Eliminating racial differences in insurance coverage will greatly reduce racial differences in health outcomes and survival.

Until age 65, Black Americans are 50% more likely to be uninsured and overall have worse health outcomes.[79] But numerous studies have shown that when healthcare coverage and access are made more equal between Black and Whites, then these health outcome differences dissipate or even reverse. For example: Black Americans in the general population suffer from increased adjusted rates of cardiovascular and noncardiovascular mortality in comparison to whites. But for those Americans, Black and white, who have access to the special Medicare program that provides comprehensive and equal by race coverage to all persons with end-stage renal disease for receiving long-term dialysis, Black Americans have better survival rates than whites in most studies.[80] Similarly, for U.S. military Veterans, both Black and white, who both have coverage under, and hence in principle equal healthcare access in, the Veterans Administration medical system, Black veterans have overall lower mortality and lower rates of coronary heart disease than the white veterans, again in contrast to the higher rates experienced by Black Americans in the general civilian U.S. population.[81] Studies like these suggest that making access to healthcare truly equal (same access and coverage without eligibility determination and premiums, and including removal of point of service cost barriers such as copays, deductible and other out-network and out-of-pocket costs), reduces, eliminates, and even reverses current healthcare disparities between Black and white Americans.

There is strong support for systemic change across race and party lines

Polling consistently shows that voters across race and party lines support systemic change in order to address shortcomings in the healthcare system.

New York residents overwhelmingly see government as the key stakeholder that should act to address health system problems.[82] When Altarum Healthcare Value Hub asked New Yorkers the top three healthcare priorities the government should work on, top vote-getters were: addressing high healthcare costs including prescription drugs (46%); getting health insurance to those who cannot afford coverage (34%); and consumer protections (31%) such as not being denied coverage or charged more if you have a pre-existing medical condition. The Altarum study found that New Yorkers believe the problem causing high healthcare costs is unfair prices charged by powerful industry stakeholders: insurance companies charging too much money (69%); hospitals charging too much money (69%); drug companies charging too much money (68%); and large hospitals or doctor groups using influence to get higher payments from insurance companies (56%). The Altarum study found high support for change regardless of respondents' political affiliation and suggests that addressing costs should be a top priority for government.

In September 2021, Data for Progress published the results of a poll which found that New York voters overwhelmingly agree that healthcare is a human right.[83] 84% of respondents agreed with the following statement: *"Healthcare is a human right. Only when our health doesn't depend on our wealth can we truly be free. Our state government must make sure that every New Yorker can go to the doctor when they need to and fill their prescriptions every month. And we must recognize that full healthcare includes mental health services and treatment and prevention for substance use disorder and overdose."* Black voters expressed the highest percentage of agreement (88%) with this statement and agreement was high across political affiliation (91% Democrats, 80% Independents, 71% Republicans). When asked about a specific policy, a majority of respondents expressed support for the New York Health Act, described by Data for Progress as: "*Some lawmakers are proposing the New York Health Act, which would replace private health insurance with high quality, publicly provided health insurance that covers all New Yorkers."* Support was highest among Black respondents (74%) and Democrats (75%).

Findings published by Robert Wood Johnson Foundation and Community Service Society in March 2022 are consistent with previous polling on healthcare, demonstrating strong concerns with healthcare affordability and support for systemic change. Nine in 10 (91%) New Yorkers agree that healthcare needs to be made affordable for everyone. Nearly seven in 10 New Yorkers blame the government, health insurers, drug companies, and hospitals—in that order—for failing to control costs. And, three-quarters of respondents to the RWJ and CSS survey said that systemic racism is a problem in the U.S. healthcare system, with Black and Latinx respondents, women, and Democrats more likely to perceive systemic racism as a problem. However, agreement was high across political affiliation with 80% of Independents and 76% of Republicans agreeing with this view.[84]

Analysis: *Universal Healthcare is Needed for Health Equity*

Americans are paying for a health insurance system that is not meeting their needs and is perpetuating inequity — and BIPOC communities suffer the worst consequences in shortened lives and economic stress. Lack of insurance or having inadequate health insurance exacerbates and perpetuates both broad inequities and health inequities — they are intertwining and have deadly consequences, as has been witnessed since the beginning of the COVID-19 pandemic. According to recent research from Families USA, each 10% increase in the proportion of a county's residents who lacked health insurance was associated with a 70% increase in COVID-19 cases and a 48% increase in COVID-19 deaths.[85] Nationally, roughly **1 out of every 3 COVID-19 deaths have been linked to health insurance gaps and more than 40% of all COVID-19 infections are associated with health insurance gaps.**

Expanding coverage improves health outcomes, but having insurance coverage alone is not enough to guarantee access to affordable or comprehensive care. We saw earlier that even Americans with insurance struggle with medical debt, and the quality of the insurance plan determines whether a patient will seek care or be able to access providers.

A universal system of publicly-funded, guaranteed healthcare, often referred to as "single-payer healthcare," is the most equitable and affordable way to achieve comprehensive coverage for all, to promote racial health equity, and to achieve fair payments to healthcare providers and hospitals. A health system that pays for care rather than increasing profits will save lives and money, and promote health equity.

"Single-payer" refers to a type of universal healthcare in which the costs of care for all residents are paid for by a single public system. All residents would be covered by the same plan, ending the current system of segregated care that is created by differences in health plans. Single-payer healthcare would eliminate the burden of medical debt by establishing a healthcare financing system without copays, deductibles, or point-of-service payments.

Several studies of both state-level and national single-payer healthcare plans show that this type of system generates substantial savings for the health system overall and for patients while also guaranteeing coverage. For example, the 2018 RAND Corporation study of the New York Health Act found that New York State would see an overall decrease in health spending with a net savings of $80 billion over ten years by transitioning to a single-payer system that shifts how healthcare payments are made, with taxes replacing premiums and out-of-pocket payments for covered services. RAND also found that 90% of New Yorkers would spend less than they do now on healthcare, with the greatest savings for individuals earning $81,000 or less annually. [86, 87] RAND's assessment that a single-payer healthcare system is more affordable than the current, fragmented privatized system of healthcare financing is backed up by studies of proposals for a national single-payer system.

By eliminating cost-sharing – the out-of-pocket costs such as copays that act as financial barriers to care – universal single-payer healthcare will end the burden of medical debt, which disproportionately harms BIPOC communities. Bringing all residents into a single public plan would eliminate the inequity in access that results from an intentionally fragmented system where the type of insurance plan determines which healthcare providers are available to patients. This is reflected in the studies previously cited of improved health outcomes for Black Americans once they reach Medicare age and lower mortality rates for Black Americans in the VA system.

A 2006 study in the American Journal of Public Health comparing access to care and health disparities in the United States and Canada found that compared with Canadians, U.S. respondents were less likely to have a regular doctor, more likely to have unmet health needs, and more likely to forgo needed medicines.[88] **Though racial disparities were present in both countries, they were more extreme in the United States, leading the authors to conclude that universal coverage reduces most inequities in care.**

While guaranteed, universal healthcare would not solve all of the conditions that lead to racial inequity in health – such as inequity in housing, food access, occupational risk, exposure to pollution – a universal, single-payer healthcare program like that proposed by the New York Health Act would significantly remove many of the structural barriers that perpetuate inequity in healthcare access for BIPOC patients.

We have to confront the ways inequality is "constructed and perpetuated." [89]

The COVID pandemic has heightened awareness of healthcare inequity and has pushed guaranteed, universal healthcare even further into mainstream conversation. People and institutions being devastated by medical debt, seeing loved ones die from preventable conditions, worker burnout, delayed care and restrictive doctor networks are seeing that universal, single-payer healthcare eliminates all of those problems. **Polls and media show that healthcare is a top concern for voters, and there is high support for systemic change.**

On December 23, 2021, Governor Kathy Hochul signed into law S.2987-A/A.5679 which declares racism as a public health crisis and establishes a working group to promote racial equity within the New York State Department of Health. This group "shall address issues related to racism as a public health crisis," which includes issuing legislative recommendations. **Based on the studies presented above, passing universal single-payer healthcare would be the most direct and systemic way to promote racial health equity.**

New Yorkers in Their Own Words

Dr. Frances Ilozue, Primary Care Doctor, Buffalo

Everyday, I have to battle with insurance companies to authorize the treatments my patients need. One of my diabetic patients has been managing her diabetes for 25 years. When I first began seeing her, her diabetes was under control. In mid-2021, her insurance company stopped covering her medication. Her new medication does not control her diabetes. Her vision became blurry and now she has to seek vision care.

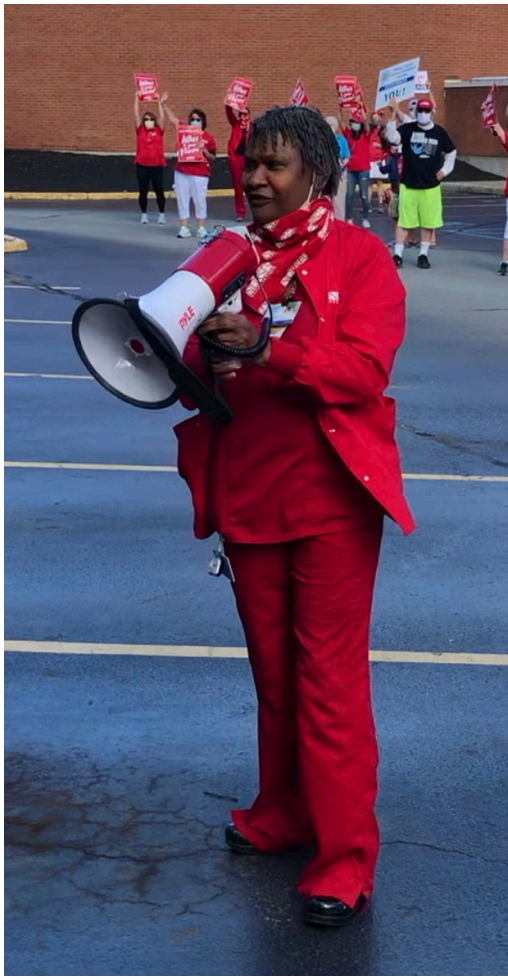
If a patient's diabetes is not under control, the risks include neuropathy and kidney failure. **The insurance companies add unnecessary barriers to care when patients are already facing other struggles that impact their health, such as their housing environment or access to quality food.** We need universal healthcare to meet the needs of our patients, reduce waste, and focus on planning to meet healthcare needs.

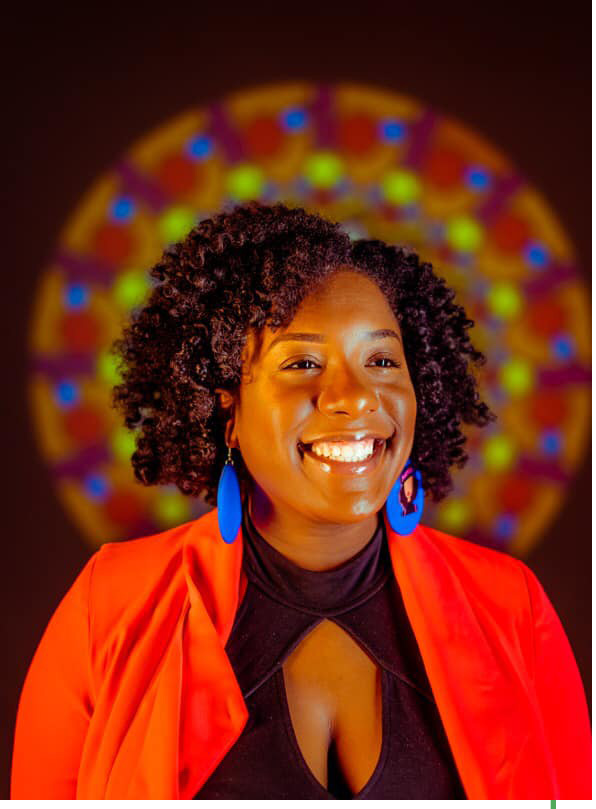
Tonia Bazel, RN, Albany Medical Centre, Infectious Disease Unit

I have cared for a multitude of patients who won't and don't go to the doctor or clinic when they are ill because they are either under-insured or not insured at all, and I have been there myself. I had to choose between feeding and keeping a safe roof over my family's head versus paying co-pays and deductibles for doctor visits and my diabetic medication. I went without medical care for 5 years. By that time my blood sugar was dangerously high and my vision had been compromised.

I had to file bankruptcy in order not to lose my home because of mounting medical bills, while on short term disability for having had two different surgical interventions on my back, consequences of my choice to be a nurse. Bankruptcy had a long-term effect on this black woman's credit.

I've had patients leave the hospital stating they can't afford their hospital stay because insurance won't cover it. I have family members who have lost a limb or two because they couldn't afford medical care, or they have died, much too soon, because they were among those who fall through the fissures in our current healthcare system. Low-income individuals and families are unable to participate in preventative care under our current system. The least our country and the state of New York should offer them is affordable healthcare for their contribution to our prosperity. A universal, single-payer system is a big step in the right direction.





Sequoia Kemp, Doula

I see the challenges my clients face by not having access to quality healthcare coverage. Women and children are suffering from preventable health issues because of this. Not being able to afford necessary medication for pre-existing medical conditions impacts their mental, physical and social well-being.

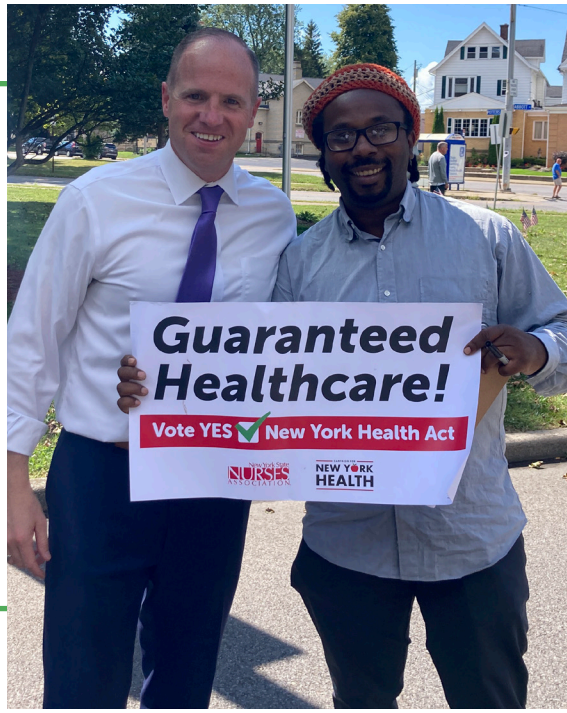
If we want to see an improvement in the health of our women and children in New York State, we need to ensure that every New Yorker has healthcare coverage. **The New York Health Act will ensure that babies have the health coverage they need with no cost to the family, especially if the infant or mother becomes ill.** It would allow mothers to have extended care during their postpartum recovery and increase access to healthcare for thousands of people who suffer from reproductive health issues such as fibroids, endometriosis, polycystic ovary syndrome and so many other conditions that often go undiagnosed or untreated.

Dejia, Buffalo

Most of my credit problems have been from medical bills for times I've been to the emergency room. Right after finishing college, I got sick with the flu, and the health insurance I had at my job came with a $5,000 deductible. My hospital visit was $2,000 and I was stuck with that cost, so straight out of college I had a really huge financial burden on my credit.

Desmond Abrams, Buffalo

In 2012, I had a mental health episode that left me in Erie County Medical Center. I was transported there in an ambulance. **A 10-minute ambulance ride cost me over $800 and stayed on my credit report for five years.** I was unable to open a credit card and meant that my options for housing were limited to places that didn't ask for a credit score.



Dariella Rodriguez, Bronx

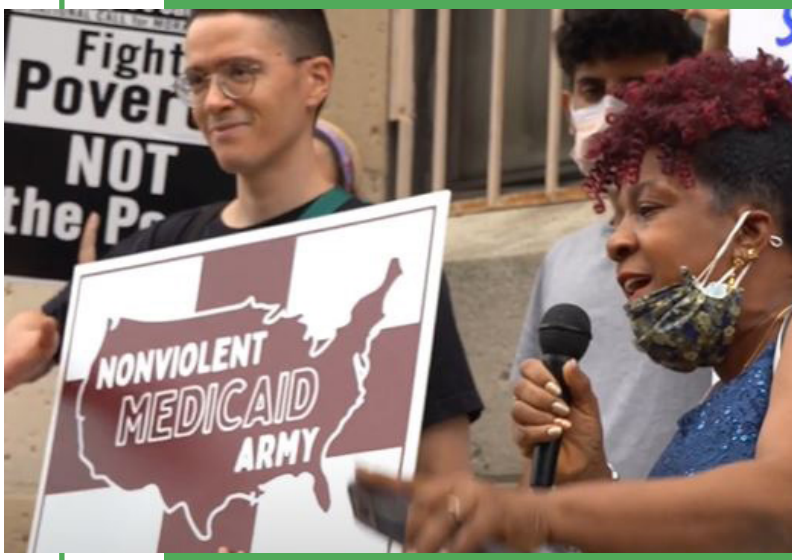
My son's appendix ruptured. We took him to the hospital and learned he needed emergency treatment. The billing department advised me to apply for Emergency Medicaid and Child Health Plus.They said there was going to be a gap between the costs and what my insurance would cover. **Before he even had the surgery, I was getting a bill for $90,000 that my insurance wouldn't cover.** I've been contacted by debt collectors and I am concerned about what this debt is going to mean for my family.

The New York Health Act is critical whether we are insured or not. It's important to have benefits that pay for the care we need and protect our families so that we are not crushed by tens of thousands of dollars for emergency medical costs.

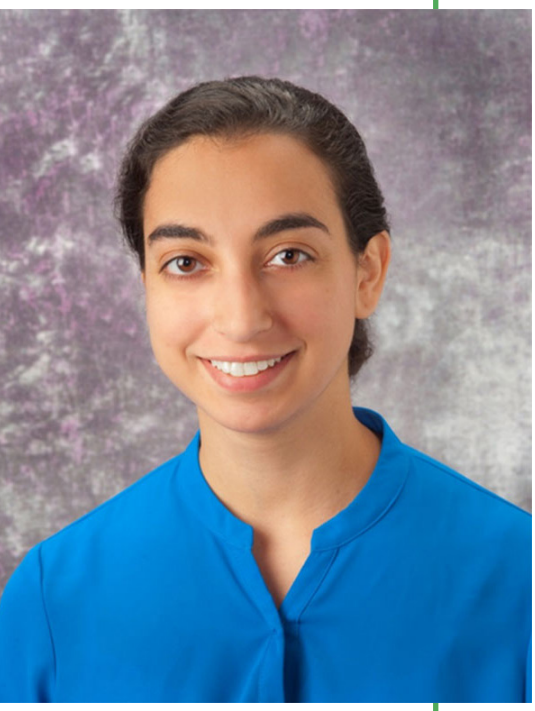
Dr. Karim Sariahmed, Medical Resident, Montefiore Medical Center

If you walk into the emergency room where I work, you can see the deprivation in the system. Even outside of a COVID surge, people are often packed like sardines because patients are going to the emergency room for things that could be taken care of by a primary care doctor. They often have no other choice. Patients with Medicaid and Medicare can't get seen by a primary care doctor soon enough. People wait for hours in what looks like a sea of suffering. There aren't enough nurses on the floors and ICU. The workers are exhausted and stressed out. Everything takes longer than it would in a wealthier part of the health system and it takes longer to identify and help people with true medical emergencies.

During one shift in the ER, a South Asian patient was complaining of a worsening dizziness he'd been feeling for several weeks. I did the exam and found neurological abnormalities. We did a CT scan and found he had metastatic cancer in his brain. While medical tragedies are a reality, many of the common cancers which go to the brain can be found and prevented through screening when patients are connected to primary care. For many, it is within the power of modern medicine to find cancer earlier. Instead of discovering cancer with a physician you know and trust, many instead are



receiving catastrophic diagnoses in undignified conditions without much support. These are the conditions inflicted on the 140 million poor people in this country by a health system built to extract wealth from them. **We need universal healthcare, we need a real public health system to manage preventable diseases, and we need to treat every life as valuable.**



Dr. Iman Hassan, Primary Care Doctor, Bronx

One of my patients doesn't have a stable place to live. He has diabetes and he needs insulin. But he doesn't have health insurance. It costs hundreds of dollars a month to be able to afford insulin and essential sugar monitoring and testing supplies that are needed when you are on insulin. I tried all kinds of other cheaper medications, but they were not enough. A few months ago, he needed an amputation. That should not be the story of our healthcare system.

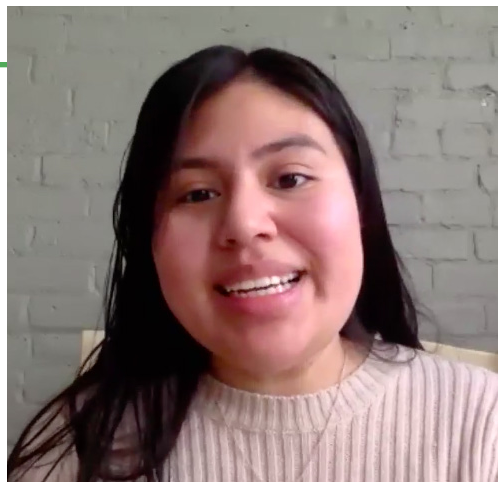
Not too long ago, a person close to me was trying to get healthcare at a clinic and was told that the clinic didn't accept his insurance. When we told them the name of the health insurance, the clinic representative asked, "Is that Medicaid? We don't take Medicaid," and hung up. Why should the type of health insurance dictate the kind of healthcare you receive or the kinds of healthcare institutions you are invited into? **There shouldn't be one healthcare system for the poor and one healthcare system for the rich.**

Y, Ithaca

I am not eligible for insurance because of my immigration status. At 47, I feel like an old car that needs a check up. My son has Medicaid and it was very difficult to find a dentist for him because many dentists don't accept Medicaid. **It's very discriminatory.**

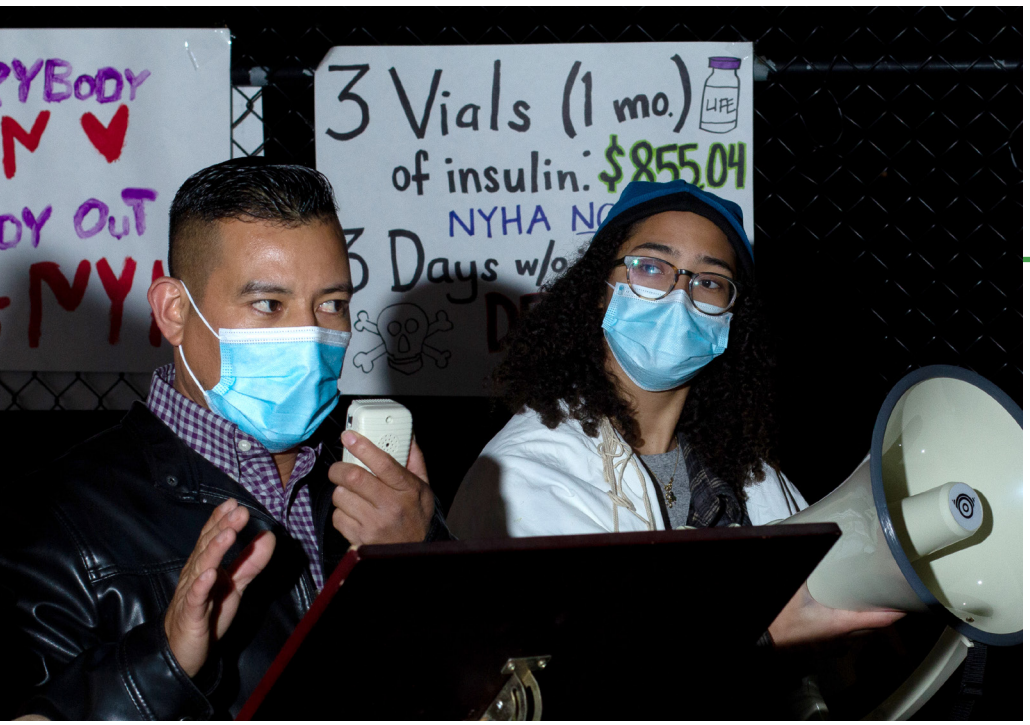
Vanessa Cid, Kingston

The health system we have continues to place profits before human lives. I lost my brother to cancer. Had he been able to get checked out for the symptoms and pain he was having, this probably could have been prevented. He was turned away from getting chemotherapy because he was undocumented and couldn't get health insurance. My brother always chose placing food before his family, paying rent and utilities over his own well-being because it's all he could afford, despite him always falling ill. **When he could finally afford treatment, it was 3 months too late and my brother passed away in debt, leaving not a single cent to his 8 year old son.**



Michelle Gonzalez, RN, Montefiore Medical Center

When COVID began, we all knew there was a risk of exposure to ourselves and our families. Because we lacked proper PPE, I got sick. And then my parents, who I live with, got sick. I watched as COVID spread through their lungs, deteriorating their health. We were able to somehow commandeer an oxygen machine because we got a prescription from Urgent Care. The oxygen machine was $3,000, and we immediately started getting calls now from the insurance company to pay for it. **Without this machine, my father was going to die.**



Eladio, Orleans County

In December 2022, my wife had a stroke and needed to go to the emergency room. We received a $3,500 bill that then went into collections. A charity helped us pay half the bill and then we finished paying in monthly installments of $200. **This was very difficult for our family.**

Acknowledgements

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About Campaign for New York Health

The Campaign for New York Health is a 501c4 statewide coalition dedicated to enacting a universal single-payer healthcare in New York State. CNYH brings together more than 300 organizations including the New York State Nurses Association, Physicians for a National Health Program, New York Statewide Senior Action Council, Metro Justice, Chinese-American Planning Council, Citizen Action of New York, Community Service Society of New York, Democratic Socialists of America (NYC), For the Many, New York Labor-Religion Coalition, Make the Road New York, Metro New York Health Care for All, New York Progressive Action Network, Northwest Bronx Community & Clergy Coalition, and Working Families Party.

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