Group 1 - Information for Discussion Leaders-Revised 01-09-21

PROGRAM PLANNING for the year - June 1, 2022 - May 31, 2023

Saturday, January 15, 2022, at 10 am on Zoom
Discussion Leaders: **Janet Youel, Jason Renaud** and **Joanna Cain**

HEALTH AND HUMAN SERVICES
Topics for discussion:

- **Healthcare inequities**
- **Mental health services & emergency services**
- **Reproductive rights**

On January 15, 2022, your group will look at the following LWVUS and LWVPDX positions regarding the 3 topics for discussion (above) and will make a recommendation on each League position to **retain** as is, **drop** the position, **update** the position, **restudy i**t or recommend a new **study** of it. You will also recommend topics, if any, for Civic Ed programs, formation of an Interest Group and for Action Committee consideration.

Also included with this information are the League's **Definitions** of terms for 2022-2023 and the **Report Form** to be completed by a discussion leader and returned to units@lwvpdx.org right after the meeting.

LWVUS positions **RETAIN - DROP - UPDATE - RESTUDY - STUDY**
Meeting Basic Human Needs
Equality of Opportunity
Healthcare
Public Policy on Repro Rights

LWVPDX positions
Teenage Girls at Risk

If your group has a topic for which there is no LWVUS or LWVPDX position, the League cannot advocate for public policy or legislative changes on that topic. If your group believes we need to develop a position on a topic, you may recommend a study or a concurrence with a position from another state or local League. Your recommendation must be approved by the League membership before it is acopted.

Here is the link to the most recent LWVUS positions:

https://www.lwv.org/sites/default/files/2020-12/LWV-impact-2020.pdf

To read more about the history of each position and other positions, click on this link to the LWVUS Impact on Issues; then click on the page # of the LWVUS position you want to see.

LWVUS POSITIONS

Meeting Basic Human Needs

The League's Position Statement of Position on Meeting Basic Human Needs, as revised by the National Board, January 1989, based on positions reached from 1971 through 1988:

The League of Women Voters of the United States believes that one of the goals of social policy in the United States should be to promote self-sufficiency for individuals and families and that the most effective social programs are those designed to prevent or reduce poverty. Persons who are unable to work, whose earnings are inadequate, or for whom jobs are not available have the right to an income and/or services sufficient to meet their basic needs for food, shelter, and access to health care. The federal government should set minimum, uniform standards and guidelines for social welfare programs and should bear primary responsibility for financing programs designed to help meet the basic needs of individuals and families. State and local governments, as well as the private sector, should have a secondary role in financing food, housing, and health care programs. Income assistance programs should be financed primarily by the federal government with state governments assuming secondary responsibility.

Preventing and Reducing Poverty: In order to prevent or reduce poverty, LWVUS supports policies and programs designed to:

- **increase job opportunities;**
- **increase access to health insurance;**
- **provide support services such as childcare and transportation;**
- **provide opportunities and/or incentives for basic or remedial education and job training;**

- decrease teen pregnancy;
- ensure that noncustodial parents contribute to the support of their children.

Access to Health Care: LWVUS believes that access to health care includes the following:

- preventive care,
- primary care,
- maternal and child health care,
- emergency care,
- catastrophic care,
- nursing home care, and
- mental health care as well as
- access to substance abuse programs,
- health and sex education programs, and
- nutrition programs.

Equality of Opportunity

The League's Position Statement of Position on Equality of Opportunity, as revised by the National Board in January 1989, based on positions announced by the National Board in January 1969, adopted by the 1972 Convention, expanded by the 1980 Convention and the 2010 Convention:

The League of Women Voters of the United States believes that the federal government shares with other levels of government the responsibility to provide equality of opportunity for education, employment, and housing for all persons in the United States regardless of their race, color, gender, religion, national origin, age, sexual orientation, or disability.

Employment opportunities in modern, technological societies are closely related to education; therefore, the League supports federal programs to increase the education and training of disadvantaged people.

The League supports federal efforts to prevent and/or remove discrimination in education, employment, and housing and to help communities bring about racial integration of their school systems.

The League of Women Voters of the United States supports equal rights for all regardless of sex.

The League supports action to bring laws into compliance with the ERA:

- **to eliminate or amend those laws that have the effect of discriminating on the basis of sex;**
- **to promote laws that support the goals of the ERA;**
- **to strengthen the enforcement of such existing laws.**

The League of Women Voters of the United States supports equal rights for all under state and federal law. LWVUS supports legislation to equalize the legal rights, obligations, and benefits available to samegender couples with those available to heterosexual couples. LWVUS supports legislation to permit same-gender couples to marry under civil law. The League believes that the civil status of marriage is already clearly distinguished from the religious institution of marriage and that religious rights will be preserved. See also Further Guidance and Criteria when interpreting this position.

Health Care

The League's Position Statement of Position on Health Care, as announced by the National Board, April 1993 and supplemented by concurrence to add Behavioral Health, June 2016:

GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

BASIC LEVEL OF QUALITY CARE: Every U.S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care, and mental health care. Every U.S. resident should have

access to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive service that is integrated with, and achieves parity with, physical health care. Dental, vision, and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

FINANCING AND ADMINISTRATION: The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League. The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state, and/or regional government agencies. The League is opposed to a strictly private market-based model of financing the health care system. The League also is opposed to the administration of the health care system solely by the private sector or the states.

TAXES: The League supports increased taxes to finance a basic level of health care for all U.S. residents, provided health care reforms contain effective cost control strategies.

COST CONTROL: The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as: • The reduction of administrative costs. • Regional planning for the allocation of personnel, facilities, and equipment. • The establishment of maximum levels of public reimbursement to providers. • Malpractice reform. • The use of managed care, • Utilization review of treatment. • Mandatory second opinions before surgery or extensive treatment. • Consumer accountability through deductibles and copayments.

EQUITY ISSUES: The League believes that health care services could be more equitably distributed by:
Allocating medical resources to underserved areas.
•Providing for training health care professionals in needed fields of care.

•Standardizing basic levels of service for publicly funded health are programs.
• Requiring insurance plans to use community rating instead of experience rating.
• Establishing insurance pools for small businesses and organizations.

ALLOCATION OF RESOURCES TO INDIVIDUALS: The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of healthcare resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

BEHAVIORAL HEALTH: The League supports:
• Behavioral health as the nationally accepted term that includes both mental illness and substance use disorder.
• Access for all people to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive services.
• Behavioral health care that is integrated with, and achieves parity with, physical health care.
• Early and affordable behavioral health diagnosis and treatment for children and youth from early childhood through adolescence.
• Early and appropriatediagnosis and treatment for children and adolescents that is family focused community-based.
• Access to safe and stable housing for people with behavioral health challenges, including those who are chronically homeless.
• Effective re-entry planning and follow-up for people released from both behavioral health hospitalization and the criminal justice system.
• Problem solving or specialty courts, including mental health and drug courts, in all judicial districts to provide needed treatment and avoid inappropriate entry into the criminal justice system.
• Health education—from early childhood throughout life—that integrates all aspects of social, emotional, and physical health and wellness.
• Efforts to decrease the stigmatization of, and normalize, behavioral health problems and care.

Public Policy on Reproductive Rights

Public Policy on Reproductive Rights The League's Position Statement of Position on Public Policy on Reproductive Rights, as announced by the National Board, January 1983: The League of Women Voters of the United States believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices.

To read the League's 3+ page History of its Public Policy on Reproductive Rights, go to the blue link to LWVUS positions and click on page 55.

Here is the link to the most recent LWVPDX positions.

https://lwvpdx.org/wp-content/uploads/2021/09/LWVPDX-Positions-Sept-2021.pdf

LWVPDX POSITIONS

Teenage Girls at Risk

Teenage Girls at Risk (1995) The League of Women Voters of Portland, Oregon supports equal access to appropriate services for at risk girls and boys. These services should be comprehensive in nature and should include outreach, treatment and followup.

We support:

- **Appropriate services that include consideration of gender, developmental phase, intellectual capacity, cultural identification, sexual orientation, as well as mental and physical clinical considerations.**
- **A comprehensive service directory plan that includes outreach, emergency services, case management, individual and family counseling, housing and follow-up. Effectiveness of these programs should be evaluated periodically.**
- **Emphasis on early detection and prevention of child abuse.**
- **The teaching of parenting skills.**

• Strategies to prevent teenage pregnancy which include the following: school-based health centers, sex education programs, teacher training, and the availability of a range of contraceptives at the schoolbased health clinics.
• Group homes and improved foster care for youth under age 16 in need of housing. Group homes as part of transition services for youth leaving residential treatment programs.
• Gender specific drug and alcohol treatment programs.

LEAGUE POSITIONS FROM ELSEWHERE (or comparison)

LWV of New York State is asking all Leagues to support concurrence at the LWVUS Convention with adding language from their Healthcare position to update the LWVUS Healthcare position:

https://pwm.tempurl.host/wp-content/uploads/2021/12/Statement-Proposed-Concurrence-with-LWVNYS-Healthcare.pdf

LWV CALIFORNIA State Position on Mental Health Care:

Position adopted 1988 - Support for:

1. **Adequately funded mental health care systems that**
    a. **provide comprehensive services to the acutely, chronically and seriously mentally ill of all ages;**
    b. **place emphasis on meeting the needs of children;**
    c. **seek additional funds to provide preventive services;**
    d. **offer mental health services for the homeless;**
    e. **maintain optimum mental health services for all clients.**
2. **Implementation of a master plan that**
    a. **ensures that there will be a network of integrated services, clearly defined and consistent with a community support model;**
    b. **advocates an awareness of and concern about the critical unmet needs;**
    c. **emphasizes case management that includes assistance with housing, financial entitlements, rehabilitative and vocational programs.**
3. **Centers for the seriously and chronically mentally ill apart from the county system.**

4. **Regulations that provide an adequate length of time for evaluation and treatment of involuntary holds.**
5. **Model mandatory outpatient care programs with adequate supervisory staff.**

LWV New Mexico reached concurrence with California's position on mental health care in 2013.

LWV WASHINGTON State position on Healthcare:

The League of Women Voters of Washington supports: HC-1: Policies, as part of comprehensive reform of the existing health system, which: • Ensure universal access for all residents to a comprehensive, uniform, and affordable set of health services. These services shall be available regardless of one's health status (i.e., pre-existing conditions) or financial status. • Provide "seamless" coverage and continuity of care, to the extent possible, regardless of changes in life circumstances such as change in employment, marital status, financial status, or health status. • Establish a mechanism to adequately control total system expenditures for health services while maintaining quality standards of care. • Assure that no one shall be forced into poverty because of medical or long-term needs. (adopted 1992)

LWV NEW YORK State position on PUBLIC POLICY ON REPRODUCTIVE CHOICES

The League of Women Voters of the United States believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices. Statement of Position on Public Policy on Reproductive Choices, as Announced by National Board, January 1983. (LWVUS Impact on Issues, 2016-2018, p.32) Using this position, LWVNYS has vigorously opposed attempts to encroach upon a woman's (including a minor) right to control her reproductive health • Measures that would make reproductive health services more difficult to obtain • Measures that would defund reproductive health programs or that would exclude reproductive health coverage from medical insurance.

OTHER RELEVANT INFORMATION RE HEALTHCARE INEQUITIES

THE FEDERAL POVERTY LEVEL IS

Yearly income no more than $12,760 for an individual
Yearly income no more than $17,240 for a family of 2
See http://aspe.hhs.gov/poverty-guidelines

YOU QUALIFY FOR THE OREGON HEALTH PLAN (OHP), also called Medicaid, IF YOU ARE

- an adult (19-64) with income up to $3013/month in a family of 4
- a single adult with income up to $1468/month
- pregnant in a family that includes you and your unborn with income up to $2730/month
- 65+; you qualify for Medicare regardless of income

See https://www.oregon.gov/boli/workers/pages/minimum-wage.aspx

THE AFFORDABLE CARE ACT (OBAMACARE) went into effect March 2010 and has had several subsequent revisions. It is intended to extend health insurance coverage to all U.S. citizens and legal residents - about 32 million Americans - who do not have health insurance as part of their employment benefits. The ACA should at least do the following:

- "Require employers to cover their workers, or pay penalties, with exceptions for small employers.
- Provide tax credits to certain small businesses that cover specified costs of health insurance for their employees, beginning in tax year 2010.
- Require individuals to have insurance, with some exceptions, such as financial hardship or religious belief.
- Require creation of state-based (or multi-state) insurance exchanges to help individuals and small businesses purchase insurance. Federal subsidies will limit premium costs to between 2 percent of income for

those with incomes at 133 percent of federal poverty guidelines, rising to 9.5 percent of income for those who earn between 300 percent and 400 percent of the poverty guidelines.

- Expand Medicaid to cover people with incomes below 133 percent of federal poverty guidelines.
- Require creation of temporary high-risk pools for those who cannot purchase insurance on the private market due to preexisting health conditions, beginning July 1, 2010.
- Require insurance plans to cover young adults on parents' policies, effective Sept. 23, 2010.
- Establish a national, voluntary long-term care insurance program for "community living assistance services and supports" (CLASS), with regulations to be issued by Oct. 1, 2012.
- Enact consumer protections to enable people to retain their insurance coverage
- Prohibit most insurance plans from excluding people for pre-existing conditions effective January 1, 2014."
  See www.ncsl.org (the ACA, a brief summary)

INCOME is the flow of money that comes into a household from wages, from ownership of a business, rents on owned property, and from state benefits.

WEALTH is the sum total of the value of homes, cars, savings, investments, personal valuables minus any debts.

THE BEST MEASURES OF A SOCIETY'S WELL BEING ARE <u>NOT</u>

- the stock market: While about half of Americans have an IRA, 401(k), or employer pension funds and therefore have some interest in the stock market, the richest 10% own 84% of the total value of the stock market.
- the GDP (Gross Domestic Product): measures the sum of private consumption, investment, government spending and the value of goods & services. See www.investopedia.com

THE BEST MEASURES OF A SOCIETY'S WELL BEING ARE FACTORS THAT MEASURE THE QUALITY OF LIFE:

- Sustainable weekly income - fewer people living at poverty level
- The percentage of children living in poverty
- Value of (appreciation for) unpaid work (housework, parenting, care-giving)
- Level of unemployment
- Level of education & training
- Life expectancy
- Confidence in receipt of affordable healthcare
- Access to childcare
- Entitlement to leave (maternity leave, sick leave, family care)
- Confidence in governing officials
- Gender equality
- Racial equality
- Safe living environment (a lock on your door, lead & asbestos free)
- Clean air, water, soil vs environmental degradation

  (I'm sorry - I cannot find the source of this list at this time. Judy)

COMPARE U.S. HEALTHCARE WITH OTHER INDUSTRIALIZED COUNTRIES - a project of the Real Reporting Foundation, a 501(c)(3)

Type into Google: "Health System Facts. Just Facts. No Slant"
to see the following information:

- Cost of care by country
- Life expectancies
- Nurses & doctors per 10,000 population
- Comparison of national healthcare systems

What does Medicare for all actually mean? It refers to a single-payer healthcare program in which all Americans are covered by a more generous version of Medicare, which is the government's health insurance program for people over 65, that would replace all other existing public and private plans with few exceptions.

What is Universal Health Care? It refers to the program that ensures that every person has access to the health care they need. The sheer cost of providing quality health care makes universal health care a large expense for governments. It would be paid for by taxes (just as taxes pay for public education, military expenditures, maintenance of roads, the Post Office, etc.).

Thirty-two countries have universal health care, including England, New Zealand, Australia, Canada, several Asian countries and most European countries who set up their Universal Health Care programs right after World War II when they were already economically devastated.

The United States is the only wealthy, industralized country in the world without Universal Health Care for its people.

THE FOUR BASIC NATIONAL HEALTH CARE SYSTEMS

1. THE BEVERIDGE MODEL is used in Great Britain, Spain, most of Scandinavia, New Zealand, Hong Kong and in its extreme example, Cuba. Instituted when England was recovering from WWII. Health care is provided and financed through tax payments, just like our libraries, police, military. **The American Veterans Administration healthcare is modeled after this system.**

2. THE BISMARCK MODEL is used in Germany, France, Belgium, Netherland, Japan, Switzerland and some countries in Latin America. It uses an insurance system (about 240 "sickness funds") to cover <u>everyone</u>, usually financed jointly by employers and employees through payroll deduction with cost-control and tight regulation by the government. **Americans who get health insurance on the job have a healthcare plan modeled to some extent on this system.**

3. THE NATIONAL HEALTH INSURANCE MODEL, called Medicare was founded in Canada and also used by South Korea and Taiwan. It was first developed in Saskatchewan and was so successful that citizen pressure was put on the Canadian Federal government to institute this plan throughout Canada. It uses private-sector providers; everyone pays into a government run insurance program - cheaper and simpler than American-style for-profit insurance. **America's Medicare for people over age 65 is modeled on this plan.**

4. THE OUT-OF-POCKET MODEL. Only about 40 industrialized, developed countries out of about 200 of the world's countries have an established healthcare system. The other countries are either too poor or too disorganized or resistant to the idea (as in America) of providing system-wide healthcare. Places such as rural Africa, India, China and South America are in this category. People in those places that are rich get medical care; people who are poor get sick and/or die. Until the Affordable Care Act, eff. March 2010, 15 % of Americans had no healthcare insurance and had to pay out of pocket or use public assistance.

As with the Affordable Care Act, countries with these models of national healthcare in place for decades, make revisions and updates to their healthcare plans.

For more information about these four healthcare models, see the PBS Newshour program "Sick Around the World - comparing healthcare systems in several countries" (4-15-2008) at https://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/etc/notebook.html

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