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THE SNaHP-SHOT

Students for a National Health Program

Quarterly Newsletter

VOL. 2 SEPT 13, 2023

In Today's Issue...

SNaHP
Students for a National Health Program

Get in touch by contacting Yusuf Cifti (aciftci1@jhmi.edu) or Jack Loftus (jloftus3@jhmi.edu)!

Perspectives on HR 3421

Joely Hannan

As I enter my fourth year of medical school, I reflect on how there we often receive very limited training around how health insurance in this country works, yet we enter clinical situations and are quickly exposed in real time to how the current system affects both patients and providers. We see providers overburdened with documentation, changing formularies, prior authorizations, and countless other insurance logistics. We also see patients having to navigate complicated networks, a burden that can sometimes be very challenging without a detailed level of health literacy. We see emotional burnout in providers unable to provide necessary care to patients due to cost or logistics. We also see patients having to make medical decisions and potentially delay care due to concern over medical debt, sometimes making decisions that seem unimaginable. Our perspectives give us clear reason to understand the current health insurance system needs to be changed.

A lot of the above challenges still imply that patients have insurance, a luxury that is not true for all Americans. In a 2022 study by the Commonwealth Fund, around 9% of the population were uninsured, 11% reported having gaps in coverage over the year, and 23% reported underinsurance, defined as having consistent insurance but still lacking affordable access to healthcare (1). Despite this, the United States spends more on healthcare per capita than other developed countries, clocking in at $12,318 per capita, with the next highest being $7,383 in Germany (2) . Therefore, even with insurance, our system is not as cost efficient as other countries. Additionally, coverage numbers will worsen as individuals are dropped from Medicaid coverage following eligibility redeterminations in the post pandemic era (3).

Universal healthcare coverage, such as through a single payer system, would be a mechanism to help address some of these problems. As an aspiring OBGYN, I am concerned by the United States having the worst maternal mortality rate of developed countries, which in recent years has been driven by higher rates of maternal mortality in states that did not choose to expand Medicaid following the passage of the Affordable Care Act 4 . This effect size of this Medicaid non-expansion on maternal outcomes is biggest in Black mothers (4). Improving coverage rates may contribute to improving the stark racial disparities in maternal outcomes.

This effect is not only relevant for OBGYN, as a study of all-cause mortality showed significant reduction in states that expanded Medicaid compared with states that did not, also with largest effect size among non-white individuals (5). Knowing that there is such marked benefit in mortality outcomes of Medicaid expansion makes the potentially millions of Americans who have been or will bekicked off Medicaid alarming.

As trainees, we want to enter a system that will allow us to serve our patients well through our entire careers. There are many initiatives to reduce provider burnout, but reducing administrative and emotional burden related to coverage has the potential to go a long way in this realm.

A single payer system would decrease administrative complexity and prevent lapses in coverage, such as those threatened for some currently on Medicaid. I urge the medical community health insurance reform, ensuring this is a priority as we move into this legislation cycle and next election season. HR 3421 to establish and improved Medicare for All national health insurance program was introduced to the US House of Representatives in May 2023 (6). Whatever a universal coverage system ultimately looks like, something must be done to simplify the complexities of our current inefficient and insufficient structure. The sustainability of our health system depends on it.

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4. Eliason EL. Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality. Womens Health Issues. 2020;30:147-152.

5. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. N Engl J Med. 2012;367:1025-1034.

6. H.R. 3421 – 118 th Congress (2023-2024): Medicare for All Act. (2023, May 17).

SUPREME COURT AFFERMATIVE ACTIVE DECISION

The Supreme Court's decision to overturn key components of the educational equality policies colloquially known as affirmative action represent an existential threat to the wellbeing of disadvantaged and underrepresented communities nationwide. The medical profession is unique it its long educational path and challenging training that follows. Indeed, physicians may spend up to two decades of their lives enrolled in higher education or undergoing training. Thus, the profession already excludes many groups that cannot afford or access this arduous process.

There is a persisting racial disparity dominating medicine; only 5.7% of physicians are Black and 7% are Hispanic, compared to approximately 64% who are White. Although recent admissions criteria have supposedly factored in these racial disparities in order to achieve a more representative workforce, this may take decades to realize and still lags far behind its intended goal. Given that there is an extensive amount of scholarship that ties physician race to patient outcomes, implicit bias among physicians and patients, and the importance of equitable representation on patient well-being, it is imperative to strive for a more diverse, representative workforce. Therefore, we must build on these policies and propose more progressive initiatives to ensure that the physician workforce is representative of the general population, a move that will result in better health for patients of all races and backgrounds.

FURTHER READING

https://www.pbs.org/newshour/show/affirmative-action-ruling-raises-concerns-over-impact-on-medical-school-diversity

https://kffhealthnews.org/news/article/medical-schools-admissions-race-affirmative-action-supreme-court-ruling/

HEALTH CARE VIOLENCE

FURTHER READING

https://www.aha.org/public-health-approach-addressing-gun-violence

https://www.pbs.org/newshour/health/attacks-at-medical-centers-contribute-to-health-care-being-one-of-nations-most-violent-fields

https://apnews.com/article/hospitals-workplace-violence-shootings-aa6918569ff8f76ff8a15b9813e31686

Over the past year there has been a noticeable rise in the incidence of work violence in healthcare. The murder of Dr. Benjamin Mauck, an orthopedic surgeon in Tennessee, and the recent fatal shooting in an Oregon hospital are two examples of recent healthcare-related violence. According to the US Bureau of Labor Statistics, healthcare workers experienced 73% of nonfatal workplace violence in 2018, the most out of any group by a large margin.

This increase in violence is a direct result of archaic policies and flaws in the structure of healthcare delivery. For example, the Affordable Care Act (ACA) partially ties funding to consumer satisfaction surveys. Therefore, there is an incentive to implement policies that appease patients and ensure maximal funding through the ACA. Although this policy has its merits in terms of patient satisfaction and quality care delivery, it is potentially harmful in situations where there is an aggressive patient. Herein lies an example of corporate greed negatively impacting patients and providers on the frontlines. Moreover, security in healthcare is another flawed structural component, although this presents unique challenges as the involvement of law enforcement in patient care would be an undesirable solution.

Nonetheless, healthcare violence continues to increase and must be addressed through innovative policy on a national level to ensure patient and provider safety. Standardization of protocols related to patient visitation, violent patients or family members, and progressive gun control legislation are some solutions that may be beneficial.

Case Study in Misinformation

By: Bryce Walker

Every now and then the youtube recommendation algorithm might offer you a video that is consistent with topics you are interested in but simultaneously completely at odds with your personal understanding of said topic. On April 6th of 2020, congressman Dan Crenshaw appeared on the popular podcast, Joe Rogan Experience to discuss topics ranging from American history to health care policy and specifically Medicare for All. A youtube clip containing congressman Crenshaw's opinion on healthcare policy was recommended to me (and presumably many other straight white men in their mid 20s). While discussions on the failures of the United States healthcare system can be difficult to find in most media with this caliber of viewership, it is more important than ever to be critical of both the arguments against Medicare for All, and the weak responses to the bipartisan political leadership that espouse Crenshaw's debunked talking points.

For that reason, I wanted to take Cranshaw's arguments point by point from the 28 minute conversation on the qualities of Medicare for All.

As Medicare for All maintains popular support in the United States, it is important that the democratic will of the electorate is not sidelined by dubious talking points from corporate sponsored political elite ; represented by not only Crenshaw, but numerous democrat politicians as well.

It is worth remembering that in our current system, an estimated 30,000 unnecessary, preventable deaths were linked to lack of health insurance in the United States in 2017 alone. The U.S. Census Bureau indicated that as of 2020, there are nearly 31,000,000 Americans who are uninsured. As future health care providers, we have the responsibility to advocate for policy that offers quality health care to all people no matter their job status, background or financial resources.

				
QUOTE	“[HR3] would put all of the smaller start-up biotech companies totally out of business because they're the ones who start that innovation.” ... “If we implemented the price controls that are inherent in medicare for all or HR3, there wouldn’t be anyone else in the world doing what we do.” (0:00, 1:00)	"We have overwhelming per capita more ICU beds in this country compared to any other Western Country” (4:34)	"Once you put price controls in, there is going to be less doctors because doctors are going to get paid less, they’ll get burned out more.” (9:45)	“The cost by most estimates is in the mid 30-something trillion dollars over ten years“ “It means doubling or tripling your taxes “ (22:14)
ARCHETYPE	“A publicly financed health system would stifle medical research.	Universal healthcare will decrease supply for medical utilities.	Doctors won’t want to work in a universal healthcare system.	How can we afford it?
RESPONSE	HR3 is an attempt to negotiate price caps for certain drugs including insulin as well as 125 drugs that take up the most national spending and have no generic competition. Maximum price cannot exceed 120% of average prices in Australia, Canada, France, Germany, Japan or the UK. It also funds innovation projects at the national institute of health. Most of the largest research innovations are publicly financed though NIH and many important medical advances have come from single payer nations. On average, pharmaceutical companies spend 2.5x as much on revenue / marketing / administration as they do on research and development.	While United States has more ICU beds / 100,000 citizens, the American patient population demonstrates a significantly higher burden of chronic illness. For instance, double the rate of diabetes and 133% higher rate of hypertension when compared to the U.K.	Of the countries evaluated in the 2015 WHO measurement of world health statistics, the United States doctor to patient ratio ranks 59th in physicians per 10,000 citizens. Countries with a single payer system including many Northern European countries, the U.K, Israel and others have a substantially better ratio. **Much of the bottleneck that exists in physician education is a result of a lack of medicare spending which funds residency training programs.**	Tax revenue currently funds nearly two-thirds of U.S. health expenditures. A national health plan like Medicare for All would benefit nearly all U.S. households by the elimination of premiums and out-of-pocket expenses as well as creating a reasonable bargaining ability to combat inflated pharmaceutical costs. Independent studies like those listed below describe how a national health plan would benefit Americans financially as well as yield enormous savings in regard to administrative waste that currently drives up health care costs in the United States.

CITATIONS

https://www.congress.gov/bill/116th-congress/house-bill/3

https://pnhp.org/what-is-single-payer/faqs/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3551445/

https://apps.who.int/iris/bitstream/handle/10665/170250/9789240694439_eng.pdf;jsessionid=C7FC278A06F5FBEF67FA657401394ED1?sequence=1

https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?end=2018&locations=GB&most_recent_year_desc=true&start=1960

https://www.acpjournals.org/doi/10.7326/M17-1403

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https://www.healthcare-now.org/wp-content/uploads/2017/08/Minnesota-Lewin-Group-2012.pdf

Additional Resources

HR3 Introduced to 116th congress (2019-2020) was introduced and passed in the house. TITLE I "The bill requires the Department of Health and Human Services (HHS) to negotiate prices for certain drugs." Including insulin, and "at least 25 single-source, brand-name drugs that do not have generic competition and that are among either the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit and Medicare Advantage" ... "The negotiated maximum price may not exceed (1) 120% of the average price in Australia, Canada, France, Germany, Japan, and the United Kingdom; or (2) if such information is not available, 85% of the U.S. average manufacturer price. Drug manufacturers that fail to comply with the bill's negotiation requirements are subject to civil and tax penalties."

TITLE VII: The bill provides additional funds for several public health programs. Among other things, the bill (1) provides specified funds for innovation projects at the National Institutes of Health through FY2030 and for innovation projects at the Food and Drug Administration through FY2029; and (2) establishes the Opioid Epidemic Response Fund to support HHS programs and initiatives, including the State Opioid Response Grant Program.

https://www.congress.gov/bill/116th-congress/house-bill/3
https://policyadvice.net/insurance/insights/how-many-uninsured-americans/

ANNOUCEMENTS

AMA CAMPAIGN

We need your help to draw national attention to our AMA resolution campaign! You can get involved by expressing your support for anti-single payer neutralization by writing an op-ed. The goal of the op-ed campaign is to shine a national spotlight on our resolution that we have worked hard on. The op-ed campaign can garner public attention and attention from the media. Email edwardsi5197@gmail.com to get involved!

VOT-ER

Last year, the American Medical Association declared voting a social determinant of health in response to the rise of voter suppression. In response to this, Cooper Hospital (Camden, NJ) is hosting their First Annual National Voter Registration Day! On September 19th (National Voter Registration Day), volunteers across the hospital campus will assist residents in checking their voter status and registering to vote!

If you're looking to start engaging patients, staff, and community members in their civic health, you can check out https://vot-er.org/ or reach out to James Waters at waters72@rowan.edu.

SNAHP SUMMIT

The annual PNHP/SNaHP Summit will be held in Atlanta, Georgia from Friday, November 10th to Sunday, November 12th! Make sure to register AND apply to the Nicholas Skala Student Activist Scholarship to help cover travel expenses (due Sept 20; https://tinyurl.com/2p8ptbya). Join us to meet your fellow student and physician activists, ge tthe latest updates, and share ideas as we work together to lay thr groundwork for our Medicare for All Campaigns.

We will also be holding our first Poster Symposium! Submit an abstract here by Oct. 6th (email waters72@rowan.edu). All research topics accepted.

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PNHP ZINE

MEDICARE 4 ALL AND THE MINNESOTA HEALTH PLAN

A QUICK GUIDE TO THE CURRENT MOVEMENT: AN ABRIDGED LOOK INTO "M4A: A CITIZEN'S GUIDE"

WHAT IS MEDICARE FOR ALL?

Medicare For All (M4A) is the idea that the government guarantees comprehensive coverage for everyone.

Let's go over some basics together!

- You may have heard of the term **single-payer health care**
- In this context, **Medicare** functions as the single payer that covers healthcare for everyone
- When we talk about M4A, this would be an **improved version** of Medicare today
  - This would be an expanded version that would remove the gaps in coverage and the need for broken systems like Medicare Advantage
- In the current model of M4A, the **payment system is public** (funded by the government)
- Hospitals and doctors would remain private, so the **delivery system would be private**
- In this system, **everyone** would be covered

Core Ideas of Medicare 4 All

Universal coverage, Comprehensive coverage, Pricing power, Administrative efficiency, Progressive financing, and Public accountability

US AND HEALTHCARE

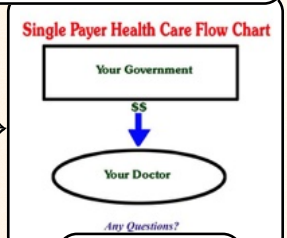
If you feel like our healthcare system is **complex**, you're not alone! It's a confusing fragmentation of private insurance through employers, Medicaid, Medicare, individual private insurance, public programs (e.g., VA), etc.

Current Issues

- As of 2021, **8.3% of Americans (27.2 million people)** were **uninsured**
- Despite ever **growing costs** of healthcare (projected to be over **$5 trillion** in 2025), the US **consistently ranks lower** than other countries when it comes to accessibility of care, health outcomes, and affordability
- **43%** of adults ages 19 to 64 had **inadequate** insurance coverage
- The system is designed to treat health as a commodity **rather than a right**

What if we could improve health and coverage?

Our $ystem



M4A!

WHY WE NEED M4A

Healthcare is too expensive

- Despite utilizing **less healthcare**, Americans pay **more** compared to patients in other countries (e.g., MRI in the US costs $1,430 vs $140 in the Netherlands)
- The **complexity** of the insurance system has driven prices up, especially with **high administrative burden**.

Contributors to High Costs

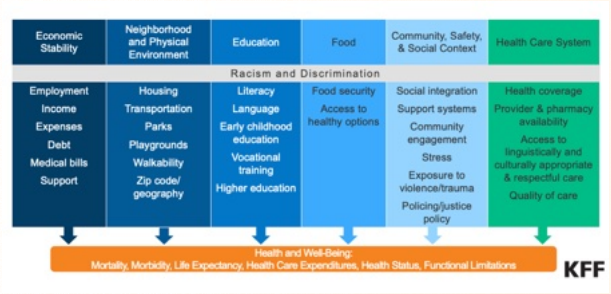
Limited negotiating power given fractionated insurance system, consolidation/monopolization of hospitals, high prices and premiums set by insurance companies for profit, high drug prices, and admin

Healthcare is inaccessible

- Accessibility challenges are **financial and geographic**
- Top reasons for being **uninsured**: high cost, losing coverage due to employment changes, coverage gaps
- 45% of non-elderly Americans are **underinsured or uninsured**
- 1/3 of Americans have **put off medical treatment** due to **cost** in the past year

- **High deductibles and out of pocket** costs pose financial challenges
- Coverage often **does not include** important services (e.g., dental)
- Rural and low-income urban communities face disproportionate challenges getting care due to **shortages**

WHY WE NEED M4A



The Bottom Line

- **All Americans** should be able to **receive care regardless of ability to pay, employment, or immigration status**
- Healthcare **should not** be viewed the same way as a commodity
- The **fractured nature** of the current system has added to rising costs and has worse health outcomes
- **Addressing healthcare and social needs** is paramount to achieving health
- We **NEED** change!

*"It is **not acceptable**...that over 70 million people today are either uninsured or underinsured...there are millions of people who would like to go to a doctor but **cannot afford** to do so. This is an **outrage**. Health care is a **human right** that all Americans, **regardless of income**, are entitled to and they **deserve the best health care** that our country can provide."*
-Sen Bernie Sanders

OVERVIEW: M4A

Buzzword Breakdown

- H.R.1976: Bill introduced in the House by Representative Pramila Jayapal
- S. 4204: Bill introduced in the Senate by Senator Bernie Sanders
- S. 4204 has now expanded language to include a global budget to alleviate costs on patients

What will it cover*?

- **Who:** All people living in the US, regardless of ability to pay, income level, immigration status, and employment status
- **What:** The current language is deemed as "Medically-necessary" care. Unlike some current discourse utilized by insurance companies, this would include expanded care, where patients can freely choose where/who they receive care from, including the following:
  - Hospitalization and doctor visits
  - Dental, vision, and hearing care
  - Mental health services
  - Reproductive care, including abortion
  - Long-term care services and supports
  - Ambulatory services
  - Prescription drugs
- **How:** Implementation over a two year period, starting with expansion of Medicare, followed by enrollment of different age groups and availability of Medicare Transition program
- **Funding:** Costs managed by national health program, and patients receive care free at point of care

*Not exhaustive; Updated as of August 2023

OVERVIEW: MN HEALTH PLAN

Context

What will it cover*?

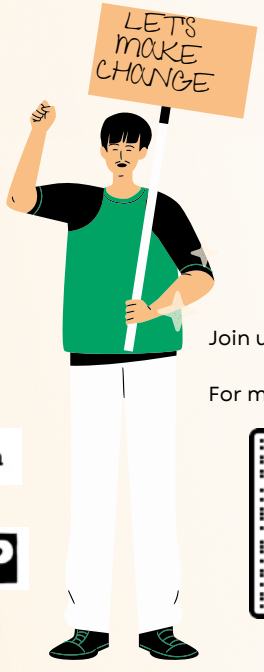
- **Who:** All Minnesotans for all their medical needs
- **What:** Coverage would enable individuals to where/who they receive care from, including the following:
  - Dental care
  - Prescription drugs
  - Vision & hearing, mental health
  - Chemical dependency treatment
  - Medical equipment and supplies
  - Home care services
  - Nursing home care
- **Funding:** Using current funding system (i.e., taxes), but remove the need for insurance premiums, as payroll tax is sufficient
- **Management:** Will be run by the Minnesota Health Board (MHB), which would be elected by the community and will focus on transparency and eliminate the need for insurance companies
- **Cost:** Premiums set on ability to pay and would need to be ratified. Although the premiums are collected by taxes, they will all go directly to the MHP rather than the government itself

*Not exhaustive; Updated as of August 2023

NEXT STEPS

YOUR VOICE MATTERS! JOIN US!

- Support efforts to pass the Minnesota Health Plan: SF 2740, HF 2798
- Support efforts to pass M4A on a federal level
- Call your representatives
- Sign petitions
- Read more



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For more info/resources:

The Kids Don’t Stand a Chance

By: Ryan Parnell

An epidemiological event is occurring in a room covered with large portraits of Looney Tunes. Flowing oxygen adds an ambient white noise like an airplane cabin. The scene would almost be relaxing if air wasn’t leaking out of a hole in the window. Skin retracts between rib cartilage, as panicked parents contribute their own tachypnic rhythm to the room. A child is intensely focused, a nascent personality smothered in carbon dioxide. Breaths are shallow and fast. It’s difficult to watch a child struggle to breathe. Shifting my gaze, I accidentally make eye contact with Bugs Bunny. The air is heavy with exhalation, tinged with the scent of lactic acid like burnt yogurt - the entire room is slowly suffocating.

Asthma, pneumonia, and bronchiolitis are the leading causes of pediatric hospitalizations, accounting for over 100,000 admissions annually (1). Breathing is a fragile process in an unknown world, where microbes have home-field-advantage against inexperienced immune systems. After initial stabilization, many of these children require admission to the pediatric intensive care unit for further management. While children are remarkable in their ability to recover, these admissions remain undetermined; a child’s life hinges on access to a hospital bed.

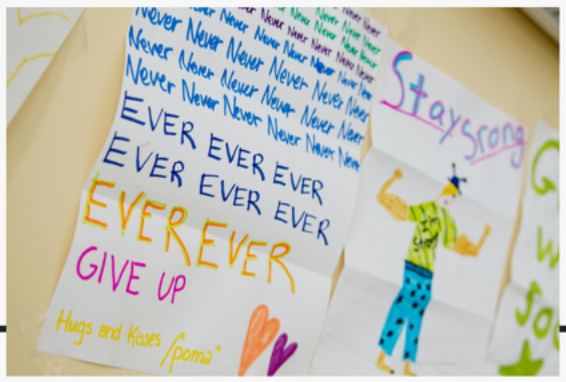
Despite these stakes, pediatric inpatient units have been reduced by 19 percent over the past 15 years. Nearly one-quarter of American children have experienced an increased distance to the nearest doctors trained to care for them (2). This reduction in bed availability became apparent with the so-called “tripledemic” of 2022 (3). Influenza, RSV and COVID one-two-three punched the United States healthcare system, which was already on the ropes after a few recent haymakers. An exponential rise in virally-replicated demand met a linear decline of pediatric bed supply; the kids never stood a chance.

How could a hospital executive reduce the capacity to care for sick children? It’s a question that has been on my mind for the past few months. Once, it was an abstracted moral argument, contained within the confines of a biomedical ethics Zoom call. Then, I saw a child struggle to catch his breath, lips blueing and nostrils flaring as he suffocated on his own secretions. So I repeat the question: how could a person decide to allow the preventable death of children across the country?

Personally, I'd like to think an intense sense of moral injury would be overwhelming if my actions directly led to the death of children in my community. But, considering the lack of private jet crashes and caviar asphyxiation, there must be some robust coping mechanisms in place. Annual bonuses must blunt the sharp edges of guilt, and publicly donating to a local animal shelter goes a long way for personal reputation. Ugly realities of the hospital can be obscured away with flowery language and fiduciary responsibilities. Perhaps, these corporate buzzwords afford enough separation between an executive boardroom and fluid-filled lungs to swallow the cognitive dissonance. Really, I've come to realize the ultimate coping mechanism is more simple than all of that: these executives really had no real choice in the matter.

A fundamental rule of healthcare in the United States: adult beds are more lucrative than pediatric beds. Bound by this rule, a hospital executive really has no choice - his hand is forced. He must reduce the pediatric beds in his hospital, converting these units into double-occupied adult rooms, adding some horsepower to his engine of profit. There isn't a moral culpability, a decision, barely even a thought. Under a for-profit healthcare system, quarterly revenue goals and operating margin are the measure of job performance, which ensures the continued ownership of the much-coveted title of hospital executive. His job is to inflate these margins, wringing the last few Medicare dollars out of cirrhotic livers and edematous abdomens. These decisions are not accompanied by the tortured cackling of a mustache-twirling strawman; the death certificate of children is signed with an air of objectivity and seriousness, all in a hard day's work.

How could the richest society in the history of human civilization be unable to take care of its children? Well, simply by following the rules that got us here. Pediatric critical care generates less revenue than adult medicine; therefore, our society must allow the preventable death of children. These deaths aren't necessarily desired, children simply aren't accounted for in this profit-driven healthcare system. It's a tolerable outcome, invisible grief pushed to the margins of our minds. In the United States healthcare system, medicine becomes a vessel for the reflex of profit-seeking, consumed by a blackhole that demands more matter, even if its the metabolic output of a child's fatiguing intercostal muscles.



Reducing pediatric hospital beds is another example of the inability of a profit-seeking society to invest in itself, foreclosing the future for the sake of this year's bottom line. It's not a matter of if, but when reducing hospital beds will lead to the unnecessary suffering of children. Less of a butterfly effect, more of a giant, neon blinking-arrow of causation. As soon as those beds were eliminated, so were the lives of children around the country. The only way to avoid this outcome is establishing a single-payer universal healthcare system, removing the profit motive from medicine. As another autumn approaches, and viral spread inevitably rises, the lives of American children are at risk, a danger amplified by the profiteers in our healthcare system. Our movement for single-payer healthcare is urgent and important - the kids are depending on us.

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What is this newsletter?

We envision this as a way for SNAHP members, friends and like-minded people who are passionate about single-payer healthcare in the US to come together. We hope this newsletter will be a useful and exciting way to get news, commentary, and other content about health justice topics from a progressive perspective. We will try to create a space to openly talk about health justice issues without pressure to be politically neutral and provide individuals a low-barrier opportunity to publish their work on a national platform. Not to mention, we'll share SNaHP and PNHP updates and ways for readers to get involved.

Anyone and everyone are invited to submit something to be included in a future newsletter! Below is information about how to go about that and relevant details. We encourage submissions on a wide range of topics, including but not limited to:

- Opinion Pieces
- News/Social Commentary
- Personal Stories and Experiences
- Editorials
- Informational Pieces
- Book Reviews

Please limit all written pieces to 1000 words (approximately 2 pages, single spaced). If you'd like to submit a finished piece of writing, poetry, visual art, musings or something else, please reach out! Additionally, we would love to hear if your SNaHP chapter has done anything similar in the past.

All submissions will have the opportunity to be revised and edited by the editorial team. Our aim here is not to censor but to provide support and curate the submissions we get for each issue to create a cohesive edition. Submissions past the deadline will be considered for future editions. Our editorial team can also be available to help people with the writing process. If you have an idea for something to submit, feel free to get in touch to discuss! You can reach the editorial team aciftci1@jhmi.edu and jloftus3@jhmi.edu.

We welcome contributions from all members of the SNaHP community, including students, educators, health care professionals, and activists. Your perspectives and experiences are invaluable in shaping our shared vision for a more equitable health care system. Thank you for your support, and we look forward to reading your work!

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