Solidarity Economics

PUBLIC HEALTH IN THE MONTEREY BAY

By Gabriella Alvarez & Chris Benner

This is part of a series on how Solidarity Economics principles of mutuality and movements can be applied to help promote inclusive economic development in the Monterey Bay Area region. For more information on Solidarity Economics, please see: https://transform.ucsc.edu/work/solidarity-economics-projects/

THE STATUS QUO

WHAT IS THE CURRENT SITUATION IN OUR REGION?

Solidarity Economics

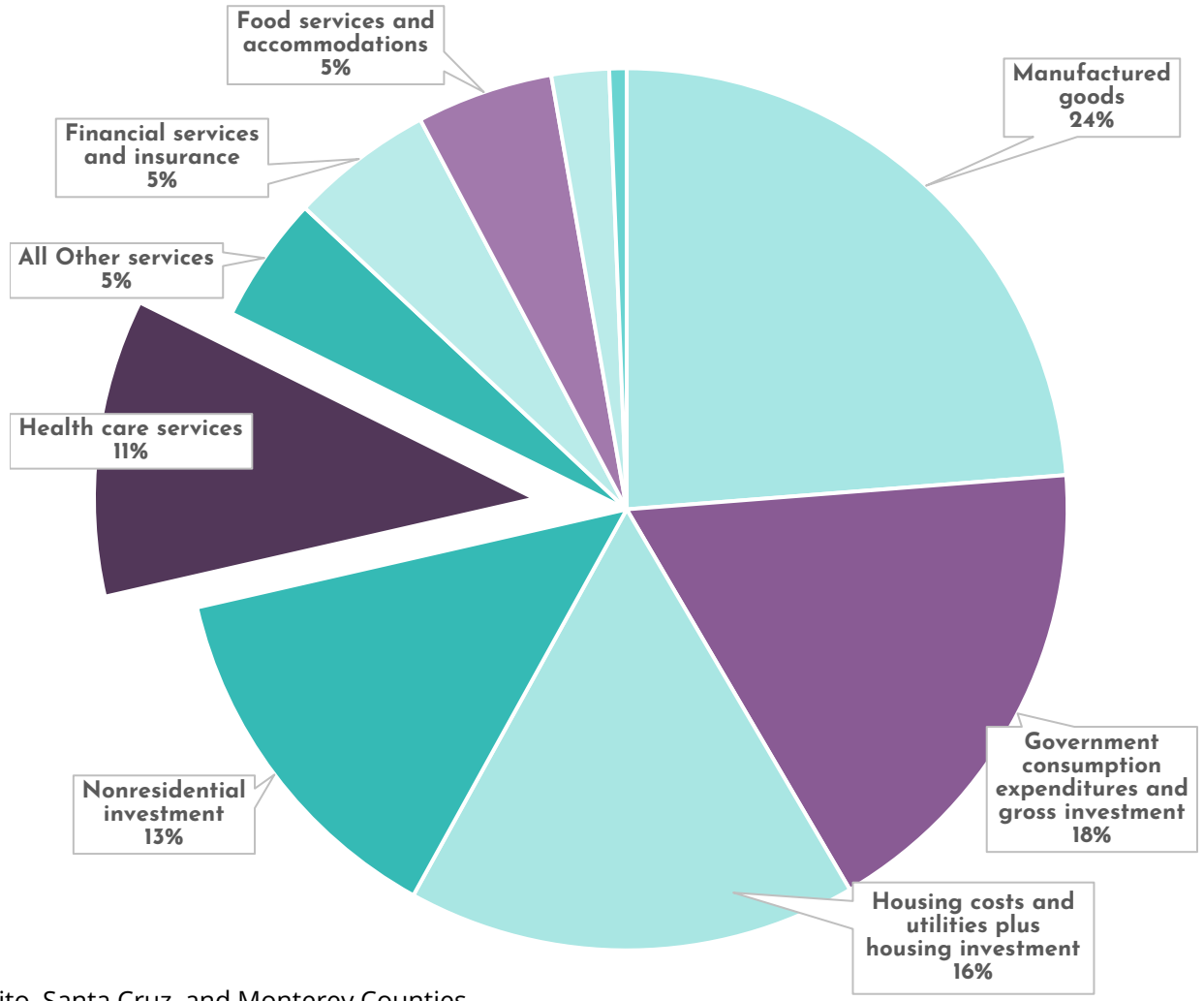
Health is a major component of our economy

11% of total economic output in the United States is associated with health care expenditures.

Prioritizing public health, not just treating illness, can not only lead to better health outcomes, but lead to substantially better economic outcomes by:

- Reducing absenteeism and lost work hours
- Improving productivity
- Reducing unnecessary health expenditures
- Leading to more efficient and effective spending of health care dollars in our economy

National GDP 2022 (imports/exports excluded)



Sources: BEA, 2023

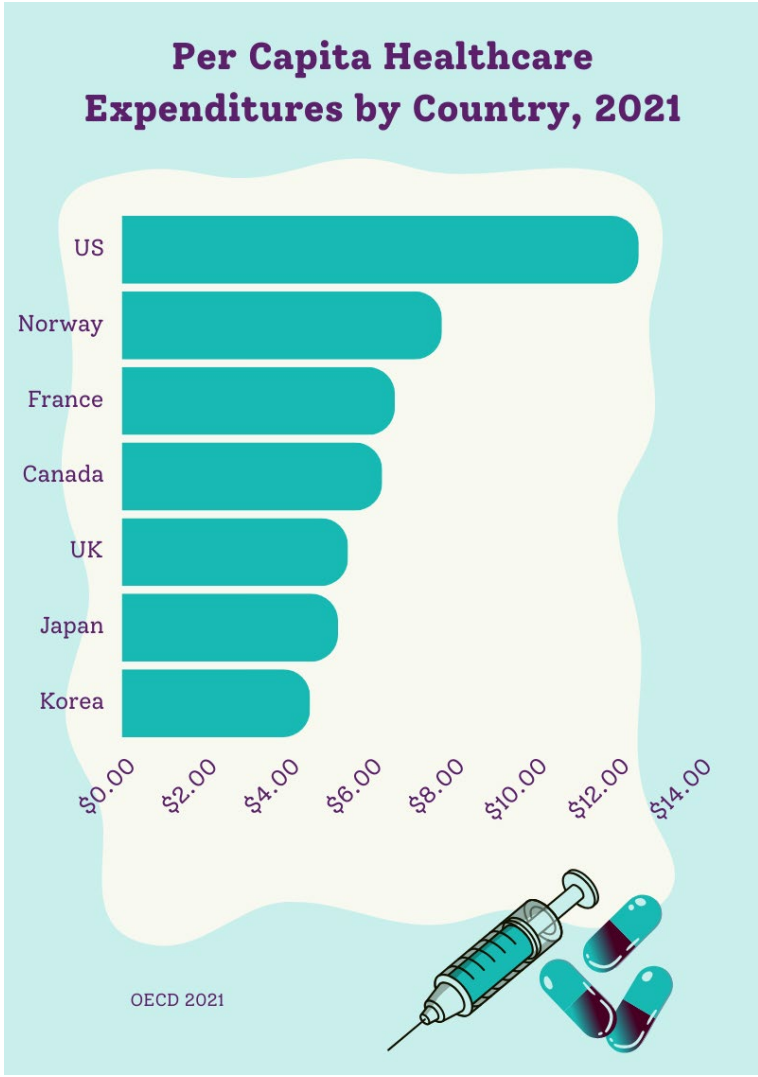
*Monterey Bay Area refers to the tri-county region of San Benito, Santa Cruz, and Monterey Counties

Poor health weakens our economic well-being

Our current health system focuses on treating illness, rather than promoting health, resulting in highly unequal health outcomes

Despite spending the most on health care expenditures per capita amongst the 37 other OECD countries, the United States ranks abysmally low on measures of healthcare quality and population health status.

- 33rd out of the 38 OECD countries in life expectancy at birth
- 37th out of 38 in the proportion of the population that is overweight or obese
- 34th out of 38 on physician coverage (physicians per 1,000 people)



Sources: OECD, 2021 (4); AMA, 2023

It doesn't have to be this way...

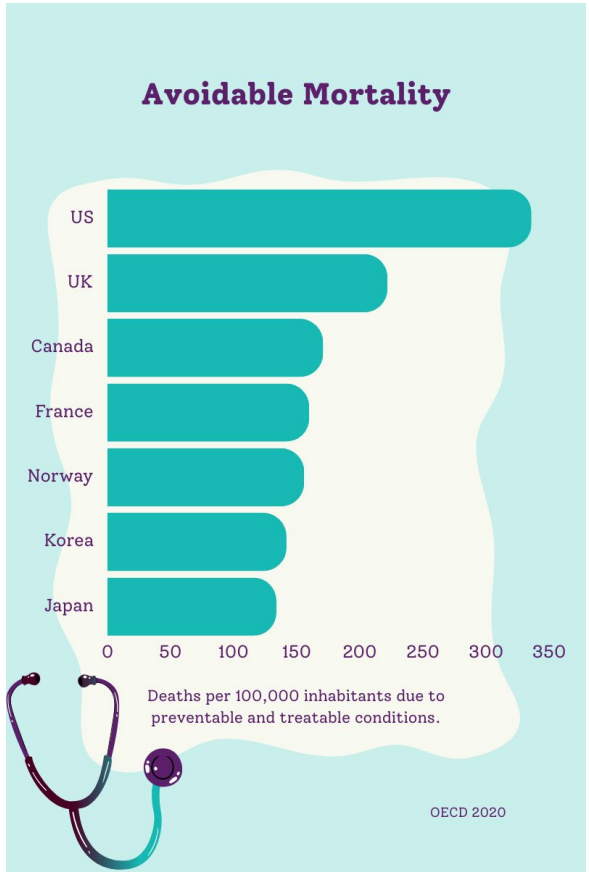
Healthier countries prioritize public health by supporting the well-being of their residents across the life course

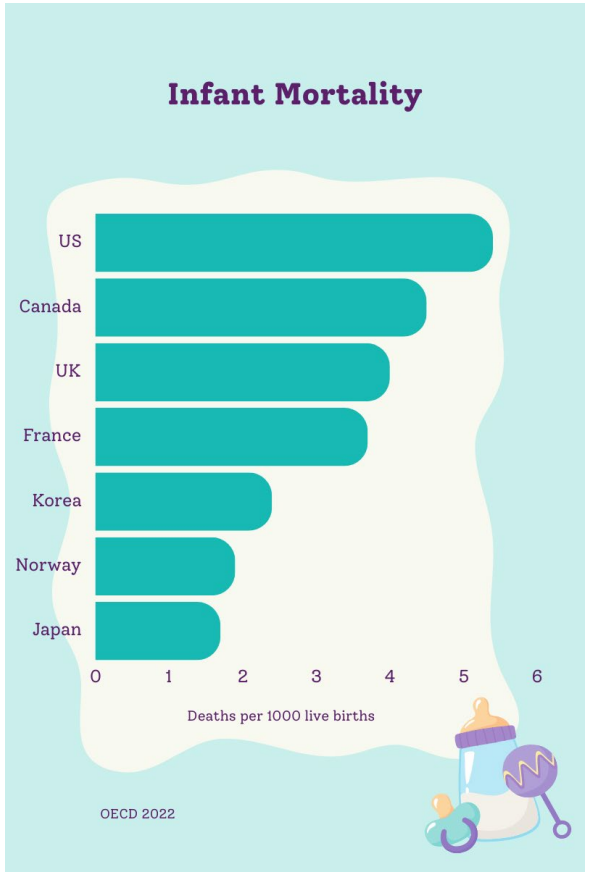
Examples:

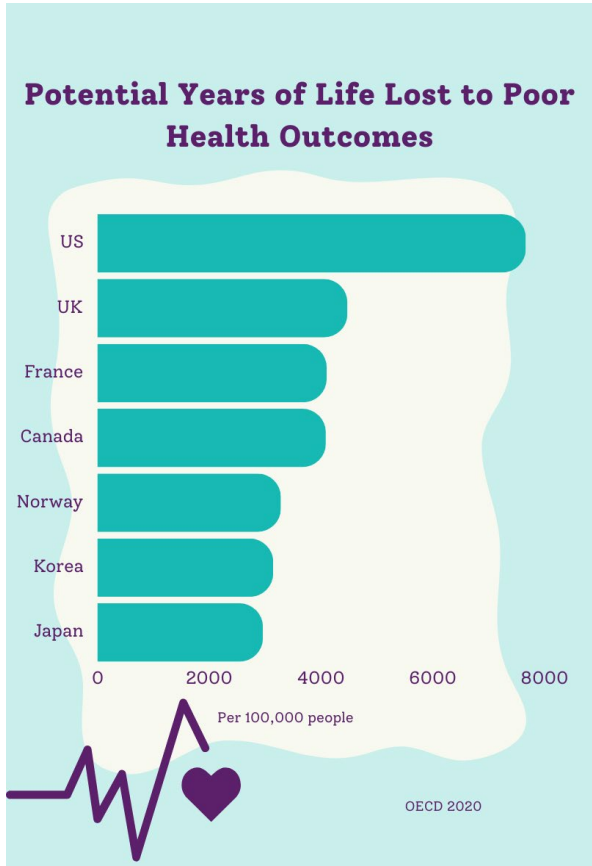
- Scotland provides **1140 hours per year of free childcare** per child & a **free "baby box"** of necessary supplies
- France requires all pregnant mothers take at **least 8 weeks of maternity leave** before they receive their guaranteed financial support. They also provide **high quality, state-run childcare** programming that is free to families that apply.
- In Denmark, **public childcare is guaranteed** for all children through the age of 6.
- Japan and Germany provide long-term care insurance to **help ensure access to caregiving** and related support systems for elderly residents
- In Sweden, local housing plans are required to **account for the housing needs of the elderly and residents with disabilities** located in the region

Sources: Bradley, 2016; Campbell, 2010; Sweden Institute, 2024

The U.S. spends more but has worse health outcomes than nearly all advanced nations.







Beyond this, our country loses an estimated **15%** of GDP annually due to poor health.

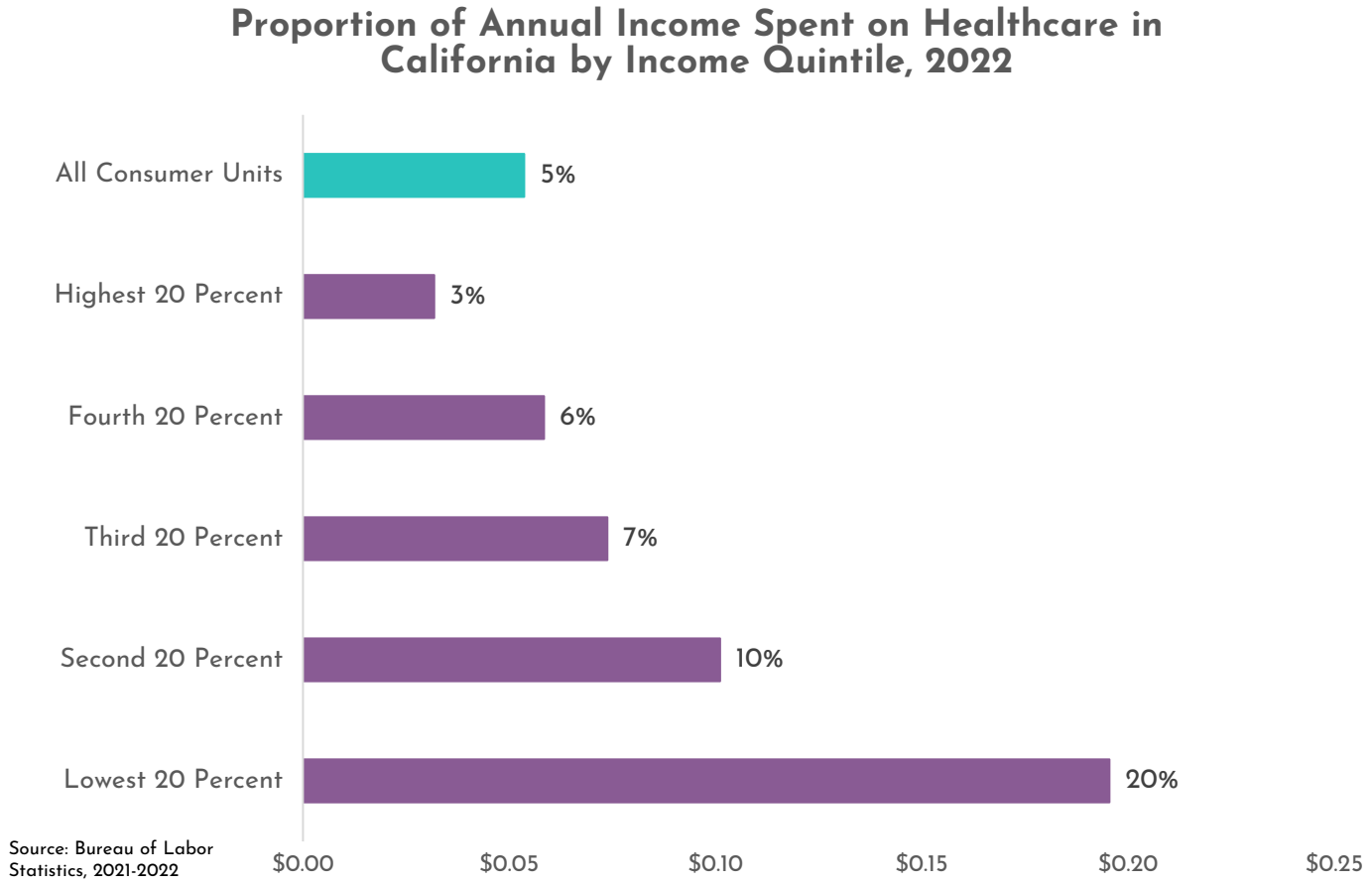
Sources: Harvard, 2020

Ineffective healthcare spending burdens our federal government and everyday residents....

Federal spending on health care services comprises nearly **30%** of total government expenses.

The average California resident spends approximately **$5,154** on health care needs per year, the majority of which are associated with personal hospital care expenses.

In 2022, California households in the lowest income quintile spent **over 20%** on healthcare as opposed to higher income households, who spent only **3%**.



Sources: Cubanski, 2023; CMMS, 2020; RAND, 2020; BLS, 2022

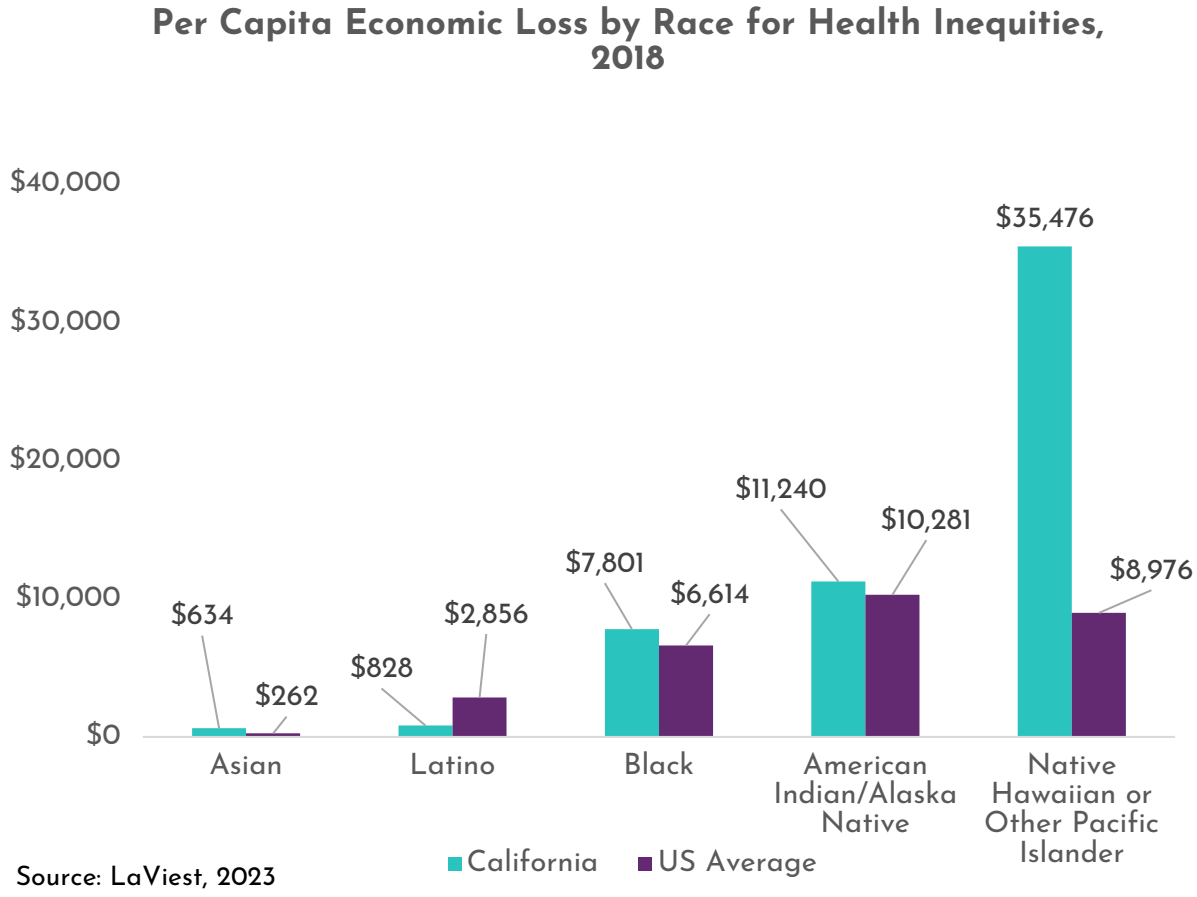
...This results in worse health and economic outcomes, and reinforces inequality

$320 billion

Estimated financial loss per year in US due to health disparities

This is projected to rise to $1 trillion dollars per year by 2040

This economic loss is also felt disproportionately, particularly by racial minority groups, as shown by **excess medical care costs, lost labor market productivity, and premature deaths**



Source: LaViest, 2023

Sources: LaViest, 2023

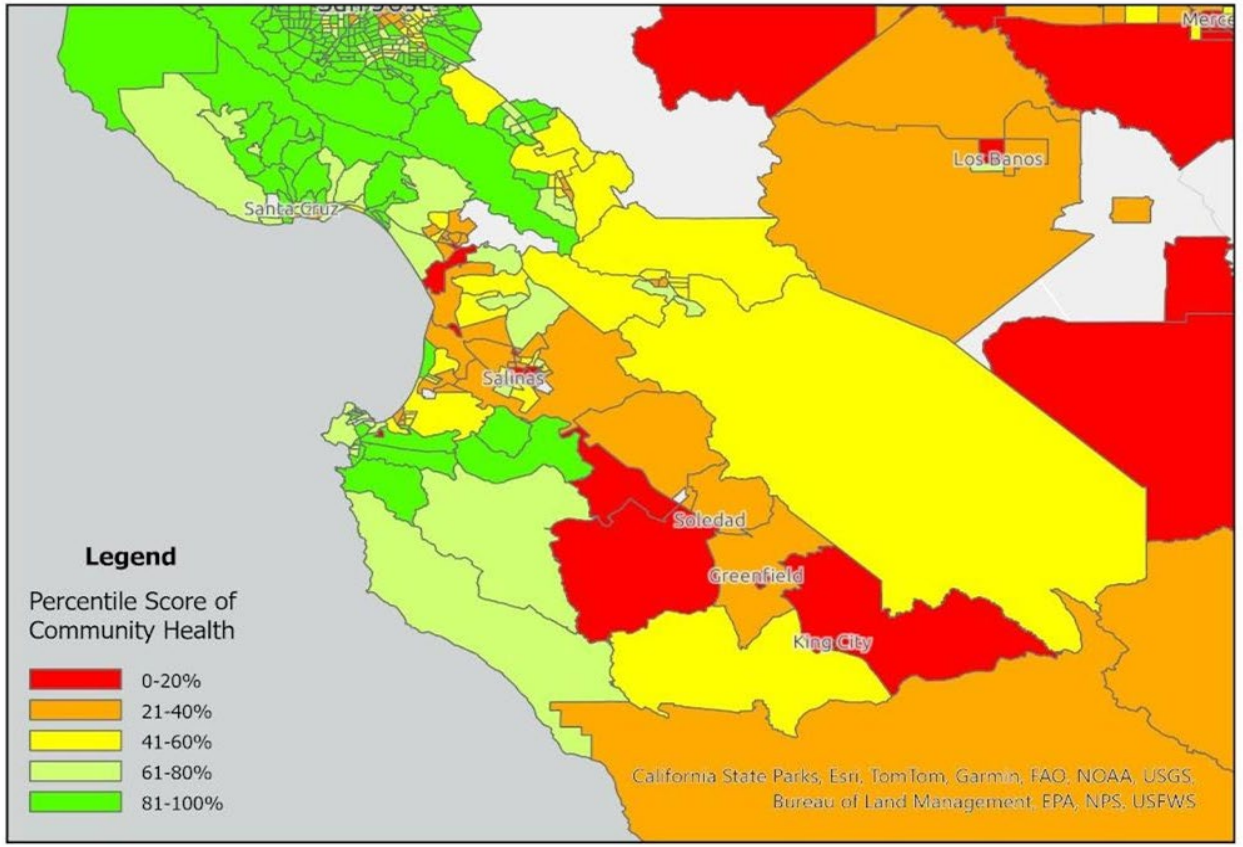
Health and economic disparities are closely related

The California Healthy Places Index 3.0 measures a healthy community across multiple dimensions such as economic stability, social safety, environmental health, and healthcare accessibility.

According to this index, our inland (predominantly Hispanic/Latino) communities across the Monterey Bay Area experienced less healthy community conditions compared to those which were coastal and predominantly Non-Hispanic White.

"The reality is that there remains serious disparities when it comes to the health and well being of certain communities, and the most disadvantaged communities carry the greater cost burden for our region."

- Dario Leon, UC Santa Cruz

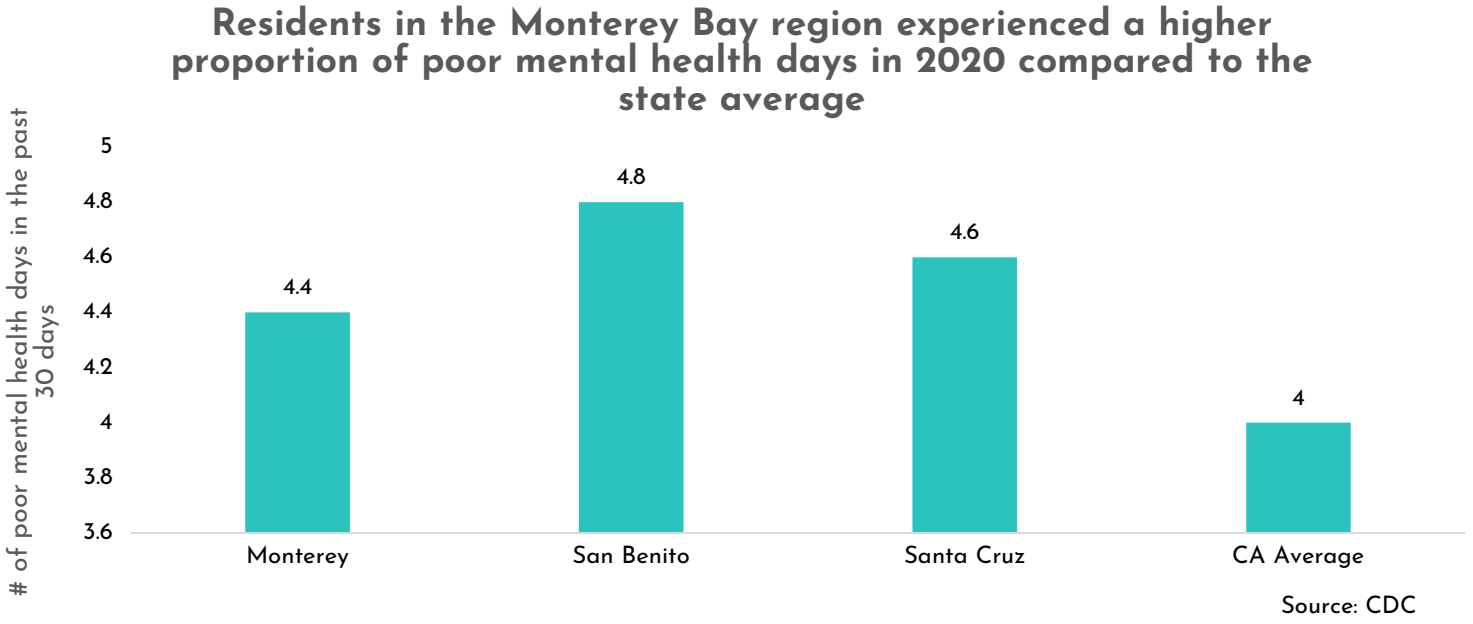


Sources: California Healthy Places Index, 2024

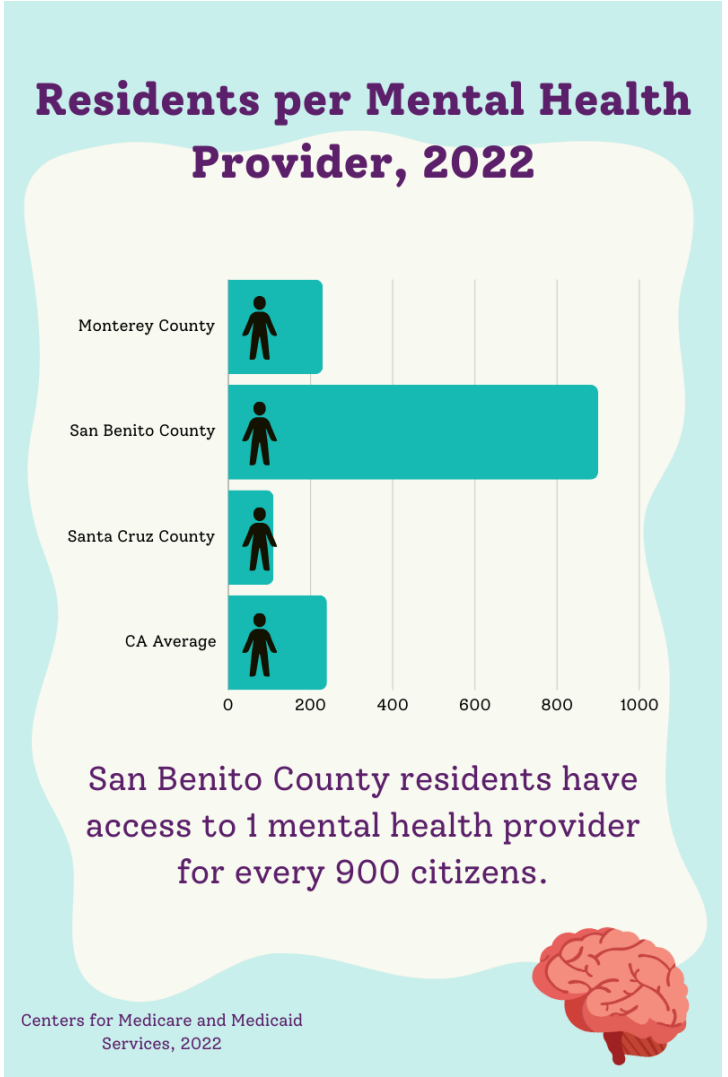
Health Inequalities: Mental Health

Our mental health has a tremendous impact on our ability to function in everyday activities. Unfortunately, our local population suffers from higher rates of poor mental health than the state average.

There is also a clear disparity in access to mental health care for those living in more rural areas.



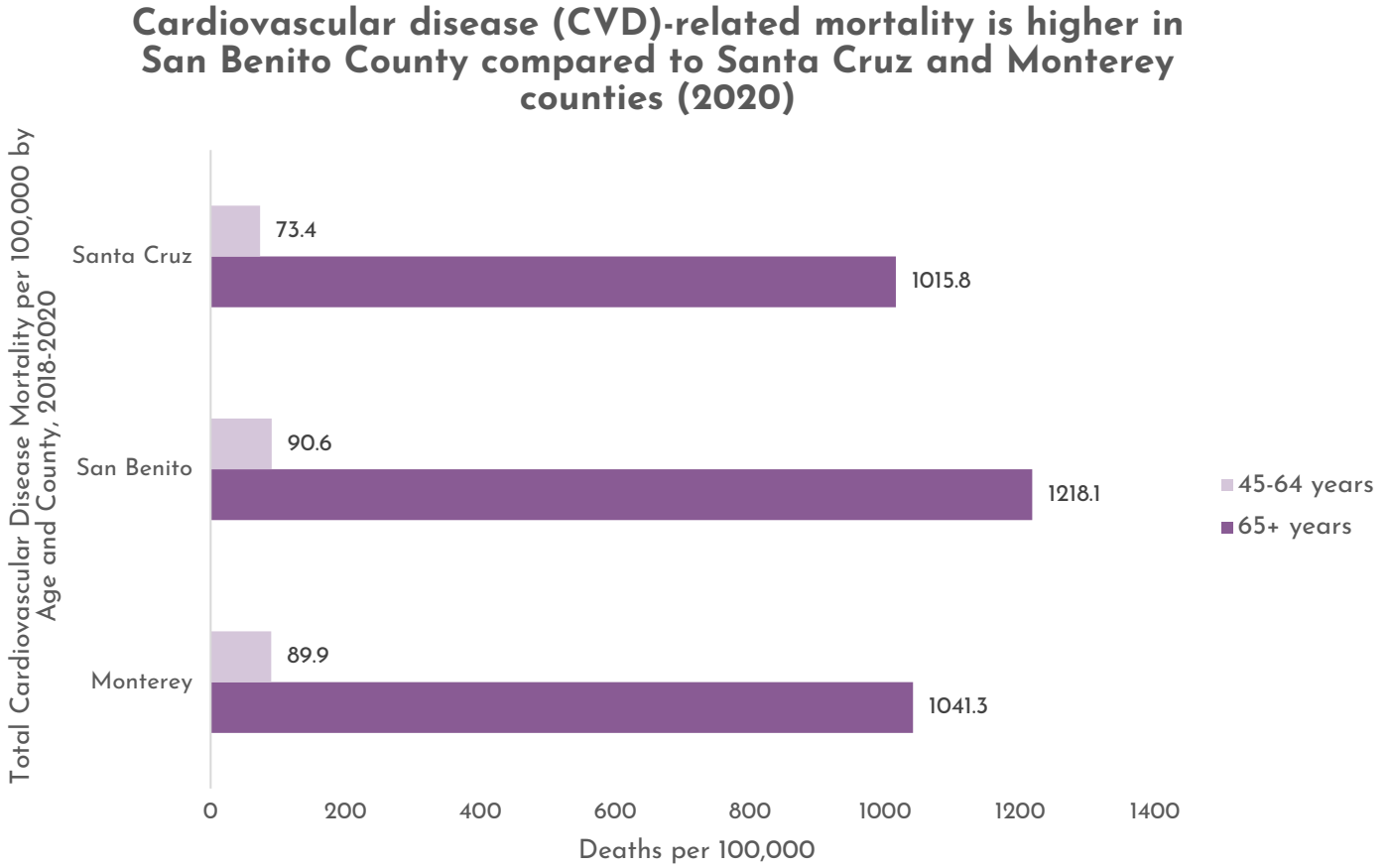
Source: CDC



Health Inequalities: Chronic Disease

Managing chronic illnesses such as diabetes, heart disease, or hypertension requires careful and constant attention to one's health. People suffering from high rates of chronic disease **are less productive** and **require higher health care utilization** than otherwise healthier populations.

San Benito County residents experience **higher rates of mortality** associated with cardiovascular disease than residents of neighboring Monterey and Santa Cruz counties. This may be attributed to lacking health care facility access in the more rural county, which makes it difficult for people to effectively manage chronic conditions.

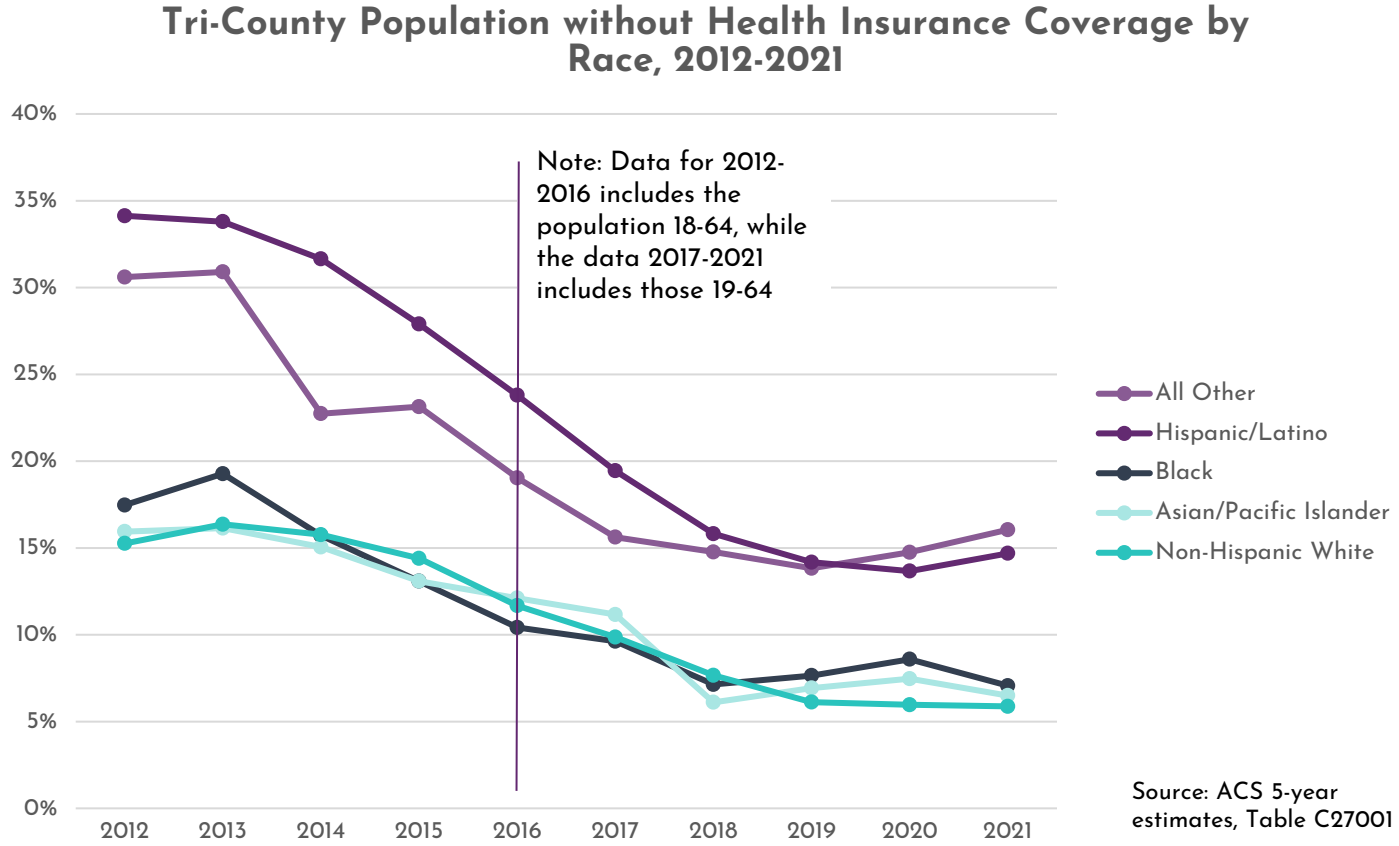


Sources: CDC 2020

Health Inequalities: Access to Healthcare Services

Nearly 10% of Monterey Bay Area residents are uninsured, which is higher than the shrinking state average. In 2021, **14.7%** of Latinos were living without health insurance compared to **5.9%** of Non-Hispanic White folks in the region.

For the approximately 82,855 undocumented residents living in our region, Medi-Cal programs only offer coverage for those ages 26 years and younger or 50 years and older, resulting in a major health care gap for undocumented residents between the ages of 27-49.



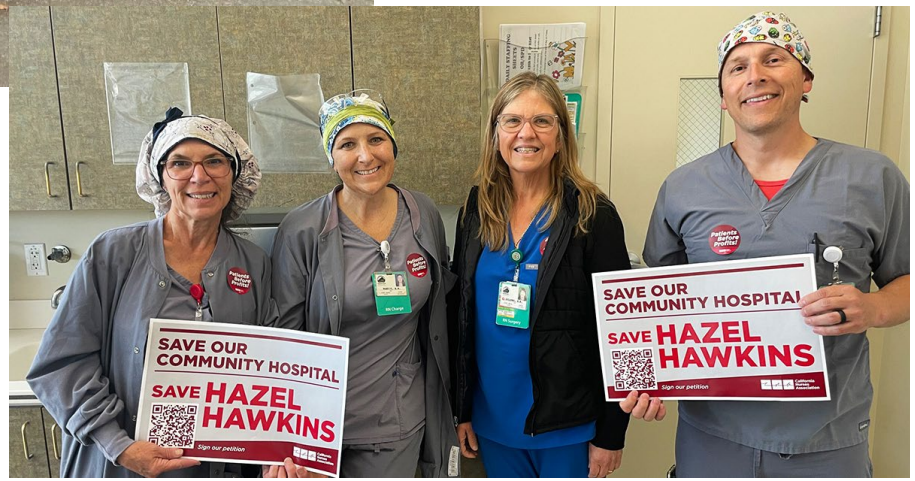
Sources: Covered CA, 2023; KION, 2022

Health Inequalities: Access to Healthcare Services

A number of health facilities in our region are under threat, and their loss could exacerbate health inequality.

Hazel Hawkins Memorial Hospital is the only emergency medical facility in San Benito County, servicing over 23,000 emergency room patients per year. Despite the high utilization of emergency services, the hospital declared a “financial emergency” in 2022 and the community has been in limbo as to whether or not the facility will be viable in the near future.

Watsonville Community Hospital filed for bankruptcy in 2021 and nearly closed as a result of alleged mismanagement. Fortunately, thanks to work by local organizations such as the Pajaro Valley Healthcare District Project and a grant acquisition by Senator John Laird, the hospital has been able to stay open.



Sources: Lookout Santa Cruz, 2023; BenitoLink, 2023; SB 418, 2022

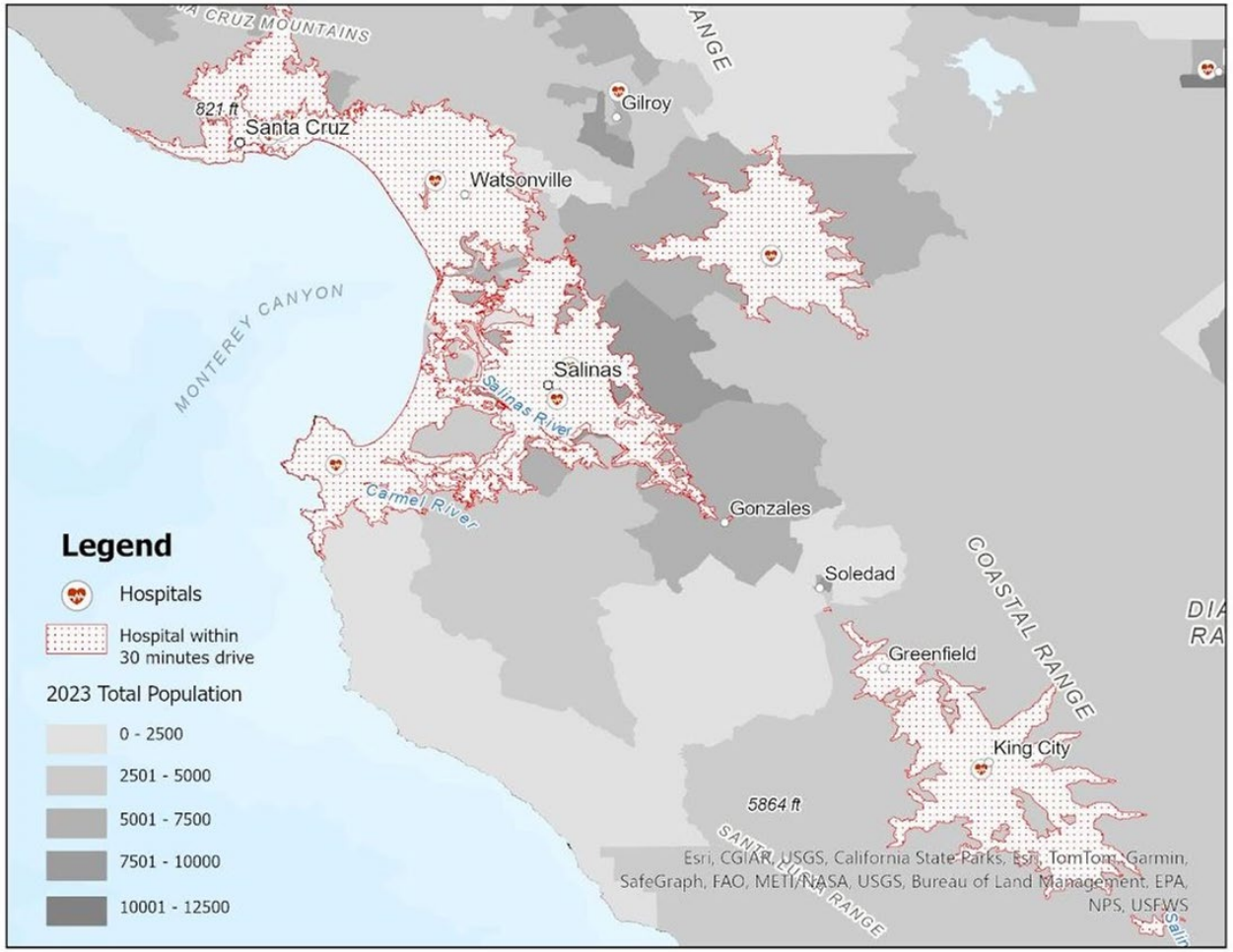
Health Inequalities: Access to Healthcare Services

The loss of our at-risk regional hospitals would **put tens of thousands of residents at risk.**

This map displays proximity to our regional hospitals within a 30-minute drive. Even with our current infrastructure, there is a major coverage gap for those living in Soledad and just outside of Gonzales. Without Hazel Hawkins, the entirety of the San Benito County population would not have a hospital within 30 minutes of them, leaving them vulnerable in times of health emergency.

"My mom recently came to visit me all the way from Pakistan and her trip was cut short because she ran out of her medicine she brought with her. The wait for a doctor's visit would have simply been too long and her medicines would have cost around $1000, so my mom decided to just return home and repurchase her medicine from her own country."

- Mahnoor Abbasi, Monterey County resident

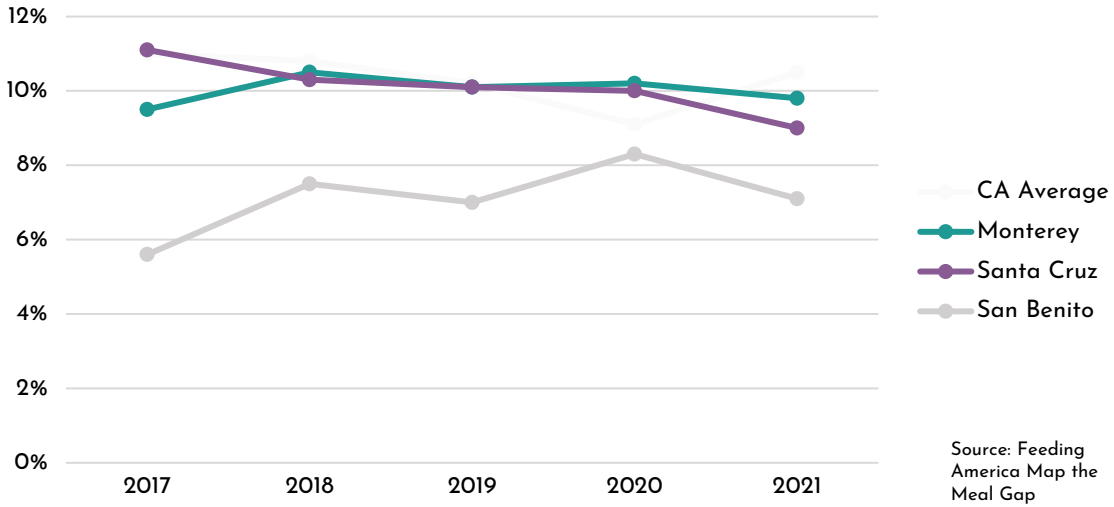


Sources: TravelTime, 2024

Health Inequalities: Food Insecurity

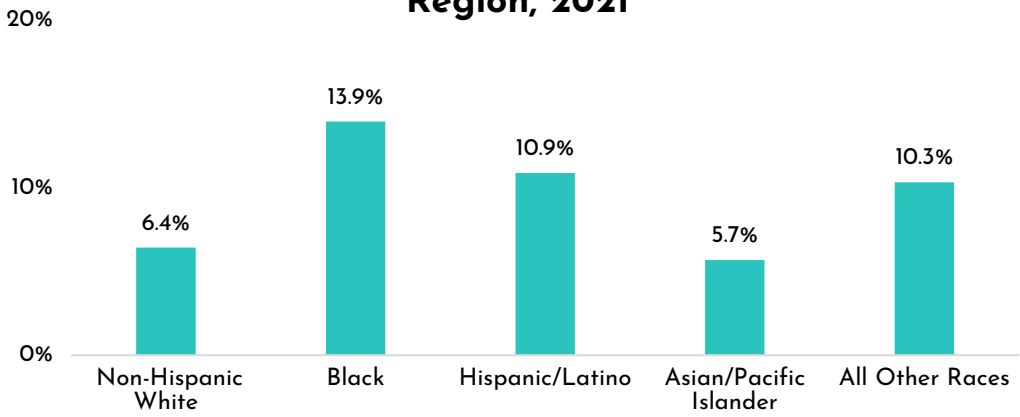
The population in rural south Monterey County are more likely to live further away from grocery markets and other fresh food sources, leaving them susceptible to higher rates of food insecurity than neighboring counties. In fact, Monterey County households spend on average over **13%** of their monthly income on food expenses alone, and **10%** of households are food secure.

Proportion of Food Insecure Households by County, 2017-2021



Source: Feeding America Map the Meal Gap

Receipt of Food Stamps/SNAP in the Past 12 Months by Race of Householder in Tri-County Region, 2021



Source: ACS 5-year estimates, Table B22005

While assistance is available, utilization is still disparate. Black and Latino residents utilize food assistance programs at **nearly double the rate** than their non-BIPOC neighbors.

Sources: Economic Policy Institute, 2021; United Way 2023

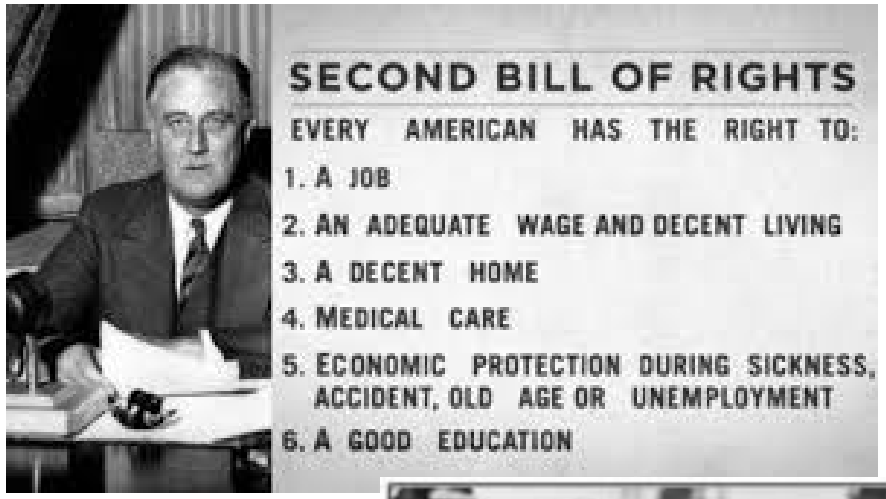
Our poor health outcomes are not an accident, but the result of decades of underinvestment and distorted priorities.

The History

Federal public healthcare in the United States first arose in the late 1700's in response to rapid industrialization of the Northeast. The prevailing view of early public healthcare aligned with the founding ideologies of **decreased government intervention and individual liberties.** Therefore, it was expected that the government would not be relied upon to provide solutions to the collective health concerns unless they were particularly dire, and that each individual was responsible for their own well-being.

Sources: Rosenkrantz, 1973

Why don't we spend more on public health?



President Franklin D. Roosevelt originally wanted to include universal health insurance as a basic right, but ultimately decided not to include it in the 1935 Social Security Bill. Roosevelt's decision was believed to be influenced by strong opposition from the American Medical Association, who threatened to sink the entire bill if universal health care was included. In its place, **the private health insurance market was developed** to offer the for-cost health care system we are familiar with.

The individualized health insurance system was reinforced in 1942, when new legislation resulting from World War 2 inflation mediation efforts reduced the ability of employers to increase wages. In consequence, certain employers chose to bolster benefits packages which included the provision of employer-sponsored health insurance coverage.

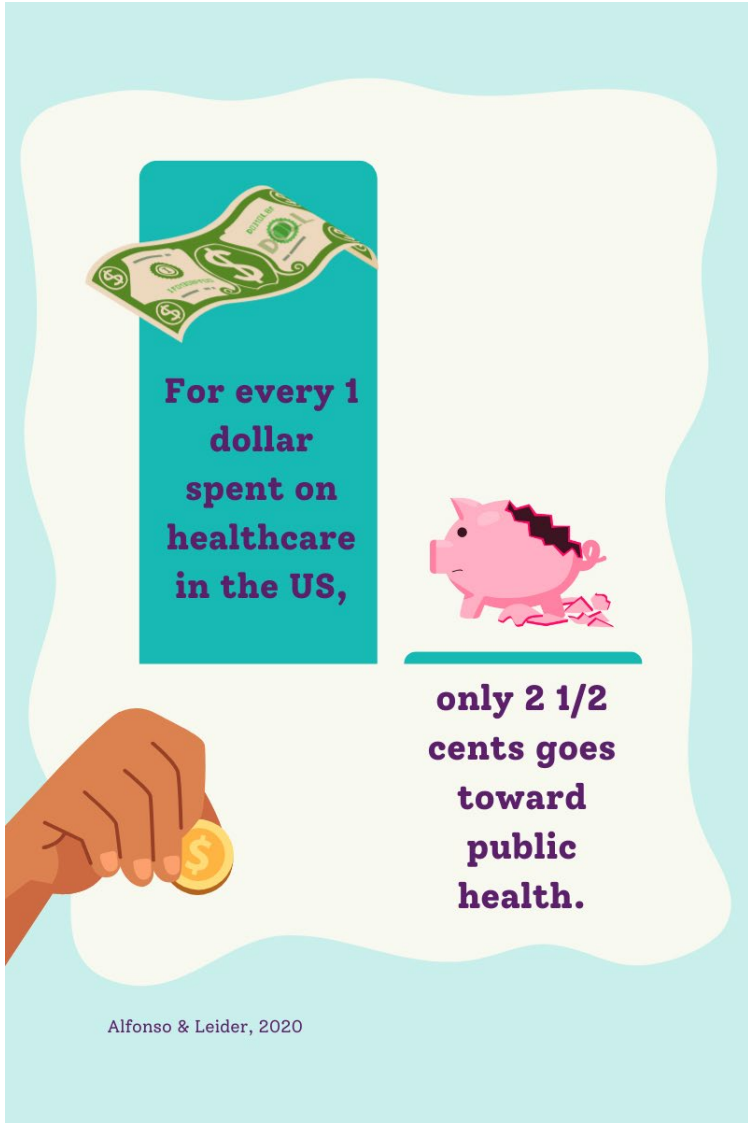
This also drives disparity between those who can access jobs with health care benefits and those who cannot.

Sources: Blumenthal, 2006

Why do we spend so little on public health?

Our nation's **individualistic approach** to health care continues to drive the private insurance market. Opponents of expanding public health measures argue that federal health care programs such as Social Security and Medicaid/Medicare should suffice to fill the healthcare gap for those that are most impoverished. As a result, the federal government has assumed fewer responsibilities for the provision of universal health care, in addition to other programs that can supplement the general populations' health.

Therefore, when major public health crises arise, such as the COVID-19 Pandemic, our weak public health system is slow to respond, leaving the population at **higher risk** than countries which have better-funded and more coordinated public health systems.



Source: Alfonso & Leider, 2020

MUTUALITY

HOW IS OUR REGION CONNECTED?

Solidarity Economics

Why don't we spend more money on preventive healthcare?

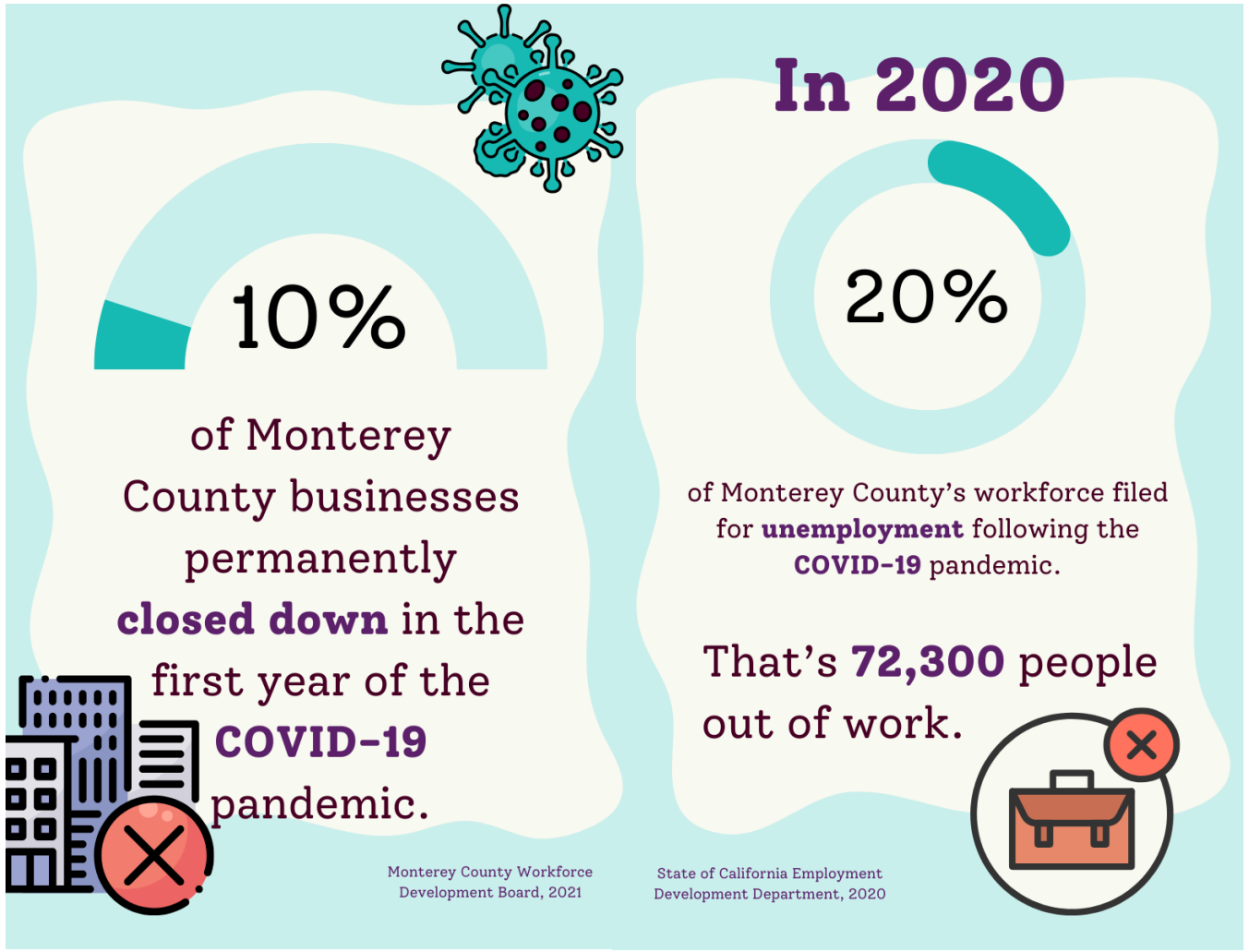
Preventive health care, such as regular check-ups, access to fresh and nutritious food, and routine screening for chronic diseases, is considered a luxury rather than a right guaranteed by our government. Therefore, these preventive measures are left to the choice of the consumers and left within the private market makes preventive care costly and unequally distributed. Yet, by viewing preventive care as expensive and assuming that acute care is only for "emergencies", **unhealthy populations end up spending more** on repetitive acute care visits, and ultimately, more on health care.

Our public health system and our economy are interdependent

The COVID-19 Pandemic highlighted how heavily we all depend on a healthy essential workforce for economic stability. However, the effects of the pandemic disproportionately impacted low-income, rural and minority populations.

In 2020, nearly **half of Monterey County farmworkers** reported income losses due to decreased work time during the pandemic. Hispanic/Latino residents in the county, who comprise the largest proportion of employees in the hospitality industry, also bore the brunt of COVID-19-related layoffs.

In 2023, Latinos comprised the largest proportion **(over 48%)** of COVID-19-related deaths for the population ages 50-79 in California, despite making up less than a third of the general population for that same age group.

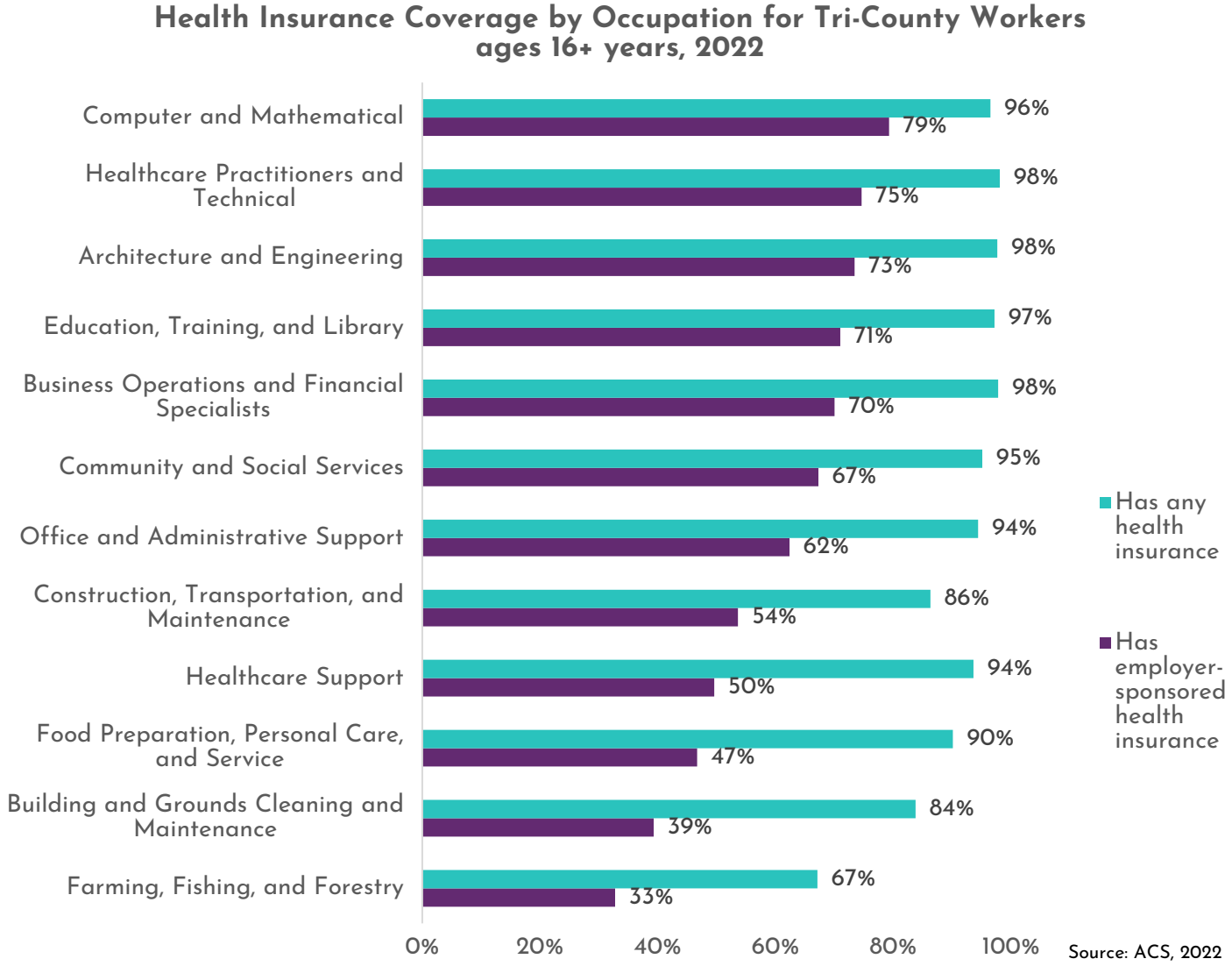


Sources: ACS, 2021; CDPH, 2023

Work and health are closely interrelated

Construction, food service, and farming-related occupations are primarily held by Hispanic-Latino residents, specifically undocumented farm laborers, and have higher rates of workplace injury compared to other professional occupations. These same industries expose workers to environmental pollution via pesticides, fertilizers, and machine gas emissions. Farmworkers in the Salinas Valley have reported harmful health outcomes related to repeated pesticide exposure. This includes negative health impacts on pregnant workers' children such as **childhood asthma, cognitive delays, and low birthweight.**

Low-paying jobs in our region often do not provide health care benefits, which drives disparity in health care access. Specifically, facilities maintenance and farming-related occupations ranked the lowest in employee-sponsored health insurance provision for our region in 2022.

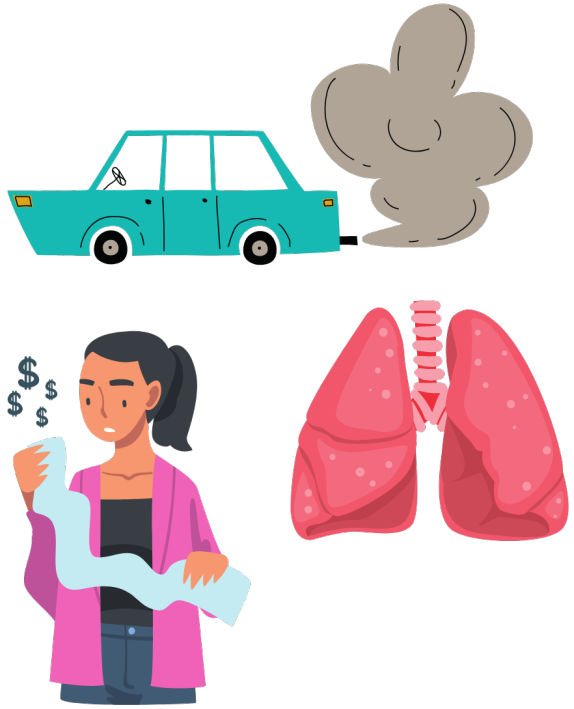


Sources: ACS, 2022; Kezios et al, 2023

The way our economy is organized also contributes to poorer health

Economic inequalities impact the health of low-income residents in countless forms:

- Inaccessible and unaffordable housing exposes families to **environmental hazards** associated with poorer quality housing conditions and contributes to **higher commuting rates**
- Excessive rates of commuting in and out of the region contributes to **worsened air quality** and **poorer health for commuters**
- This poor air quality impacts all residents through **increased rates of respiratory and cardiovascular injury**
- High levels of poverty contributes to food insecurity and **increased rates of malnutrition**
- Conversely, living in a food desert (over one mile from a grocery store) leaves families without fresh food choices and contributes to **higher risk of obesity**



Sources: NRDC, 2021; UCB CERCH, 2021; Lopez-Espinosa et al, 2011

When we invest in public health equity, both our health and economy improve.

Investing into the public health system can promote economic advancement. A study of California county public health departments found that every $1 invested in public health operations over an 8-year period, resulted in a return-on-investment of between $67.07 to $88.21. The return on investment was calculated from the economic benefits of decreased mortality and improved health status.

"Public health is an excellent investment opportunity and great improvements in health are likely if these investments occur."

– Brown, 2016

Sources: Brown, 2016

MOVEMENTS

WHO IS CURRENTLY FIGHTING TO BRING MUTUAL PROSPERITY TO OUR REGION?

Solidarity Economics

Shifting the status quo

After identifying how we can improve our mutual prosperity through expanded public health, we can then aim to shift power by supporting regional organizations already working to change the status quo.

Shifting the status quo will require a change in who has power in our health system policies and decision-making processes. We need greater investment of funds and more collaborative work to strengthen our regional work on public health into a movement. Here are the core philosophies shared by our regional change-makers:

- Building strong connections between different constituencies (i.e. urban planners, city government, neighborhood groups, school boards)
- Acknowledging the racial dimensions of health
- Advocating for increased access to healthcare and medical facilities, and increased investment in public health
- Mobilizing community members to build trust between patients and providers

Shifting the status quo

One example of a powerful effort to support improved health in our region is the VIDA (Virus Integrated Distribution of Aid) Project. In response to the rampant impact of the COVID-19 Pandemic, the Community Foundation of Monterey County, in partnership with over 10 local organizations, hired and trained over 100 community health workers to advocate for COVID-19 protection measures across the county. The program filled several gaps in care and community support beyond simply addressing the medical needs of those in need. Community health workers connected low-income and/or migrant workers with COVID-19 vaccinations and testing, as well as helping workers advocate for wage loss compensation or housing assistance.

This robust and community-led approach to public health services serves as an excellent model for how other community organizers can collaborate to support efforts to expand and improve the health of our regional population.

Sources: CFMC, 2024

Shifting the status quo

Who is currently shifting the status quo?

Monterey County Health Needs Collaborative (link)
- Group of regional hospitals and health facilities dedicated to improving the health of the Monterey County community

Center for Community Advocacy (CCA)
- Home of the Strong Families Program for preventing domestic violence and abusive behaviors within family units (link)
- Operates Promotoras Program to support health of local farmworker (link)

Mujeres en Acción (link)
- Active members and supporters of the VIDA Project through the COVID-19 pandemic
- Also provided mobile health services for COVID-19 testing and vaccinations through their Mobile Van Clinic Program

Building Healthy Communities (BHC) (link)
- Working to increase Medi-Cal enrollment across region
- Supports the continued work of the VIDA Project through community health worker training

CHISPA
- Collaborates with the food bank of Monterey County to connect residents with hunger relief programs (link)
- Provides housing and shelter opportunities

Monterey County Health Department "Health in All Policies" (link)
- Collaborative effort to improve population health by prioritizing health-informed decision making in all sectors and policy areas

ACTIONS

WHAT KEY STEPS SHOULD WE TAKE TO ENSURE A MORE PROSPEROUS FUTURE?

Solidarity Economics

SOLUTIONS

NORTH STAR

Promoting healthy communities and health for all. Achieving this will require reorienting towards promoting health, rather than just treating illness..

Ensure universal access to health insurance and services	**Action Steps:** Address the accessibility, availability, acceptability, and quality of health care services, especially for marginalized communities
Support healthy neighborhoods and communities	**Action Steps:** Modify aspects of our natural and urban environments in order to promote the health of local residents
Address social & financial determinants of health	**Action Steps:** Alter our financial and social systems needed in order to improve the health of local residents

Solutions: Build Out Robust Health Insurance and Services

Our regional healthcare system should ensure*:

Accessibility

Non-discriminatory economic and physical access for all through expanded health insurance coverage

Availability

Functioning healthcare services throughout all parts of our region, especially in more rural areas

Acceptability

Culturally appropriate healthcare services, sensitive to age, language, and location

Quality

Services meet good standards of healthcare, medically appropriate as well as a holistic approach to personal well-being

*These tenants are based on the **Right to the Highest Standard of Health** as outlined by the International Covenant on Economic, Social, and Cultural Rights (United Nations, 1966)

Solutions: Support Healthy Communities

Potential Action Steps:

Increase access to parks and recreation areas

Shorten or eliminate long commutes to work

Improves cardiovascular health and air quality

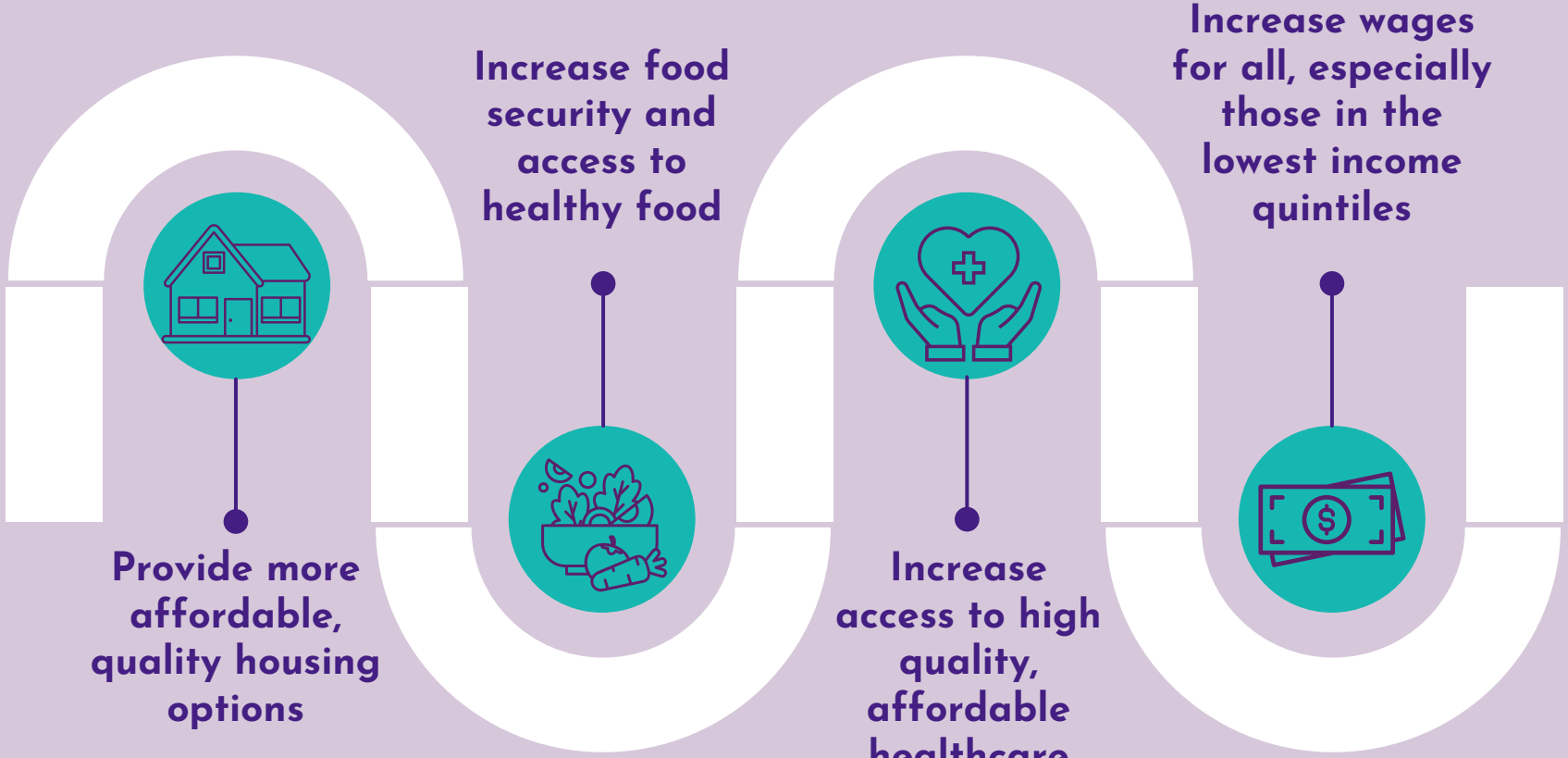
Repaved sidewalks & more streetlights

Increase walkability of neighborhoods

Clear and safe pedestrian walkways and bike lanes

Solutions: Address Social and Financial Determinants

Potential Action Steps:



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