The Health Equity Variant
Whose Law Is It Anyway?
Podcast 4 Transcription

Matthew Martinez Hannon: Welcome back to Whose Law Is It Anyway?, an American Bar Foundation podcast. Today, in our fourth episode, we'll discuss the COVID-19 pandemic, international health law, and health equity.

At this point, we all know the COVID-19 story because we're experiencing it in real-time together. Just a few months ago, many of us were starting to take advantage of the distribution of effective vaccines. We were so excited about returning to the "old normal…" seeing friends and family, coming back together, celebrating the end of the shutdowns and quarantines. But as recent weeks (and the delta variant) have shown us, we're not through this yet. Instead, we're continuing to watch this unprecedented global emergency overwhelm healthcare systems, shape economies, and change lives.

There's another critical element to all of this: health equity. While the pandemic effects have been global, it has been particularly devastating to vulnerable and marginalized communities. According to the Centers for Disease Control, some social determinants of health have historically prevented racial and ethnic minority groups from having fair opportunities for physical, emotional, and economic health. These major inequities -- such as discrimination, healthcare access and use, occupation, education, income and wealth gaps, and housing -- put racial and ethnic groups at increased risk of getting sick and dying from COVID-19.

So, how did COVID impact international health governance and health equity around the world? Was the vaccine rolled out equitably? And, looking beyond COVID, how can we reduce health disparities in the U.S. and around the world?

First up, Carol Heimer, ABF Research Professor and Northwestern University Professor of Sociology, will join me to discuss how international health law confronts and contends with public health issues. Pandemics raise unique questions, and she'll walk us through how the law mitigates these public health threats and how legal tools can be enhanced to protect public health in the face of pandemics. Stay tuned after that interview as I speak with Miguel Alexander Pozo and Reuben Moore, executive leaders for Minnesota Community Care. While Carol is giving us a look at international public health equity, Miguel and Reuben will chat with me about what COVID-19 and health equity have looked like on the ground in the United States.

And now, let's get on with the interviews.

Matthew Martinez Hannon: Hi Carol, thanks for being here today. As only you can, can you describe your path to scholarship?

Carol Heimer: Well, I grew up in Congo and it's not totally irrelevant to some of the things that I'll talk about because I have more of an understanding of what it's like to live in a very poor country than lots of people would. I went to college at Reed college and then to graduate school at the university of

Chicago. I have never taught a class that I think I ever took myself either as an undergraduate, certainly not as a graduate student. And I said, I guess that says something about the kind of weird trajectory that I followed. But once I started, uh, several, several years into my career, I'd been writing stuff about insurance, actually. And then I was thinking about what I wanted to do as my next project. And I started thinking about the relationship between the stuff that I had been studying, which was really about shirking and insurance and how it related to issues about trust and the rest of social life.

And I decided, I wanted to think more deeply about a different point on the continuum. And that was situations where it wasn't a question of whether people were shirking or not, but about whether they were going to take responsibility for something. And so I ended up studying families who had had babies at infinite intensive care units and how they came to divide the responsibilities between one or more parents and the grandparents and so forth and how they tried to induce a high level of responsibility and the staff members and the staff members in turn tried to induce a high level of responsibility on them. And then after I studied that well, while I was studying those two infant intensive care units that I did research, and I noticed that they had all of these books with regulations and rules sitting around the infinite intensive care units, and the residents were supposed to be reading them all the time.

Yes, well, they were, but it was much more than they could keep up on. Um, and I thought, well, this is really interesting, you know, so what's going on here with all of this production of rules and guidelines. And, you know, on some of the times these things were hooked a formal line and some of the times they weren't. And, um, and so I decided, okay, this is what I want to study next. And then I started thinking about what's a good place to study it and decided that HIV was really the right disease to study this kind of legal phenomenon. And because it came onto the radar screen of health care around the same time as medicine was becoming, as I say, legalized that is that people were starting to work very much, uh, with an orientation to what the rules and guidelines and actual laws were, but it was also a good place to study the legalization of medicine because it's such a global disease.

And a lot of the rules that people working with are transported from one place to another. And so, you know, and a lot of times I was transported from the us to other parts of the world because the rules follow the money, but people have to use the accounting rules. And if they're involved in clinical trials, they have to use the protocols that are developed in the United States and follow our rules about IRB and so forth. And there's not all that much attention given to the vast resources that are required to comply with all these rules and the dissonance between the rules and other local, um, cultures and even medical cultures. And so I ended up doing research into HIV clinics in the U S one was a clinic that had largely insured patients. And one was a clinic that had largely indigent patients and then three clinics outside the U S one in Uganda, one in South Africa and one in Thailand.

And these were three good places to be studying HIV and HIV clinics because of their different relations to the medical global medical world. I mean, the U S has great pharmaceutical companies and so forth, but let me just say, Uganda does not mean they can maybe produce aspirin. And also the governments were had different relations to HIV. So, you know, South Africa was basically in denial for a lot of years about the disease Uganda was onboard for acknowledging it and dealing with, and it bringing in as many outside resources as possible to deal with it. But also there were differences in who the disease was, did affect and was thought to affect. So, you know, in the U S it's never really been a generalized pandemic, but it has been a generalized pandemic and other parts of the world. And so that led to a kind of

different orientation about how to control it. Um, so that's how I got to thinking a lot about, uh, pandemics and global governance of medicine and so forth.

Matthew Martinez Hannon: That's incredible. So in regards to global health law, how did global health law begin? How has it evolved? What does it look like now? I know that you said, you know, the rules sort of follow the money, but was the U S always sort of the leader in this, or did it take the position because of the power as a nation to sort of spread these laws throughout the world? How did that happen?

Carol Heimer: Well, first of all, anything global is, sad to say, is kind of incoherent in a lot of ways. I mean, so that, there's really only one thing in global health that reaches the level of treaties and that's the international health regulations. Um, and those have been around for a long time. The first sanitary conventions were held, and I think it was 1851 or something like that. And, you know, these were around things like cholera and stuff like that. So, you know, no that U S wasn't dominating, I, and a lot of global health was actually colonial health, right. And so, and it wasn't oriented. Let's figure out how to take care of the world's people. It was instead, let's figure out how to protect the colonial administrators who are often Uganda. That's a pretty good example or Congo, and, you know, what, what we need to do to protect.

And in so far as the international health regulations were worrying about the whole world, they were really worrying about the diseases that might move from poor countries to rich countries. And they were very focused on the balance between trade and shutting down epidemics. And so what's really astonishing about this, that lots of people don't realize is that the international health regulations until the 2005 revisions had only three diseases that we're required to report on. And that was cholera and yellow fever and plague. I'm not sure where that got those three, right. But anyway, three, and there were maybe three others that, you know, weren't quite at the same level, but, you know, there's so many more infectious diseases and there's global health problems that aren't infectious diseases, but none of those things were covered by the international health regulations.

Matthew Martinez Hannon: You said in that happened in 2005, that they expanded that.

Carol Heimer: So it was in 2005 that they expanded that. And in some senses, it was partly in response to SARS because SARS which occurred in a previous, one of the previous pandemics occurred in 2002, 2003. And, you know, there were only about 8,000 cases and, you know, some less than 800 deaths in it, but nevertheless, it was a terrifying event. And one of the things that really became obvious during that period was that the, the requirements for reporting were really, really an adequate. So there was this sort of interesting phenomenon that there was a lot of information floating around, but it wasn't information that the world health organization, which is the, you know, the dominant player in all of this, in the global part of it, they weren't able to act on it because of the rule said that you could only act on official reports before that time.

There had been the development of a whole lot of ways of collecting information informally through email based communications, among physicians and other kinds of health workers around the world promoed mail and then chief, and which is a web scraping tool that looked for interests, you know, hints of health problems around the world. So there was a lot of information that Mount SARS having started in China in November of 2002, and going into early 2003 long before there was any official report, it, it was four months before there was any official report. And so, you know, as they were revising the international health regulations, um, they were seeing this, uh, really unfortunate example of the failures of the system. But then, you know, it was sort of weird because the norms have changed. So everybody was mad at China for sealing information, but, you know, China was not doing anything that was really counter to the international health regulations because they require reporting on something like that.

It wasn't cholera, wasn't play wasn't yellow fever, but another difficulty with all of this is that there's a lot of times not harmony between the international health regulations and domestic regulations. And so in China, it was illegal for the local health authorities to be talking about what they have seen. They were prohibited from doing it draconian punishments, if they said anything, um, at the same time that there was pressure not to be letting out information. And so one of the other changes in the nutria and international health regulations has been providing tools and resources to help bring domestic law and to conformity into harmony with, uh, the international health regulations.

Matthew Martinez Hannon: And so currently who were, who were the, like, would you identify as the important players and what is their role in promoting and coordinating international cooperation?

Carol Heimer: Well, I mean, so obviously the world health organization is the big one, but it works also lot of entities. Like the CDC mean the CDC is a very big player in all of this. Um, and you know, then I mean that the world health organization is a very large organization. And so there's many sub-parts of it. You know, there's things that have to do with essential medicines. There are things that have to do with tracking of disease. There's things that have to do with harmonization of rules mean what they don't really have is very many, um, there's no sticks to be applied here, really. So there's no, you know, if you violate the rules, there's not a lot that the world health, uh, community can do to you over conformity. And that's true with most areas of global law. So it's not unique to medicine, but you know, the other big players are the big pharmaceutical companies, but, you know, they're by no means under the control of entities, like the world health organization or any government, and then there's a big fat pill anthropic organizations. Um, there's also the FDA and the European medicines council and, you know, and entities that resemble the FDA and other parts of the world. Um, and then there are some big international organizations that are deeply involved in healthcare, like, uh, med Sasol fault. Yeah. And social movements are more disease, specific kinds of social movements.

Matthew Martinez Hannon: In your opinion, how prepared were we as a global community to confront the COVID-19 pandemic?

Carol Heimer: Pretty badly prepared. Um, and, you know, the U S was worse prepared than other places. And it's, uh, it's really a horrible indictment of the United States, how badly, badly, badly we did

on this. Um, we would have been prepared better before the Trump era, because, you know, there were stockpiles of appropriate equipment and supplies, but those were not maintained. Um, the coordination, the federal government and the state government has been horrible. I mean, in some senses, this is a fractal system, right. And so just as you see, lack of harmony between things like the international health regulations and, uh, the regulations of individual countries, there was also a lack of harmony between federal regulations and, and some state level regulations or provincial regulations and various countries. So the coordination mechanisms have been pretty bad. Um, and then just, there were a lot of mistakes made along the way. Some of them are really quite unfathomable.

And then of course, there's also the problems of the just very deep, shocking inequalities around the world and the selfishness of rich countries. And, you know, the selfishness of rich countries occurs all the way through the system. So, you know, if you think about, okay, if you think about something like an entity, like the gates foundation, people say, oh, that's wonderful. The gates foundation is going to give money for all of these, all of these global initiatives. And yet, you know, a lot disproportionate share of the money actually gets spent in Seattle. Um, not the place that we need it the most. And the gates foundation doesn't really have its finger on the pulse of the world and thinking through what are the most important things to be paying attention to and how to allocate funds. And so I think one of the issues is that, you know, we need better mechanisms for allocating class, but we also need rich countries to step up and provide support for the things that it's actually in their interest to do.

So, one of the things under the international health regulations revision is that other rich countries are supposed to be helping to set up things like laboratory facilities and reporting facilities and testing facilities. And in poor countries, you know, that hasn't a task that has not by any means been completed, but as these things unfold, I mean, rich countries keep throwing in new things that continue to advantage them. And so, as you know, samples get collected around the world, they get collected and, and used for the development of vaccines in a way that favors the pharmaceutical companies are rich countries. And so every once in a while, a country will withdraw from three agreement to supply samples like Indonesia did. But that also when, you know, when a disease is produced, what's the first thing we do. We buy up huge supplies of the vaccine for the U S and, you know, sort of leave the rest of the world to fend for itself, even in a time of shortage. And in a time when, I mean, if there's ever been a virus that has shown the interdependence of the world, it's this one, because it's been hard to confine it hasn't been confinable and the production new variants around the world shows so clearly that we actually need to pay attention to getting the whole world vaccinated that you would think we would do a little better than giving away 25 million doses. Right.

Matthew Martinez Hannon: Right now, you know, and again, because I will claim my ignorance about a lot of this, cause, you know, re reading news articles, watching, you know, what's on CNN and whatnot. There seems to be like some lack of information, which I think you've touched on a little bit or, um, but countries like, and I'm going off script here, but countries like, you know, New Zealand and Australia that seemed to have managed it in a way where they were able to confine it, what were they doing differently that you noticed?

Carol Heimer: Well, so part of it is that you have to deal with something like this early. I mean, the way that if you look at the graphs of the growth in cases, I mean, I was like, they multiply very quickly. That's a very sharp, upward slope. And so if you can start controlling disease before it starts to spread, then you have a much better chance of shutting it down. Both of them of course have the huge advantage that they're islands. You can close the borders much more easily. Um, you know, Australian colleagues, lots of times complain about the distance between Australia and other places, but in this case that's been an advantage. Uh, but they have also, you know, they've done, they've done a lockdown that has been very harsh. I talked to somebody in Australia the other day, and they were saying that, you know, there were 26 cases.

And so now they've gone down to lockdown again. Right. And so, you know, the country's orientation, the government's orientation is we're not going to let this spread as soon as there's any cases that are detected, we're shutting you all back in and you know how that would work in the United States. So some of this is about isolation. Some of it is about culture. And some of it is about the relationship between state and federal governments and, you know, the diversity of opinion in places like the United States. But we're just like, honestly, we're not a very compliant country. I think that's part of the problem. And we have deep distrust of science and medicine these days, even though those have been professions that have been more trusted for a long time.

Matthew Martinez Hannon: You mentioned earlier, you know, the global health laws, don't always line up with specific domestic laws and regulations in certain countries. And so when we have a pandemic or like the same public health event, that's impacting countries, it will impact them in different ways. Like you said, because of the relationship that the citizens have to their government.

Carol Heimer: Yes, yes. That's one of the things for sure.

Matthew Martinez Hannon: Are there other things?

Carol Heimer: Well, I mean, you know, it's like, it's a bit of a mystery actually, why it is that the pattern of, of the distribution of cases of COVID has been what it is around the world, because generally, you know, when you have, you know, awful diseases, they tend to occur with a higher frequency in poor countries than enrich countries. Right. This one isn't. So, you know, it's like, if you look at the maps of COVID cases around the world, do you know, you keep sitting there saying to yourself, wait, why is it that in central Africa, they haven't been hit by this. I mean, if you, if you can compare it to a map of HIV with a map of COVID, they're stunningly different. And so you wonder why that's the case, because you know, a lot of what goes on and, and, and public health is not about medicine.

It's about, you know, sanitation and nutrition and, you know, having access to clean water and decent places to live and so forth. But in this case, part of it is apparently that, you know, since this is not a waterborne disease, like say cholera, whether you have access to clean water, isn't that big a deal here. What matters is whether, you know, you have enough air blowing through to keep the virus rates and viral levels in the air. People are breathing in relatively low. But the other thing is that age distributions matter a great deal for this particular disease, because it hits older people much, much harder than it

hits younger people and wonderful between poor countries and rich countries, rich countries have a much higher proportion of older people than poorer countries do. And so of course we have higher infection rates and higher death rates.

And then also there's issues about how we deal with particular things like congregate populations. And, you know, the fact that we in prison, a lot of people in the United States means that we've had a lot of cases of COVID and a lot of COVID deaths in prisons. The fact that we tend to take care of old people in congregate facilities like nursing homes. I mean, first we have morals people, and secondly, we isolate them and put them together in facilities where disease is going to spread, but it's also going to spread among people who are very vulnerable to it. So, you know, yes, the relationship between governments and their citizens is really important here, but it's also important, you know, what the features of the population are. And, you know, and we're things like, you know, whether you're a population that largely lives inside or spends more time outside, but you know, the, the fact that our healthcare isn't free, it's also really consequential here, you know, in countries where there's already universal healthcare, um, and no questions about whether people are going to be able to get medical care without having a horrendous bill arrive after the fact. Or whether they're, they might be turned away if they don't have the right kind of insurance card, that makes it much more likely that you're going to be able to deal with the infection right at the outset, rather than having people stall around, waiting to decide whether to get tested or go to a hospital.

Matthew Martinez Hannon: I'd love to turn to the vaccine distribution and would love for you to discuss how that's been rolled out across the world. And I was going to ask, you know, has it been equitable, but it seems like it hasn't based off what you've already shared. And you've actually shared a little bit about like, why that's happening, but I'd love, I'd love for you to expand on that a little more, if you can.

Carol Heimer: Sure. So if you, if you read the stats on this, I mean, there's only a few countries, the very sort of rich countries of Europe and the United States where there's been a wide distribution of the vaccine. I mean, in poor countries that simply hasn't been available. And even in some of the ddle-income countries, there hasn't been a great deal of vaccination going on. And partly that's because of who supported. I mean, I guess so one thing we did do right, is we threw money at vaccine development. And, you know, the FDA, which is known for being, uh, careful, perhaps to a fault. Um, but you know, that's part of its reputation. It was that, you know, it's the entity that, you know, didn't give, uh, thalidomide to pregnant women. And so it kept us from having a lot of these born with birth defects when other countries, particularly European countries had a lot of them.

So the FDA has always been known for being super cautious. It loosened up its rules a little bit, uh, during the HIV era. And in some ways has been pretty flexible this time around. I mean, so the thing is that the development process has been different because it's the mechanism for the vaccine is different than the previous kinds of mechanisms that have been used. And I think that a lot of people have been very suspicious then, you know, how is it that when it normally takes so long to get a vaccine available, why is it that it's been so fast now? Is it because they're cutting corners and no, it's not exactly cause they're cutting corners. It's because it's a different mechanism that's being used in the vaccine.

Matthew Martinez Hannon: Do you have enough knowledge to talk a little bit about that

Carol Heimer: In a theoretical sense I should, because I just recently read books, like Codebreaker about the development of CRISPR and so forth. And so I know a little bit about the RNA DNA kind of stuff, but no, I can't really speak competently on that.

Matthew Martinez Hannon: Okay. That's okay. Neither can I, so that makes two of us.

Carol Heimer: Well enough to know that I think it's okay that they were, that it's been developed rapidly and that the testing has, has been able to go forward quickly. And, and honestly, it's only been, only now that the two major producers have applied for regular FDA approval rather than emergency use approval. I think that's part of what makes people hesitant, but in supplying a lot of the money for the drug development that US also then put in place contracts to get a disproportionate share of the new vaccines, right. And other countries I think have been better about contributing money to, I think it's called Kovacs, but it's a consortium to develop, to distribute a vaccine worldwide. We haven't contributed as much. I think we're starting to contribute somewhat more now, but I think it's also important to realize that drug availability is a huge problem worldwide.

Okay. So it's like with the issues about access to drugs, you know, have been so important that, you know, there's been an essential drugs program at the world health organization for many, many years. That's part of what a lot of the disputes are about and the world trade organization and trips, um, about, you know, about intellectual property and drug patents and so forth. So it's not like the distribution of the problems with the distribution of COVID vaccines is something new. This is an old problem, an old problem that we just have never bothered to get right. And so one of the things I think also to keep in mind is that, you know, as the drug was being developed in the US, the government kind of acted as if -- I am overstating it a bit, but not by too much -- that you know, what you have to do is you produce the drug and then you just, everybody's going to put out their arm. And there's no problem about getting it out there.

And then when the vaccine became available, lo and behold, we discovered shock, amazement that there's actually issues about how you distribute drugs. Oh my goodness. You know who we're actually going to give vaccines, do we have adequate refrigeration? Do we have ways of lining people up? Do we, we have ways of getting it to populations that have been resistant in the past to getting vaccines. You know, it's like all of these kind of more social science-y kind of things just have taken a total backseat to the problem of drug production. There's no reason we couldn't have been working on these things simultaneously, but the sort of awe that Americans have for STEM disciplines means I think that they've sort of given short shrift to the equal and maybe not equally, but very serious issues about how you actually get drugs distributed and how you set up administration programs and you know, how you track side effects and you know, how you decide what's equitable in the way of distributing between areas of the country or sub-areas of the country where everybody's going to line up and put their arms out and the places where they're going to be reluctant. But with a little easier accessibility and a little more understanding of that reluctance, we could get people vaccinated.

Matthew Martinez Hannon: I feel like a lot of times when I hear about systemic change, it's in specific communities, whether that be, you know, for instance, I live in the Edgewater neighborhood of Chicago, right? So there's like, what are we doing in Edgewater? Therefore, what are we doing in Chicago and Illinois in the United States. But this is something, systemically it's global. So how do we go about making changes that will, um, benefit us all in the long run?

Carol Heimer: Yeah. So I think one of the things that we have to pay attention to, as you know, we have to do some tending of global funding mechanisms. So at one point I wrote an essay for, I can't remember where it came up, but you know, it was, uh, for, for the reading public, I guess would be the more polite way of saying that, uh, about, uh, Ebola and you know, how, as soon as it's looks like it's not a crisis in the United States, then we take our eye off the ball. And for these global pandemics and for global health issues, generally, you know, we can't have bake sales, you know, that's not, that's not how we're going to do it.

We need to actually really pay attention to shoring up the funding. And honestly, the rich countries really have to shoulder much more of the burden there. And, you know, it's like sometimes I think rich countries think this is unfair, but I don't actually think it is unfair because, you know, we've taken a lot of resources from four countries. But also because we need poor countries to get vaccinated. So I think there has to be a lot more attention to creating the kind of global mechanisms, um, that are needed. And so, you know, if you think about things like the international criminal court and the U.S.'s reluctance to participants participate in things like that, because you know, what would happen if some of our armed forces were found to have been, to have done something wrong. I mean, this isn't a case where, we should be worrying about participating and, and global networks to deal with disease. Because what if we were, you know, one of our soldiers were found to be doing something wrong. There's no fingers that are going to be pointed here, right? Nobody's going to end up being put in jail over these kinds of things.

Instead that we might conceivably prevent disease. So, you know, it seems to me that, you know, yes, it's going to cost money, but, um, it's, uh, it really is a win-win situation. So I think that we have to move away from, um, our isolationism on these things. And, you know, and if you look at the sort of core hearts of the United States government, I mean, they have helped a lot with this. I mean, the CDC has laboratories all over the world and there's a lot of consortia and working together to fund things and putting together resources and tracking information together. But there are also places where we've really fallen down where we've let the drug companies charge rates that are inappropriate, um, where we have let the rules be created in a way that favor pharmaceuticals, where we haven't done enough to sort of think about what the needs are and the cultural patterns are in other countries, so that we don't try to impose rules that are inappropriate.

I mean, so, you know, it's like, I mean, here's a sort of silly little example, but this happened in Chicago and one of my students told me about it just the other day. So, before we all in the us got on board with mask wearing, uh, one of my students was at a meeting and Chinatown in Chicago, where somebody from the CDC was lecturing the largely Asian attendees at this meeting about how silly it was for them to be wearing masks. And then we all came to accept that actually, you know, the practice of wearing

masks was something that was a really good idea, but, you know, if we had been a little more humble about that in the first place, we might've gotten there a little faster.

Matthew Martinez Hannon: You know, I read that officials are still trying to determine how COVID actually began spreading. And I think the two leading theories, they said where the zoonotic transmission or, or a lab leak, but that the country possibly responsible will not disclose certain information. And I'm wondering like, how does that, I mean, obviously I feel like I can guess about how that would impede, you know, research and assist science, but are there global laws to sort of demand that information to prevent things like this happening in the future?

Carol Heimer: Yeah, that's a, that's a very good question. And I don't think there's a clear answer to it. So China has been pretty cooperative compared within the past. Okay. So remember I said with SARS, that was four months before any information came out, it was much, much briefer this around, but there is that question of the origins, right? So in with SARS, it was pretty clearly in the, in the wet markets in Guandong. I mean, I'm probably butchering that province name, but in this case, Wuhan, you know, it's like, it's a thousand miles from the main case where the bats with Coronavirus are, at least that's what I've read. And so that's one suspicious point. Then there's some suspicious points about how, you know, there didn't seem to be any sort of only of the sort of intermediate kinds of genetic transformations that you would expect, but instead it emerged just suddenly, boom, here, we have this very infectious, very deadly disease.

And since then nobody's been able to sort of trace the kind of precursor modifications. That's the thing I wanted, the things, those two things are the things I think that make people wonder about the lab and the fact that, you know, the Chinese have been unwilling to share some of the very earliest samples, I guess. I think that's what the point is, but you know, it's an important question and it's important, important question, partly because it's a terrifying thought if a lab mistake can lead to an epidemic, a pandemic on this scale, right? Yeah. Because, you know, lab mistakes, you know, we want labs to be doing work, but we need to make sure that we can trust that they will prevent the release, even accidental, of deadly germs.

Matthew Martinez Hannon: Thank you to Carol for speaking with me about international public health law. Next up, as I mentioned earlier, I'll interview Miguel Alexander Pozo and Reuben Moore. Miguel is an ABF Fellow and Senior Vice President, General Counsel, and Compliance Officer for Minnesota Community Care (MCC). Reuben is President and Executive Officer for MCC-- and, as Miguel told me, Reuben is his boss. Now, those are just the basics, but I'll let them provide a bit more background in just a moment. Miguel and Reuben will speak with me about health equity in the U.S. and some critical lessons learned that might support systemic change in confronting pandemics in the future.

Thank you, Miguel and Reuben, for joining us. And we got to understand that you just joined Minnesota community care as senior vice president general counsel and compliance officer. So congratulations. Can you tell us a little bit about your path to this position?

Miguel Alexander Pozo: Thanks so much, Matt really appreciate the opportunity to be with you this afternoon. Reuben and I are excited about our conversation. Um, I've been a law firm partner board member bar association leader for 20 years. And during that time I've devoted myself to dealing with healthcare disparities, educational access and social justice issues, um, in particular during the last 18 months or so, I had the privilege of working with Uber Moore and Minnesota community care as their outside general counsel. And during that time, it got to know the organization really got enamored with their mission and their focus on advancing the interest of the community. And I was delighted to be invited to join the organization on June one. It's, it's really been a highlight of my career to be able to join this outstanding team of professionals and a leadership team here at Minnesota community care.

Matthew Martinez Hannon: And you really mean that you're not just saying that because Reuben, your boss, as he was introduced to me, is sitting right next to you?

Miguel Alexander Pozo: No, I actually mean it actually like moving a lot and I left, I left my job at the firm to come join him because he's a visionary leader and the work that we're doing everyday in the trenches, it's not easy work and it's really one patient at a time and it takes a lot of foresight, but also a willingness to grow up your sleeves. And he does that day in and day out as, as, as does the rest of the leadership team. So I'm really excited to be here, frankly.

Matthew Martinez Hannon: Amazing. And Reuben, now that you've been talked up so much, can you please share a little bit about your background?

Reuben Moore: Oh, you know, I've been so fortunate to have had the opportunity to be a part of Minnesota community care for the last four years prior to joining. Um, I was honored with the opportunity to be a vice chair of global business for Mayo clinic, their health insurance companies, their PBM as their pharmacy benefit management companies and their golf state relationships. And so working kind of with the various autopsies and medical and medical ministers in the golf, it provides access to the male clinic, global medicine resources. Prior to that, it's been a lot of time in insurance. I've worked for organizations like Humana, uh, United health care and care Minnesota. But most importantly, I've been in community trying to do my best to, to help improve a healthcare system that has been historically fragmented.

Matthew Martinez Hannon: And can you talk a little bit, you know, about Minnesota community care as an organization? What, what does it do for, you know, somebody like me, who's just hearing about it. The people who are listening, what do they need to know?

Reuben Moore: The Minnesota community care is one of the 1400 federally qualified health centers across the country who serve about 30 million Americans. We are a part of this country's largest safety net and primary care network. And at the root of our mission is really healthcare for all. We're here to break down barriers, provide zero barrier access to healthcare for anyone in any community. It's all about understanding what folks need in communities. Who've been historically marginalized setback may have economic or financial challenges, but giving them the opportunity to experience a healthcare

solution. That's built around them. Our board is 51% patients. And so everything we do is centered around our communities. And so we think about, uh, linguistically competent, harshly, competent care, uh, designing programs that are targeted specifically to impact special populations like our healthcare care for the homeless mission. Those are all the many things we do to serve the 40,000 Minnesotans. We get a chance to impact

Matthew Martinez Hannon: That's incredible shifting to a broader view. And whichever of you feels like you want to take on this big question. You know, I want to ask you about healthcare and health law in the United States through the lens of the COVID-19 pandemic. And, uh, you can say sort of your professional opinion or your personal opinion on how prepared you believe we were to confront the pandemic.

Miguel Alexander Pozo: Reuben is going to take that first from a medical perspective or from a healthcare perspective, and then I'll chime in from a legal perspective.

Reuben Moore: Great. Yeah, I can say that the country, although aware in terms of, Hey, we know the world has pandemics, we've experienced pandemics in the past, in the modern healthcare structure, we really weren't. We really weren't ready. Right? We didn't have the proper integrations, the proper centralized set of protocols and standard operating procedures or federal policies to really implement a comprehensive plan across the country. We built, we ended up responding in our fried minute or approach at the, every American, at least from a, from a United States standpoint, really felt that every state had the Republic of the United States. It allowed every state to have its own authority. And so, uh, the true tension between a state authority and federal authority became very prominent.

And you really saw that the holes in our health care system and how you have this public resources, public utilities, public good. That really is here for everyone trying to be integrated into a large and complex capitalist structure, federal and state authority structure. And it really failed, right. It really failed luckily, but at the heart of healthcare humans, and as our humans really picked it up and we've done a really good job of where policies didn't exist. We tried to create policies. We've amazing governors who tried to fill the gap where solutions and resources did not exist. We tried to tie them together and we've done it temporarily. Don't COVID. I think we need to do a lot more work from a legal standpoint, a lot more work from a system standpoint, a lot more work from a data integration standpoint and from a human service standpoint, to be better prepared for any pandemic will come in the future.

Miguel Alexander Pozo: And I think from a legal perspective, we found ourselves really trying to keep up of the law was, was not prepared to deal with all the various issues that were presented with both, from working from home to employees, crossing state lines, to what you do. What do you do with employees who gets sick with COVID in the middle of the pandemic? So there was a myriad of issues that were coming up at a really fast pace. The EOC tried his best to keep up. Obviously you had, you had states trying to create a patch, quilt of orders and, and laws that we all have to try to interpret on the

fly. So CDC came out with guidance that often changed as the pandemic ebbs and flows. So it created for a perfect storm of having to deal with a ever-changing situation on a day to day, hour to hour, basis.

Matthew Martinez Hannon: Thinking about what COVID has revealed about health governance, health equity in the U S why do we need laws governing healthcare equity?

Miguel Alexander Pozo: Well, this is one of one of Rubin's favorite topics, right? But, and I'll say I'll tee it up this way by saying, when you have a community that's historically marginalized, underserved under, uh, provided for. And when you have people that are living in a situation where they can't get access much less, get a preventative care, then you layer on top of that, a pandemic, you further victimize a community has been victimized for decades, and it creates a perfect storm that we're going to take years and years and years to recover from. If we, if we ever can effectively recover from it. Reuben, what do you think?

Reuben Moore: You know, we, we talk in the, you know, around more than 50 years, our institution is 52 years old and the onset, we created community health institutions. We did it as a compliment to the civil rights social movement.

And what we found is in our countries, we looked in rural areas because the way healthcare have become industrialized, that it became a market, a market based industry. And so it became an industry bill for those who could pay for it. And capitalism is good in some respects, but really hard when you have a public utility like healthcare. And so when FQHC, federal qualified health centers are designed to kind of offer a counterbalance to say that everyone still needs to have access to healthcare, even if they can't afford it, or they're not located in areas where you see a high density of healthcare resources. And so why don't we need laws to help govern and shape health equity in our country? Like we've seen in some of the great legal passages or laws passed or about affirmative action, uh, some of the great, uh, Roe vs. Wade, we can go down the list of all the integration of school, our schools, we needed a political instrument, a legal instrument to help guide the country toward the more just it helped me. Equity is about justice, right? We want to ensure that everyone has access to a specific set of resources. We can't rely upon the capitalistic marketplace to do it in a way that really addresses the need for public good. And so the law must be in effect, but it's hard. What is health equity? What should it look like? Who is it for? Those are still a lot of questions we need to answer. As we look at being much more intentional about designing laws practices and in federal policy, federal and state policies that can help us improve cocaine inequities in our country.

Matthew Martinez Hannon: That's a great segue to the sort of second question I had around this, which was, are there disparities that we have not addressed yet regarding all of these things?

Miguel Alexander Pozo: Absolutely. And you know, uh, one of the things COVID really showed us is that it illuminated those disparities that are easy to see if we look at healthcare. So healthcare access folks who were specifically vulnerable to a respiratory disease, really easy for the country to see that, but healthcare is beyond just the respiratory disease. Why don't we have a respiratory disease? So we have a lot of lead based paint in communities. What is their pollution control policies and practices? How

does that impact high dense communities and cities where you have a lot of cards and other factors that impact the environment and of course impacts the environmental health of communities. All these factors play in to the deeper questions we need to explore. Yeah, Matt, and by the way, when you talk to them about what do you need laws is because anytime you want to remove barriers, you have to do that through the legal system, right?

That's been shown time and time again in our country. And it's interesting. Reuben talked about the social justice aspect of health equity and health equity issues and eliminating disparities. We think about what happened during the pandemic. We hadn't been happening at the same time that we had the social justice issues associated with the George Floyd murder that happened here in Minnesota last spring. So you have all of these convergence of events coming together to really bring a magnifying glass around all these issues and they're interrelated. And it's, it's now because of the focus, the laser like focus. There's so many different institutions and people, politicians and others are focusing on these issues. We see a glimmer of hope that we will start to make traction around starting to make some long lasting systematic change, whether that will actually occur or not is yet to be seen, but you have people's attention. And now the key is to make sure that that attention gets down to the granular level becomes action. That's sustainable for the long long term. That system change has to contemplate the social determinants of health. And I think that as, as a country, that we are, we are behind in every key measure as compared to our other westernized, highly developed countries, uh, in terms of dollar for dollar spin on health outcomes. We lack, we spend more on healthcare with, with much worse outcomes because we don't address the social determinants of health.

Matthew Martinez Hannon: Yeah. And there's something that you just said, and this is I'm taking us off track. So please go with me. You've mentioned that laws have to be in place to remove barriers. And I feel like there's lots of conversations about how certain laws that are in place create barriers. So how do you reconcile those two ideologies around, I mean, in particular, you know, like health governance?

Miguel Alexander Pozo: Well, one of the things that we're going to start to see in already, you, you see this in the periphery is litigation around some of these issues, right? The more you test the current systems are in place, the more you bring illegal magnifying glass to whether the laws in place right now are being effective or themselves the root causes of the disparities. You go back to Jim Crow laws, for example, you're going to start to now, as you test these laws, start to see whether or not these laws need to be modified, and whether they are in the current 21st century world that we live in continuing to be in a way that's harmful, keeping people suppressed that have been historically suppressed, whether the laws themselves are the problem, or whether the laws need to be modified in a way that just comes into reality that we're faced with in our communities today.

So the legal system, as it stands, has to continue to test the laws that are in place. And those laws either need to be reformed modified or new ones implemented as appropriate. You know, I love the look at the laws. One of the things that they depend coupled with the racial inequities in our country, which of course exactly was exasperated by COVID. Is it exposed as the Jim Crow structure, legal structure? Did it expose the T tensions between the state's authority and the, and the federal authorities, right. Uh, if you looked at what happened in COVID, you know, w can New York shut down, can New York shut down and is that right for its citizens? They look at Jim Crow can Alabama holds its citizens. Can they do it or not?

Right. And so I think that what we are seeing is that there is a need for more federal influence on the national landscape, right on the law of the land.

And I think that hopefully our, our country, and I know where Republican Federation will begin to see and accept a stronger influence from our FA at the federal, our most, our state authorities and Matt to rent out the answer I was giving you earlier. I mean, the key here, I think is that Congress needs to act right. If you're going to dismantle this patch, quilt of laws that invariably continue to disenfranchise people and continue to promote some of the inequities that we see in healthcare, you're going to have to have Congress act. Ultimately if they're going to have meaningful, robust, and standing change, that removes the barriers that we've been talking about. There's, there's an absence of congressional authority. We talked about what laws are in place. And one of the, part of the problem, well, part of the problem is that there's no federal law that addresses issues in a meaningful way.

Matthew Martinez Hannon: Yeah. Yes. Thank you. Thank you for answering that. Turning to vaccine distribution. Can you reflect on how that's been rolled out? And if you think it's been equitable and if not, why not?

Reuben Moore: You know, I want to command the experience in our state in terms of vaccine distribution, our governor and Lieutenant governor, governor walls, and Dr. Flanagan did a wonderful job of ensuring that the vaccine was distributed equity. At first phase of the vaccination program was hard for the whole country. We chose to vaccinate the elder of us first that could have been done in a different way. We could have possibly chosen to vaccinate those most vulnerable. That was the private, the only challenge after that, the country got it. Right. Right. We began to think in waves about how we vaccinate folks based on key, uh, life stages, key segments, key populations. And we did our, we did our best to do it. The challenge is that we don't know enough about our own populations, and do they want to be vaccinated? Do Americans want to be vaccinated? Why are we hesitant? Do we distrust the larger system? And can you legally enforce right folks to participate in any form of vaccination program without a true FDA approval or any true confidence in the car vaccination program? So, it was a, I could tell it was done well. Uh, but we got a lot of work we need to consider as we look to deepen the vaccination impact and key communities.

Miguel Alexander Pozo: And I would just add to that, Matt, that I was, you know, you heard a lot of voices early on in the pandemic that thought it was impossible or unlikely that we would get a vaccination of vaccine much less three in the short time period that we did, obviously all the various professionals and people that worked so diligently to make that a reality are to be commended for that. What, what was unforeseeable? And depending on who you ask was the politicization of the process, um, that we all saw in, in the aftermath or the vaccines hitting, hitting the marketplace.

But I think overall as Reuben points out there, there was a lot of work that was done. That was meaningful. Messaging is an area of improvement. Um, education is an area of improvement. People have hesitancy for variety of reasons. I think we're still learning about how to best address the various levels of hesitancy that exists some of, for historical reasons, others, for other reasons, we won't get into on this conversation, but the messaging education pieces has been critical and potentially be critical,

especially as we head back to school in a month from now. And as we go into the next stage of the Delta variants, not having messaging, that's clear and comprehensible by the vast majority of Americans is part of the problem.

Matthew Martinez Hannon: What is the future of medicine and health law, you know, in a post COVID world look like based on what you both have learned and are experiencing.

Miguel Alexander Pozo: I'll give Reuben the first word, and then I'll chime in, in a moment.

Reuben Moore: So, future of medicine in health law, one is we need more talented, passionate and competent attorneys like Miguel Alexander Pozo to enter into this space to say, I want to be a disruptor and help improve a fragmented system where the practice of healthcare is far outpacing the legal structure of healthcare in every area, whether it be healthcare, it data's changed PA you name the area. I don't know if we have a legal structure that's kept up. Right? And so, I think that the future of healthcare is going to be more, more dynamic. It's going to be much more virtual, right? If we saw the increase in virtual visits during COVID, it's going to be, it's got to be much more individualized, it's gotta be much more portable. And so, all these things will require us to be much more thoughtful about our legal practices at state federal, and even as an employer level, right.

Miguel Alexander Pozo: Yeah. And I think, you know, one of the things that's important to me and that resonates is that the, the, the ABF, the American bar foundation should be applauded for the work that has been doing is continuing to do in this space and the ABA as well, continuing to shed light on these issues, shining a flashlight on these issues is going to be critical. If we're going to evolve in a way that's meaningful for the vast majority of us, I think getting reasonable minds around the table, getting us to focus critically on these issues is going to continue to be an important facet of what happens next. I think one of the things is going to be very challenging from a legal perspective, as what happens in the fall. You know, you're going to continue to have issues about employees returning to the workplace. What does that look like? Hybrid work models, working from home employees who are now being asked to not show up, unless they have a vaccination card. All these issues are going to create challenges for our legal system and are going to keep lawyers on both sides of the V very busy in the coming weeks and months as we start to figure out what this new normal is, uh, when we all get back to work.

Matthew Martinez Hannon: And this is the last question, because, you know, I'm a Pisces and I'm a creative and I studied psychology. So I'm always concerned about people's feelings. So why do people need to care about this?

Reuben Moore: Look on a human level. I mean, you could point around any room where there are more than two people in the room and you could everybody in the room complaint too, or talk about somebody that has passed away in the last year. I've lost a number of people that I know they will close to me to the, so we should all care on a human level because we're losing people, whether you agree or not with mask wearing and what have you, you get into the political aspects of it. The fact of the matter is the pandemic is killing people. And so we should care a human level because people that we care about or loved ones are passing away. And in many instances, you can't even be at their bedside to say

goodbye. So that's one reason. There are a whole host of other reasons that would take us a long time, but that's one reason.

What do you think healthcare so interconnected in our society and our social construct in our economy, that it help if we don't get this right, we have pact our ability to produce new products. Right? If you look at the labor, the labor market effects, you look at the effects on education, look at the effects on housing. We use it. We're talking actively now about a rent moratorium expiring help. This has to, we have to get this right. And it is a health concern, right? I think that as a world, do we want us to be spinning year over year, around every new pandemic, every new variant, uh COVID uh, I think we have to wear a mask. If we have to get vaccinated, whatever we can do to help stabilize our well it'll be world, it'd be better for all of us. And its interconnections can be, can be catastrophic if we don't do the right thing.

Matthew Martinez Hannon: Thank you to our guests, Carol Heimer, Reuben Moore, and Miguel Alexander Pozo. And thank you for joining us for episode four of Whose Law Is It Anyway?, an American Bar Foundation podcast. This podcast was produced by Whitney Peterson and Crissonna Tennison, with associate producers Devin Johnson and Natalie Shoop. And I'm your host, Matthew Martinez Hannon. We'll see you (or you'll hear us) on the next episode, where we'll be covering race and gender in legal academia and the legal profession.

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Until next time, be well.