Health Care That Works For All Americans

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

September 29, 2006

The Honorable George W. Bush
President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

The United States spends nearly two trillion dollars on health each year. Yet, the health care system that captures vast amounts of America's resources, employs many of its talented citizens and promises to both promote health as well as relieve the burdens of disease is failing many Americans.

Beyond the well published numbers of uninsured, everyone in the system, from hard-working Americans and their employers, to the government agencies that strive to support them is feeling the financial pressure of rising health care costs.

Of equal significance, Americans are confronted with a system that has become disconnected from the health and protection of citizens in the event of sickness. Many people are bewildered by its complexity. As one citizen voiced to us, you cannot "navigate the health care system without luck, a relationship, money and perseverance."

The legislation that created the Citizens' Health Care Working Group emphasizes the need to listen to the views of everyday Americans. In previous health care reform efforts, too little has been heard from the public about several key issues. The Citizens' Health Care Working Group did hear from the public and developed goals, values and aspirations they wish to be at the heart of the health care system's mission. These should be considered in addressing current health care financing and delivery issues.

Through our public meetings, online surveys, and research, a panoramic picture has been sketched of the American health care experience. Mr. President, in the spirit of giving a greater voice to everyday people, we deliver the recommendations and ask for your leadership and support in making health care work for all Americans.

Respectfully Yours,

Patricia A. Maryland, Chair
Citizens' Health Care Working Group

7201 Wisconsin Avenue, Suite 575 • Bethesda, MD 20814 • 301-443-1502 • 301-480-3095 (Fax) • E-mail: CitizensHealth@arhq.gov • www.CitizensHealthCare.gov

Working Group Members

Mission

The Citizens' Health Care Working Group is comprised of 14 citizens from diverse backgrounds who were selected to represent an informed cross-section of the American people, in addition to the Secretary of Health and Human Services. The Working Group was authorized by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, to develop recommendations for the President and Congress that will result in "*Health Care that Works for All Americans*."

The nonpartisan group was tasked with engaging the public in a nationwide discussion of options to address the current crisis in health care and improve the health care system in the United States. By listening to citizens from communities across the country, the Working Group has developed recommendations to transform the nation's health care system while addressing runaway costs, unaffordable care, and unreliable quality.

Chair

Patricia A. Maryland

Vice Chair

Richard G. Frank

Members

Frank J. Baumeister, Jr.

Dorothy A. Bazos

Montye S. Conlan

Joseph T. Hansen

Therese A. Hughes

Brent C. James

Randall L. Johnson

Michael O. Leavitt, Secretary of HHS*

Catherine G. McLaughlin

Rosario Perez

Aaron Shirley

Deborah R. Stehr

Christine L. Wright

* As Secretary of Health and Human Services, Michael Leavitt serves as the 15th member of the Working Group by law. Secretary Leavitt has neither participated in the development of the Working Group's recommendations nor has he endorsed them. When referred to HHS for review, he will carefully consider them and take appropriate action.

Contents

Executive Summary

Americans want a health care system that works for everyone. But the reality is that the health care system that captures vast amounts of America's resources, employs many of its talented citizens, and promises to both promote health as well as relieve the burdens of illness is failing far too many of us.

Over the past year, the number of uninsured has grown by more than one million, and tens of millions more are underinsured, and at immediate risk of financial ruin if they are seriously ill or injured. Individuals, families, employers, and every level of government are feeling the financial pressure of rising health care costs. More often than not, people do not receive the best care that science has to offer. Many are bewildered by the complexity of health care and insurance coverage. As one citizen voiced to us, you cannot "*navigate the health care system without luck, a relationship, money and perseverance.*"

The need for change is clear, but transforming health care so that it works for all Americans is a daunting prospect. It will involve difficult decisions about how health care is organized, delivered, and financed. Years of stalemate on health reform prompted a bipartisan call to go back to the American people, to explore their values and aspirations for the health care system, and to provide the energy needed to sustain real health reform.

The Citizens' Health Care Working Group was established by Congress to "*engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage*."

What we heard was that many Americans believe that public policy designed to address the growing crisis in health care cannot succeed unless all Americans are able to get the health care they need, when they need it.

Public Dialogue

Following six regional hearings held in 2005 with experts, stakeholders, scholars, and public officials, the Working Group issued *The Health Report to the American People*, a report intended to facilitate a national dialogue on health care reform. In addition, the Working Group made the presentations from its hearings available to the public via the Internet, at www.CitizensHealthCare.gov.

The Working Group then began its conversations in communities all across America. This required an extraordinary effort to reach out to diverse communities representing a full spectrum of the American public. This also included a review and analysis of policy and research literature, national polls and surveys, and special analyses of health data; live one-on-one conversations and community meetings; expert research; and mass

communications through the Internet and press. Over nearly eighteen months, the Working Group engaged thousands of Americans, including:

- About 6,650 people attending 84 community meetings across the nation as well as meetings organized by individual Working Group Members and other organizations by the end of May, 2006, and input from over 700 people attending 14 meetings after the Interim Recommendations were published on June 2nd.
- Over 14,000 responses to the Working Group Internet poll; and another 6,000 sets of responses to open-ended questions about health care in America
- Over 500 descriptions of experiences with the health care system submitted via the Internet or on paper, and about 400 email letters, handwritten notes, letters, essays, and copies of reports that people sent to the Working Group.
- About 7,300 individual email and written comments on the Working Group's Interim Recommendations

The Working Group recognized that many people attending the meetings or providing input in writing are apt to be especially interested in health care. Because of this, the Working Group held a variety of special topic meetings, some in collaboration with partner organizations, and also worked with a range of organizations to encourage their members to complete the Working Group poll or to write in comments. Among these were meetings organized by, or with the help of, groups including local Chambers of Commerce, The National Association of Realtors, The Consolidated Tribal Health Council, a consortium of Big Ten Universities, local chapters of the League of Women Voters, professional nursing associations, organizations serving homeless persons, unemployed persons, people with disabilities, and elderly persons. Several national corporations and national labor unions encouraged members to attend meetings and provide input via the Internet, and both the Catholic Health Association and the United Church of Christ were particularly active in eliciting input to the Working Group.

The remarkable consistency of findings across many communities and between the poll data obtained through the Working Group Internet site, the University Town Hall Survey, and the community meetings provides support for the view that was heard from a significant segment of the American people. The consistency with findings from recent national polls and surveys provides even stronger support for the findings. We do not claim that we know, with complete certainty, the health care values and preferences of all Americans. Rather, we based our deliberations on a careful assessment of input from as many sources as feasible, including tens of thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in the data.

What We Heard

In every venue, we heard from Americans who are deeply concerned about access to health care, and the rising costs of care and insurance. While Americans recognize that health care costs are a major problem for businesses, industry, and government as well as families, many believe that the tremendous amount of resources now being spent on health care should be enough to ensure access to quality care for everyone, if these resources were allocated more efficiently. At the same time, people consistently emphasized the importance of shared responsibility and fairness – a clear willingness to pay a fair share, to try to do a better job of taking care of themselves, and to accept limits on coverage if based on good medical evidence. Many believe that health coverage should be comprehensive enough to ensure people can get the care they need, when they need it, without having to negotiate or hurdle complicated administrative barriers. They told us they want health care to be available where people need it, in their communities. Finally, people told us that they want interactions with health providers to be based on mutual trust and respect.

The Working Group heard a variety of preferences regarding how a national system of health care should be organized -- from support for an entirely federal system with no private health insurance at all, to state-based single payer systems, to private sector participation in a system with established standards for benefits, coverage, and cost with minimum government involvement in day-to-day operations, to entirely free-market approaches. There was, however, overwhelming support for a plan that covered all Americans. In addition, there was considerable discussion at many meetings about interim reforms that could increase coverage until comprehensive changes could be made. Opinions about incremental reforms were sharply divided, and varied considerably from community to community. The overriding message, however, was consistent across every venue we explored:

> ***Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security.***

People also conveyed a sense of urgency and wanted changes to start immediately.

Values and Principles

In developing recommendations, the Citizens' Health Care Working Group believes that reform of the health care system should be guided by principles that reflect the values of the American people:

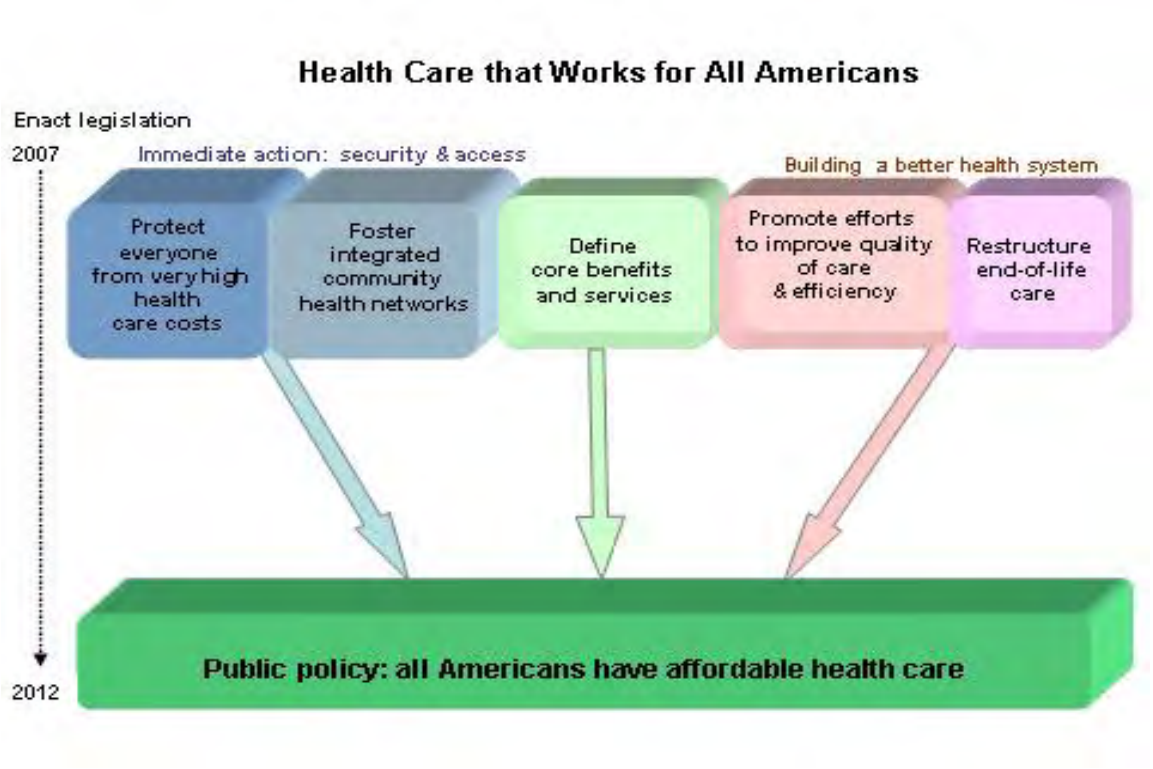
- **Health and health care are fundamental to the well-being and security of the American people.**
- **Health care is a shared social responsibility. This is defined as, on the one hand, the nation or community's responsibility for the health and security of its people, and on the other hand, the individual's responsibility to be a good steward of health care resources.**
- **All Americans should have access to a set of core health care services across the continuum of care that includes wellness and preventive services. This defined set of benefits should be guaranteed for all, across their lifespan, in a simple and seamless manner. These benefits should be portable and independent of health status, working status, age, income or other categorical factors that might otherwise affect health-insurance status.**
- **Health care spending needs to be considered in the context of other societal needs and responsibilities. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical.**

Recommendations

Based on these values and principles, the Working Group proposes six recommendations – organized into three sets – to accomplish its central goal, stated in Recommendation 1: **Establish public policy that all Americans have affordable health care**.

A clear majority of participants in community meetings, as well as those who responded to a variety of national polls conducted over the past few years, are in favor of a national system that provides universal coverage. However, "universal coverage" means different things to different people. The values and preferences being expressed did not lead the Working Group to conclude that there was only one particular model for ensuring that all Americans have access to high quality health care. Several approaches need to be analyzed and debated.

What is clear is that all Americans want a health care system that is easy to navigate. They want to have stable coverage when circumstances change, such as when they change jobs, get married, or move to different state. People want decisions about what is and what is not covered to be made in a participatory process that is transparent and accountable. It should draw on best practices, resulting in a clearly defined set of benefits guaranteed for all Americans. The overwhelming majority of Americans that the Working Group heard from also want health care system change to begin now. The Working Group is therefore recommending immediate action with a target of 2012 for ensuring a core set of benefits and services for all Americans.



The Working Group proposes a five-year transition with the immediate first step to address serious threats to health security – very high costs, and gaps in access to basic health care, preventive services, and health education at the community level. This step combines two recommendations.

ONE: Immediate action to improve security and access

Recommendation 2 calls for creating a program that could be implemented in the relatively short term that would provide a basic level of financial protection to everyone: **Guarantee financial protection against very high health care costs.**

The program the Working Group is recommending would provide some level of immediate protection for everyone, and also has the potential to stabilize existing employer-based health insurance markets and expand the private individual and small group health insurance market to more Americans. More important, it will provide the foundation for providing core benefits and services to all Americans called for in Recommendation 1. This program could be structured in a number of ways, using market- based or public social insurance models.

Recommendation 3 addresses serious concerns we heard across the country related to a lack of primary-care providers; the inability to access specialty care; and, difficulties in navigating a complicated system, especially for those with chronic conditions: **Foster innovative integrated community health networks.**

Citizens in multiple locations spoke highly of the continuity of care and easy access to needed services they receive from comprehensive delivery systems. The goal is to help communities build programs where health care providers at the local level work together to ensure that more people can have a "medical home" and access to primary care, mental health, and dental health care, and improve the effectiveness and efficiency of health care delivery.

TWO: Define Core Benefits and Services for All Americans

Perhaps the most challenging component of the Working Group's strategy is Recommendation 4: **Defining the core benefits and services that will be assured to all Americans**.

The conversations in each and every community meeting demonstrated how difficult the task of defining basic health care coverage will be for policymakers. Many people expressed concerns about what they view as the arbitrary exclusion of benefits or services from coverage. As was the case in many deliberations, the public was aware of the political challenges involved in making such decisions and the virtues of independent commissions in helping policymakers with such choices.

To define core benefits and services for all Americans, the best methods must be applied in a transparent process. Consumer participation is critical to ensuring public trust in the process and essential for ensuring that personal values and preferences are taken into consideration in coverage decisions. The group making decisions should be established as a public/private entity to insulate it from both political and financial influence. The group should be an ongoing entity with stable funding, to guarantee its independence and to assure that the benefits continue to reflect advances in medical research and practice. Evidence used to make decisions about coverage can contribute to improvements in the overall efficiency of health care delivery and help patients and providers make informed decisions. Identifying core benefits can help make all health care more effective and efficient, helping to control health care costs overall.

THREE: Build a Better Health System

A message that resonated throughout the public discourse centered on how America could do a better job with its $2 trillion a year spending on health by achieving greater efficiency and improving quality.

Recommendation 5 reflects the urgency of creating the tools and infrastructure to support a more efficient and effective health care system: **Promote efforts to improve quality of care and efficiency.**

Concerted efforts in some integrated health care systems have demonstrated how care can be improved and waste largely eliminated. Continuous improvement methods have reduced costs by managing chronic conditions, providing tools for informed decision-making, reducing preventable care-associated patient injuries, and designing coordinated

systems of care delivery that reduce hassle and the need to redo tests and procedures. However, continuous improvement efforts rest on fundamental changes in medical practice and culture – a difficult, long-term, proposition. Widespread improvement will require a much better understanding of how to "do it better" (investment in health care delivery research), restructured training programs, significant organizational restructuring, and investment in aligned health information technologies and systems.

The federal government is a dominant purchaser of health care. It also plays a significant role in the research and evaluation of the delivery of health care services. It is well positioned to provide leadership in these areas. A variety of federal programs could be used for development, demonstration, and dissemination. Federal health programs run the full range of design possibilities, making them particularly useful for the "beta testing" of new ideas. Recommendation 5 focuses on advancing the pace of the work that needs to be done to build a health care system that works better for everyone.

Recommendation 6 focuses on an especially difficult, often expensive aspect of health care that, in many ways, reveals some of the most serious problems with our health care system: **End-of-life care should be fundamentally restructured so that people of all ages have increased access to these services in the environment they choose.**

Many end-of-life issues are intertwined with effectiveness, quality of care, clinical decision-making, and patient education addressed in Recommendation 5. The concerned and thoughtful attention to end-of-life issues that emerged through its public dialogue made clear to the Working Group that change is needed.

Currently, the policy development is hampered by a lack of useful information about patients' needs and use of services. The development and use of standardized instruments for collecting demographic, epidemiological, and clinical information, careful evaluation of emerging care models, and the dissemination of best practices are all needed to improve care for the dying. The Working Group acknowledges that end-of-life issues are often difficult, painful, and complicated and thus not conducive to quick or easy fixes This recommendation seeks to better define, communicate, and make available at individual, family, community, and societal levels the support needed and wanted in one's last days.

Public and private payers should integrate evidence-based science, expert consensus, and linguistically appropriate and culturally sensitive end-of-life care models so that health services and community-based care can better handle the clinical realities and actual needs of patients of any age and their families.

Concluding Remarks

Adopting these strategies simultaneously enables the American health care delivery and financing systems to take several important steps toward universality. It sets in motion a plan that responds to overwhelming public support for a new dynamic in American health care where everyone is protected, not just select portions of the population.

In the recommendations that follow, the Working Group acknowledges that while improvements in health care organization and delivery can yield savings over time, implementing these recommendations will likely require new resources. It has identified principles that any new funding source should meet and offers examples of options already part of the policy debate that meet these criteria.

More detailed information, including background on the state of health care in America, analysis from the community meetings, comments and opinions provided to the Working Group, and relevant data from national polls and surveys, is provided in *Health Care That Works for All Americans: Dialogue With the American People* and *Report to the American People (Revised 2006).*

Health Care That Works For All Americans

Recommendations of the Citizens' Health Care Working Group

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

Table of Contents

An American Dialogue

Bipartisan legislation created the Citizens' Health Care Working Group to go to the American people, to explore their values and aspirations for the American health care system, and to bring their ideas and energy for health reform back to Washington.

A Working Group as Diverse as America

Appointed by the Comptroller General of the United States, the Citizens' Health Care Working Group is a nonpartisan body made up of 14 citizens plus the Secretary of Health and Human Services – all from very different backgrounds, experiences within the health care system, and communities across the nation. A complete list of members is available at the end of this report.

Charged to Open a Discussion

Enacted in the Medicare Prescription Drug, Improvement and Modernization Act of 2003, section 1014, the Citizens' Health Care Working Group was charged to open a discussion about health care for every American and to "engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage." More specifically, the statute requested that the following questions be addressed:

- What health care benefits and services should be provided?
- How does the American public want health care delivered?
- How should health care coverage be financed?
- What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

How the Working Group did its work:

Community forums

Over 28,000 citizen responses via the Internet

One-on-one discussions in personal encounters with individual Americans

Individual essays and stories

Blogs, message boards and other on-line dialogue

Research, including a review of all national polls from 2002 - 2006

Expert hearings

Media coverage

Internet message boards

Following six regional hearings held in 2005 with experts, stakeholders, scholars, and public officials, the Working Group issued a report entitled *The Health Report to the American People*, to enable the American public to become informed participants in a national debate on health care reform. The Working Group then began its conversations across America.

Overall, this public dialogue required an extraordinary breadth of effort to reach out to diverse communities representing a full spectrum of the American public. Working Group members participated in discussions ranging from one-on-one conversations and community meetings, to expert research and mass communications through the Internet and press. For nearly eighteen months, the Working Group engaged America through town-hall meetings, thousands of Internet communications, hearings with experts, analysis of national polls and personal face-to-face conversations, including many deliberations among the Working Group members themselves. In turn, these efforts attracted unsolicited essays, an extensive array of written comments and other communications. The Working Group carefully reviewed public input and available literature employing an inclusive, transparent, and accessible process.

Following the drafting of initial recommendations based on accumulated public and expert input, the Working Group issued Interim Recommendations which were made available for a 90-day comment period which ended on August 31, 2006. More than 6,000 individuals responded and over 100 organizations, representing millions of Americans, issued formal statements in response to these recommendations.

Outlining Broad-Based Change in American Health Care

The American people spoke about creating health care that works for everyone with remarkable consistency. Across many communities the views we heard based on community meetings, the Internet polls, and national polls formed the basis for the recommendations in this report. The Working Group does not claim to know, with complete certainty, the health care values and preferences of all Americans. Rather, deliberations were based on a careful assessment of input from many sources taking into account the gaps or biases that may be reflected in each type of information obtained.

The report that follows is a product of all these efforts – a product that is being presented to the President and United States Congress, where five committees will hold hearings.

The final recommendations from the Working Group outline both a vision and a plan for achieving broad-based change in the delivery and financing of health care in America. The Citizens' Health Care Working Group recognizes that the issues involved are complex and challenging, and that it will take time, technical expertise and, especially, a great deal of political will to implement these strategies. The American people, who have called for these changes, will, in the end, be the ones to sustain this new vision.

For more information on the findings of the Citizens' Health Care Working Group, visit www.CitizensHealthCare.gov.

Values and Principles

The Citizens' Health Care Working Group believes that reform of the health care system should be guided by principles that reflect the values of the American people. In community meetings across the nation, the following principles were identified as important to most Americans:

- Health and health care are fundamental to the well-being and security of the American people.

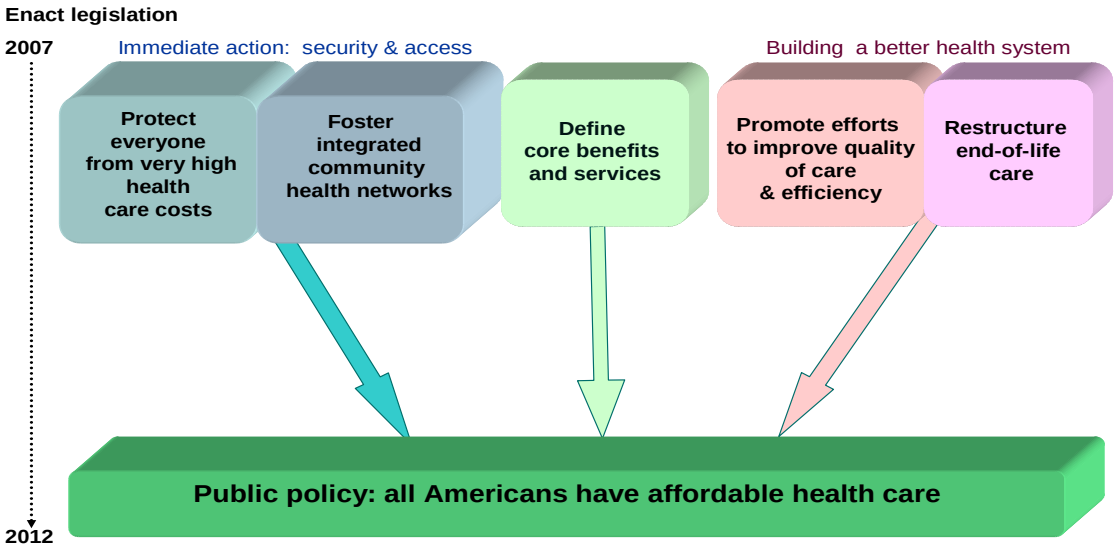
- Health care is a shared social responsibility. This is defined as, on the one hand, the nation's or community's responsibility for the health and security of its people and, on the other hand, the individual's responsibility to be a good steward of health care resources.

- All Americans should have access to a set of core health care services across the continuum of care that includes wellness and preventive services. This defined set of benefits should be guaranteed for all, across their lifespan, in a simple and seamless manner. These benefits should be portable and independent of health status, working status, age, income or other categorical factors that might otherwise affect health-insurance status.

- Health care spending needs to be considered in the context of other societal needs and responsibilities. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical.

Summary

Health Care that Works for All Americans



These recommendations reflect a desire by an overwhelming majority of Americans that everyone has access to affordable, appropriate health care by an established date in the not-too-distant future--2012. Encompassed in this goal is the need to make changes in the current health care system to expand access to care for those who need it as well as to improve outcomes and increase the value for money spent.

The Working Group is proposing six recommendations – organized into three sets and one overarching goal – as the forces for change. Commencing immediately, these recommendations will guide a five-year transition in American health care. The first set addresses serious threats to health security – very high costs and gaps in access to basic health care, preventive services, and health education at the community level. The second defines a package of core benefits and services, reflecting evidence-based practices and the principle of shared responsibility. The third builds a better health care system by achieving greater efficiency, improving quality, and restructuring end-of-life care.

Achieving Health Care that Works for All by 2012
Within these three sets, the Working Group recommends five multi-step actions for accomplishing its central goal stated in Recommendation 1, that "**It Should Be Public Policy that All Americans Have Affordable Health Care" and that all Americans have access to a set of affordable and appropriate core health care services by the year 2012.**

Initiating the work encompassed by these sets of supporting recommendations simultaneously will enable the American health care delivery and financing system to move toward achieving the broader imperative voiced by the American public.

ONE: Immediate Action to Improve Security and Access

Guarantee Financial Protection Against Very High Health Care Costs
By establishing protection against very high medical costs *for all*, the Working Group's Recommendation 2 responds to two major messages from the American people. First, people believe that no one should be financially ruined by health care costs. Further, there was overwhelming public support for a new dynamic in American health care where everyone is protected, not just select portions of the population. This Recommendation can be implemented in the short term and provide a basic level of financial protection to those who do not already possess this coverage. Building this system will provide some level of immediate protection for everyone, and also has the potential to stabilize existing employer-based health insurance markets and expand the private individual and small group health insurance markets to more Americans. More important, it will provide the foundation for providing core benefits and services to all Americans called for in Recommendation 1.

Innovative Integrated Community Health Networks
Coupled with this high-cost protection, Recommendation 3 calls for bringing together national leadership and best practices with local know-how to foster innovative, integrated community health networks. This piece of health care reform draws on America's ability to think "globally" but act "locally." These networks will be better suited to coordinate federal, state, and local resources, improving the capacity of existing community health programs to deliver basic care and provide health promotion and education services. The combination of strong and caring community networks with innovations in quality and efficiency is key to making affordable health care available for all by 2012.

TWO: Define Core Benefits and Services for All Americans

Recommendation 4 calls for establishing an independent, nonpartisan group to begin the work of defining benefits and services that would be the standard for all Americans. This is perhaps the most challenging component of the strategy the Working Group is recommending. Identifying these core benefits through a transparent, evidence-based process, with consumer participation, can help to make all health care more effective and control health care costs. The group making these decisions would be established as a public/private entity to insulate it from both political and financial influence. It would also be an ongoing entity with stable funding, to guarantee its independence and to ensure that the benefit package continues to be responsive to evolving medical knowledge and practice.

THREE: Build a Better Health Care System

Promote Efforts to Improve Quality of Care and Efficiency

Recommendation 5 centers on how America can do a better job with the two trillion dollars spent every year on health by achieving greater efficiency and improving quality. Building on innovative strategies from both the marketplace and government to improve the quality and efficiency of the health care system and enhance the ability of individuals to receive high quality care will help to control health care costs. To date, most early successes have come in integrated delivery systems which have the concentrated resources and organizational structures to address waste and inefficiency. These resources and efforts should grow with implementation of the integrated community networks described above. The federal government, as a dominant purchaser of health care, has the ability to play a significant leadership role in promoting research and the development, demonstration, and dissemination of quality improvement efforts.

Fundamentally Restructure End-of-Life Care

As a part of improving the health care system and in response to the issue being raised persistently by the public, Recommendation 6 addresses the need to restructure end-of-life care. The American health care system must find ways to help individuals, families, and health care professionals deal with complex medical and supportive care needs more effectively by improving access to more appropriate and better care at the end of life. The Working Group acknowledges that end-of-life issues are often difficult, painful, complicated, and thus not conducive to quick or easy fixes. This recommendation seeks to better define, communicate, and make available at individual, family, community, and societal levels the support needed and wanted for one's last days.

Proposed Financing

Implementing these recommendations requires considering how to pay for them. There may be important opportunities to reallocate existing funds spent by state and federal governments. In addition, some of the actions proposed here may yield savings to the health care system in the long term, although it is unlikely that health system improvements will yield sufficient savings over the next few years to pay for the immediate actions recommended. In response to the potential need for new resources, the Working Group has identified principles which any new funding source should meet and offers examples of options which are currently part of the national policy debate and meet these criteria.

More detailed information, including background on the state of health care in America, analysis from the community meetings, comments and opinions provided to the Working Group, and relevant data from national polls and surveys, is reported in *Dialogue With the American People* and *The Report to the American People (revised 2006)*.

1. Establish Public Policy that All Americans Have Affordable Health Care

- **Americans should have a health care system in which everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security.**
- **This public policy should be established immediately and implemented by 2012.**

Context

In the discussion of underlying values and perceptions that began each community meeting, 94 percent of all participants agreed with the statement, "It should be public policy [written in law] that all Americans have affordable health care." Additionally, most respondents to the Working Group's Internet poll strongly agreed (80 percent) or agreed (12 percent) with that statement. People at many of the community meetings expressed the desire for "cradle to grave" access to health care, guaranteed in law.

A clear majority of participants preferred that all Americans receive health care coverage for a defined level of services. Currently, heath coverage – whether one has it and what is covered – depends on various characteristics, such as age or employment status. Between 68 and 98 percent of participants at the community meetings said that some defined level of services should be provided for everyone. In the Working Group's Internet poll, 85 percent of participants also opted for a defined level of services for everyone. These findings are consistent with national polls conducted that show a clear majority expressing the view that all Americans should have health insurance. For example, a national poll conducted in September 2005 found that 75 percent of U.S. adults strongly favored (52 percent) or somewhat favored (23 percent) health insurance that covers all Americans.

Americans Share Their Vision of a New System

Americans clearly want a system that guarantees health care for everyone. The most important considerations expressed focused on people having access to affordable health care and on coverage being reliable and secure.

In addition to reliable, affordable care, people want a system in which everyone is covered for most health care costs. They want a plan that, unlike many existing health insurance plans, cannot be cancelled or lost because of a change in employment status, be priced at unaffordable levels, or exclude those with pre-existing health conditions or ongoing health problems. This health care system would provide coverage for treatment of illness and injury, as well as preventive and palliative care.

Many Americans want to choose their health care providers and be able to communicate openly with them so that they can make good decisions about their care. They also believe that a simpler, more seamless system could

provide coverage to everyone more efficiently than the current system.

The implications of this vision for a new health care system are very important: Many Americans hold the view that public policy aimed at the growing crisis in health care costs cannot succeed unless all Americans are able to get the health care they need when they need it, and that all Americans pay their fair share.

Defining a Comprehensive National System

The Working Group heard from people supporting a wide variety of approaches ranging from enhanced free market choice to a totally public program as a way to ensure access to health care. A clear majority of Americans are in favor of a national policy ensuring universal coverage. However, "universal coverage" means different things to different people.

Some of the approaches advocated could be administered by private sector health plans, others could be organized through employer-sponsored coverage in the group market, and others could be run directly by the government. Many cited Medicare or the Federal Employees Health Benefits Program as models for a national system. Some identified the Veterans Health Administration (VA) system as another possible model, while others suggested that existing large integrated private health care systems could provide the best models. People pointed to these programs not only as examples of how to provide coverage, but also as systems that can better control costs and provide the infrastructure and resources needed to improve the quality and efficiency of health care delivery.

In addition to reflecting on existing systems in America, people who attended the community meetings frequently asked why other nations could provide universal coverage and still spend less per capita on health care while producing higher quality and better health for their citizens. They called attention to the strengths of these systems and many talked about their own positive experiences with a foreign health care system. Other participants pointed to problems to avoid within health care systems of other nations such as the lack of provider choice. For many, difficulties with cost and access to health care in America suggested a failure to apply widely held principles of fairness, careful management of resources, and shared responsibility.

The message clearly emerged that Americans want a health care system that is easy to navigate. They want to have stable coverage when circumstances change, such as when they graduate from college, change jobs, get married, or move to a different state. People want decisions about what is and what is not covered to be made in a participatory process that is transparent and accountable. These decisions would draw on best practices and be responsive to innovation in the marketplace, resulting in a clearly defined set of benefits and services for all Americans.

An important step in realizing this vision is establishing an ongoing mechanism for identifying and updating core benefits and services that would ensure access to appropriate health care for all Americans. This "core," described in

Recommendation 4, does not limit Americans to these benefits and services alone. However, it will describe a set of basic benefits that everyone should have. Most importantly, this mechanism would employ the best available evidence and promote the use of efficient, high-quality care rather than create barriers to it.

Setting a Timeline for Realizing Change

The overwhelming majority of Americans that the Working Group heard from want health care system change to begin now. Consistent with timeframes associated with other major health system reforms, the Working Group is proposing immediate action to establish the policy that all Americans have affordable health care, with a suggested target of 2012 for both implementing core benefits and services and making substantial progress in implementing the improvements that are needed to support it.

2. Guarantee Financial Protection Against Very High Health Care Costs

No one in America should be impoverished by health care costs. A national public or private program must be established to ensure:

- **Participation by all Americans**
- **Protection against very high out-of-pocket medical costs for everyone**
- **Financial assistance to pay for this coverage to families and individuals based on ability to pay**

Context

Devastating injuries and serious illness can cost families and individuals hundreds of thousands or even millions of dollars in health care expenses. As one participant said, "*homes and savings can be lost in the blink of an eye*." Out-of-pocket costs of treating an injury or illness can bankrupt not only those with little or no health insurance and modest incomes, but also many insured or wealthy families.

Many Americans already have coverage that protects them against these high costs. However, protecting all Americans against impoverishment from high health care costs is not just a simple matter of providing some form of standard coverage, because catastrophic costs are experienced relative to income and wealth.

Coverage that protects against high out-of-pocket medical costs can be designed in many ways. A number of states have designed re-insurance programs that cover the highest health care costs in the small group or individual insurance markets. Others have set up high-risk pools designed to provide coverage for people who cannot get insurance in the private market. These programs are intended to help open up private insurance markets to more people by limiting the risk that insurers face if people incur very high health care costs. Policy experts and professional organizations have proposed different types of federal programs to provide re-insurance or to protect individuals from very high out-of-pocket costs.

Stabilizing Employer-Based, Individual & Small Group Markets

Currently, many employers facing high and rising premiums are reducing their level of support for health insurance coverage to their employees. This in turn exposes more Americans to the potentially devastating financial impact of getting sick or injured. The expectation is that a policy requiring all Americans to be covered for high out-of-pocket costs would help to both stabilize existing employer-based health insurance markets and expand the private individual and small group health insurance markets. This would result in the ability to offer protection to Americans who are currently uninsured or underinsured. High-cost coverage protection would also result in lower premiums for "front end" individual, small-group, and large-group health insurance products.

If new requirements for insurance coverage are put into place, whether in a

private, public, or private/public blended program, incentives to employers and individuals would change. Some employers may reduce the coverage they offer because their employees would be able to obtain this new high-cost protection coverage on their own. However, many employers who were intending to drop or reduce health insurance coverage as a fringe benefit would now participate in the purchase of high-cost protection coverage for their employees. This would result in an expansion in coverage over what would occur under current market conditions.

Relief for Public Programs

In addition to helping stabilize private health insurance markets, a federal program providing high-cost coverage could shift some burdens among federal and state programs. For example, although the federal government would have to spend more to subsidize the costs of the new coverage, it could eliminate some payments it now makes for unpaid health care bills. High-cost coverage could also provide significant relief to some public programs, including Medicaid, which in turn would give states the opportunity to redirect funds to expand coverage for low-income individuals or families or others who are uninsured or underinsured.

Ensuring Everyone Can Get and Keep Coverage

Although there are important differences in the ways that approaches to catastrophic coverage could work in a national program, any solution will have to address the basic issue of making sure everyone is able to get and keep coverage, regardless of health care status, need for services or ability to pay. Building a system that protects all Americans from very high medical costs will offer immediate help to people at serious risk. In addition, it will offer lessons on how to structure broader coverage of core benefits and services.

Features of Universal Protection:

- Everyone participates, with households, businesses, and government sharing in the financing.
- Regulations ensure
  - community rated premiums
  - benefit standardization
  - guaranteed reissue provisions, and
  - the organization of risk pools.
- Government-financed subsidies be made available based on ability to pay.

After listening to and analyzing the needs and ideas of the American people and discussing the topic with experts, the Working Group developed two possible frameworks that would meet the requirements of universal protection and guard against very high health care costs: The Market–Based and the Social Insurance models.

The Market-Based Model

The basics of the market-based model are as follows:

- All Americans would have to obtain coverage against high out-of-pocket costs.
- Individuals would be offered a choice of standardized high-cost insurance products, whose details would be easy to understand and easy to compare.
- The products would offer protection at different levels of out-of-pocket costs to individuals.
- Individuals would be free to purchase the policy that best suits their needs. Since individuals with the lowest incomes also face impoverishment with all but the most expensive plans, premium subsidies would be provided based on ability to pay, and would diminish with increasing income levels.
- Employers would retain a role in paying for or providing health plans.

The Market-Based Model: An Example

For illustrative purposes only, consider three policies covering the same set of services:

- Policy A with a deductible of $4,000 in out-of-pocket expenses prior to full coverage of covered services
- Policy B with a deductible of $12,000, and
- Policy C with a deductible of $30,000.

These deductible levels are similar to policies currently offered in the individual insurance market. Based strictly on coverage offered, Policy A would have the highest premium, Policy C the lowest premium.

The Social Insurance Model

A second approach is based on a social insurance model:

- All Americans would be required to participate in a federal government program protecting against very high out-of-pocket costs.
- The program, like Medicare, would be administered by the federal government through private-sector contractors.
- The program would be funded through a combination of premiums and earmarked federal revenues. Premiums would be structured to be fair and affordable, based on a sliding scale or surcharges related to income.
- Federal subsidies, based on ability to pay, would be provided to pay premiums.

The Social Insurance Model: An Example

In an illustration of this coverage approach, protection would be provided against out-of-pocket costs for covered services that exceed some percentage of income—such as 20 percent of taxable income above the federal poverty level—or that exceed a fixed dollar amount of individual liability—such as $30,000—whichever is lower.

3. Foster Innovative Integrated Community Health Networks

The federal government will provide leadership and financing for a national initiative to develop and expand integrated public/private community networks of health care providers. This recommendation should be accomplished through the following actions:

- **Focus first on people and localities where improved access to high quality care is most needed. These networks would offer local residents – including, but not limited to, low-income and uninsured individuals and people living in rural and underserved areas – a source of coordinated health care.**
- **Identify governmental agencies at the national, state and local levels to coordinate private and public funding sources currently dedicated to helping provide care to the underserved by supplying the necessary information and leadership.**
- **Establish a public/private group or not-for-profit entity at the national level responsible for advising the federal government on the community health care network's performance, funding streams, best practices and research.**
- **Expand and modify the Federally Qualified Health Center concept to accommodate other community-based health centers and practices serving vulnerable populations with special emphasis on families and prevention.**

Context

At community meetings and through online discussions, the Citizens' Health Care Working Group heard stories about the difficulties many people face obtaining health care. While anyone can experience these problems, they are especially severe for certain populations, particularly those with lower incomes, who lack insurance, or who live in underserved areas.

"Fix the delivery system first," was the closing comment at one community meeting and a sentiment expressed throughout the public engagement process and by many experts. Among the many delivery system problems cited were: a lack of primary-care providers, the inability to access specialty care, and difficulties in navigating a complicated system, especially for those with chronic conditions.

Participants emphasized the importance of having access to health care in their local communities and the need to keep systems simple and easy to navigate. Citizens in multiple locations spoke highly of the continuity of care and easy access to needed services they receive from some of the large, integrated delivery systems and health plans.

Across the board, citizens expressed strong support for neighborhood health clinics. When asked about ways to help ensure access to affordable health care services, participants consistently ranked expanding community health clinics as the second or third choice. Online, 74

percent of respondents either agreed or strongly agreed with such expansion.

The Current Picture

The Working Group has been impressed by the creativity and energy some localities have brought to improving their health care delivery systems. Many of these localities have successfully coordinated public and private funding sources to achieve seamless local systems of care that address health care needs throughout the lifespan. Examples of such local initiatives are described in *The Health Report to the American People.*

However, despite these positive examples, more needs to be done to fill gaps in both financial support to and services provided by local health care providers and organizations. Efforts to do so will allow these networks to function as truly integrated community systems.

At present, local providers negotiate a host of diverse funding programs targeted at different subpopulations, from a variety of state and local government agencies as well as national, regional, and local philanthropic organizations, foundations and other private organizations. Community systems also receive reimbursement for services from public and private insurers and direct payments from patients.

The result is a mixture of revenue streams, with each source beginning or ending at different times. From this ever-changing pool of funding, local systems must design a set of short-term programs providing services some of the time to some of the people. Inconsistencies in services provided and population served contribute to confusion, frustration and missed opportunities.

In order to meet their full potential to serve those most in need, these systems must be able to devote more of their energies and talents to the provision and management of care. As one participant remarked, *"by assisting the development of community-based health care centers, we begin offering services at more convenient times for the ever busy American public and take pressure off the emergency room systems."*

Developing Innovative Integrated Community Networks

At meetings, participants described a vision of an integrated community network. It would be a system where health care providers at the local level work together to ensure:

- Everyone has a "medical home" and access to primary, mental, and dental health care
- Wellness and prevention are emphasized at the community level
- Referrals to medical specialists, hospitals, and other providers, when necessary, are made easily and follow-ups are made consistently
- Medical records are available to providers within the network when needed and in full compliance with privacy laws
- Evidence-based care is delivered effectively and efficiently, making use of certified nurse practitioners, licensed visiting and practical nurses, medical assistants and other physician extenders

- Patients do not encounter bureaucratic barriers in seeking and receiving appropriate care

Primary care, as the entry point for the health care system, is the foundation of an integrated network. But the networks also could play an important role in coordinating care for people with acute and chronic health conditions, as well as offer mental health and dental health care. In addition, they should further best practices in health promotion and prevention, including services such as health education, nutrition counseling, and wellness checks to the healthy members of their communities. In essence, community networks can provide the tools needed to help everyone in the community be good stewards of their health and their health care.

The Working Group has concluded that a community-centered approach will not only be good for the health of individuals but also will improve the community's general well-being. These networks should be open to all who wish to participate—with special efforts being made to find, connect with, and offer needed support to those who are most in need of help.

Expanding What Works: Technology, Innovation, Federal Support

Better communication across providers of care is essential to sharing resources and reducing duplication of effort. This can be facilitated through the use of new technologies, in particular, electronic health records and telemedicine. Implementing these technologies at the community level has the potential to benefit community providers and their patients by improving the continuity of care, reducing duplication and medical errors, and providing increased access to specialty care for individuals in urban, as well as remote and isolated areas.

Encouraging innovation at the community level through new or expanded public/private partnerships is central to improving community health networks. Public support, both structural and financial, from all levels of government, will give any community the tools it needs to better coordinate and manage the health resources already at its disposal.

In addition, the Working Group recommends that some of the eligibility requirements for Federally Qualified Health Centers be modified for community-based health care providers offering comparable services to similar populations. With certain exceptions, benefits at the federal government level, such as grant funding, cost-based reimbursement, access to reduced-price prescription drugs, and malpractice liability coverage under the Federal Tort Claims Act, are limited to Federally Qualified Health Centers. Expanding these benefits would serve as an incentive for a community-based organization to participate in an integrated network.

Americans in the community meetings expressed approval of and appreciation for responsive, accessible local health care. Fostering integrated community health networks through these changes will build on current successes and strengthen the safety net for those who need it most while expanding innovative health care to more Americans.

4. Define Core Benefits and Services for All Americans

Establish a nonpartisan public/private group to define America's core benefits and services and to update it on an ongoing basis

- **Members will be appointed through a process defined in law that includes citizens who represent a broad spectrum of the population, including, but not limited to, patients, providers and payers.**
- **The group will be staffed by experts.**
- **Identification of core benefits and services will be made through an independent, fair, transparent, and scientific process.**

Within economic constraints and guided by evidence-based science and expert consensus regarding the medical effectiveness of treatments, the group will define the core benefits and services based on the following principles:

- **Core health services will cover the continuum of care throughout the individual's lifespan.**
- **Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education, and the treatment and management of health problems provided across a full range of inpatient and outpatient settings.**
- **Health is defined to include physical, mental, and dental health.**
- **Over time, this entity would appropriately take into consideration advances in clinical science**

Context

The conversations in each and every community meeting demonstrated how difficult the task of defining basic health care coverage will be for policymakers. In almost every instance, groups of citizens could not agree on much except including everything in a basic benefit plan. Discussion groups had difficulty reaching consensus about what types of services would be optional, reflecting how differently people value services and types of care.

Participants made it clear that they trusted their fellow citizens and medical providers and, to a lesser degree, governments to make the tough choices in the absence of unlimited resources. They also expressed a clear interest in using sound information on cost-effectiveness as criteria for making smart choices.

As was the case in many deliberations, the public was aware of the political challenges involved in making such decisions. They highlighted the virtues of independent commissions along the lines of the "Base Closing Commission" in helping policymakers with such choices. Several times it was suggested that "some new entity or process needs to be created that includes all the relevant stakeholders, the foremost of which would be the consumer." Consequently, the Working Group recommends the creation of a structured process and guidelines for how decisions are made when determining what should be included in a core benefit package.

Determining Core Benefits and Services

To define a set of benefits and services that works for all Americans, the best methods must be applied in a transparent process. Consumer participation is critical to ensuring public trust in the process and that personal values and preferences are taken into consideration in coverage decisions. The group making decisions would be established as a public/private entity to insulate it from both political and financial influence. The group would be an ongoing entity with stable funding, to guarantee its independence and to ensure that coverage continues to be responsive to evolving medical knowledge and practice.

The work of this entity can simultaneously help to make all health care more effective and efficient, while aiding to control health care costs overall. This recommendation works in conjunction with the recommendation on efficiency, effectiveness, and quality of care because up-to-date evidence on what works best in health care will be the basis for decisions about the benefits and services included in the core set.

Defining benefits and services can be accomplished through a structured, participatory process. Decisions would be based on assessments of how important it is to ensure that treatment is covered while taking into consideration the effect on individuals' health, public health, and the effectiveness of treatment options. The process would include full participation of consumers, health care providers, and relevant experts.

This process of identifying core benefits should also reinforce the principle of comprehensive health care coverage through a system of shared responsibility. Evidence used to make decisions about coverage can contribute to improvements in the overall efficiency of health care delivery and help patients and providers make informed decisions. Sound evidence could also provide a way to link cost sharing to more efficient health care.

Evidence-Based Practices as a Foundation

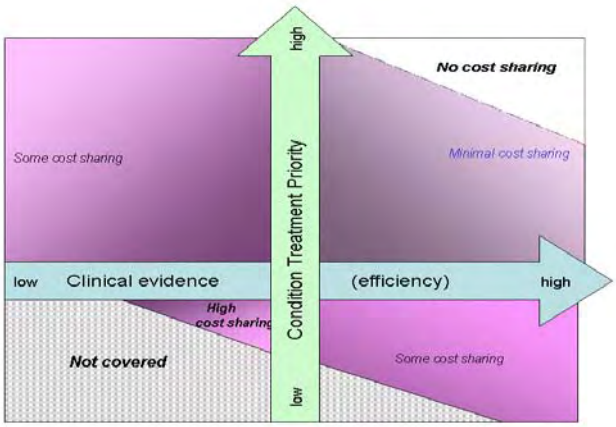
The core benefits will be developed using the growing body of evidence on the effectiveness of medical therapies, procedures, and devices. This information is based on specific levels of evidence, such as clinical trials, effectiveness studies, comprehensive reviews of published analyses, and expert consensus. It is being gathered through ongoing processes organized by professional organizations and providers, state-led efforts to inform coverage policy for Medicaid and the State Children's Health Insurance Program, federal activities such as the U.S. Preventive Services Task Force and the Evidence-Based Practice Centers and supported by the Agency for Healthcare Research and Quality, and international collaborations focused on assessing the effectiveness of clinical care.

The group would draw upon these multiple sources of expertise to establish a clear set of rules for assessing the evidence that will, in turn, be used to determine benefits and services included in the core set and to update it when appropriate.

A Fair, Evidence-Based System to Determine Benefits

A look at the graphic representation on the right reveals how this process of defining benefits could work:

- The vertical arrow represents a structured process that identifies, then prioritizes the medical conditions and the treatments and services that need to be covered.
- The horizontal arrow represents the efficiency of specific treatments or services, based on credible evidence that takes into account cost-effectiveness.



Benefit design can promote more efficient health care

By way of illustration, if there are two equally effective ways to treat a particular medical condition, but one costs twice as much as the other, the less expensive treatment would have a higher efficiency rating. Health services and treatments that are deemed essential and cost-effective could be offered with little or no cost-sharing. Certain kinds of preventive care, such as childhood vaccinations, would be prime examples. Treatments that have not been proven to be medically effective would not be covered at all, to discourage their use. People who choose to obtain treatments or services proven to be not as cost-effective as covered alternatives would pay more of the costs for that care.

Aligning the Core Benefits with Current Coverage

Most people currently get their health coverage through employer sponsored insurance, while more than a quarter of all Americans receive health care coverage from a public program. Establishing a core set of benefits and services for all Americans means reassessing the benefits currently provided in both public and private programs. Coverage and benefits vary across types of employment or industry, local insurance markets, and public programs reflecting specific requirements set out in law, as well as policies driven by budgetary constraints and other factors.

For many people covered by public programs, the services and benefits being provided represent specific forms of commitment that society has made to tens of millions of women and children living in poverty, people with disabilities, people who are elderly, veterans and military families, Native Americans, and others. Benefits often cover a broad spectrum of health care reflecting the needs of these specific populations and can include prescription drug coverage, mental health assistance, personal services, dental care, and vision and hearing services.

The core set that results from this process may look different from many public and private systems. It would likely be broader in some respects than the current Medicare benefits package. For example, Medicare's mental health

coverage is very limited, and hearing and vision services are generally not covered. If broader coverage contributes to more effective treatment and management of illness, changes to Medicare's benefit package would be appropriate.

The Working Group understands that some services may not be included. Some benefits and support services now covered by Medicaid can help people with disabilities and serious chronic illnesses live as productively as possible in their homes and communities. Since specifically targeted programs, including those that are part of state Medicaid systems, can provide some of these services more effectively, and some of these services include nonmedical support, they may not be covered as core benefits. Examples include personal assistance and respite services, medical supplies and assistive devices, home and vehicle modifications and transportation services. As discussed in Recommendation 6, on end-of-life care, these services, along with the full range of long-term care services that will become increasingly important as society ages, need to be integrated more effectively in a health care system that works for everyone.

Similarly, the core benefits may be more generous than benefit packages of some employer based plans and less generous than others. However, establishing a core set of benefits and services, reflecting sound medical evidence, as a standard against which any coverage plan can be evaluated will go a long way toward creating health care that works for all Americans.

5. Promote Efforts to Improve Quality of Care and Efficiency

The federal government will expand and accelerate its use of public programs for advancing strategies that improve quality and efficiency across the health care system.

Using federally funded health care programs, the federal government will promote:

- **Integrated health care systems built around evidence-based best practices**
- **Health information technologies and electronic health record systems**
- **Elimination of fraud and waste in administration and clinical practices**
- **Widespread availability of consumer-friendly information about health care services, including transparency on prices, cost-sharing, quality, efficiency, and benefits**
- **Increased focus on health education, disease prevention and health promotion, patient-provider communication, and patient-centered care**
- **Biomedical research aimed at improved quality and efficiency**

Context

Throughout the public discourse, major concerns were voiced repeatedly: How can America do a better job with the two trillion dollars a year spent on health? What can be done to achieve greater efficiency and improve quality?

Part of the public's interest stemmed from concerns about the cost of health care and what many perceived as waste and inefficiency in the current system. Many spoke out about administrative costs and profits, often pointing in particular to the high costs of prescription drugs and a frustration with for-profit health insurance. A common theme was "Who, or what, is the current system designed to serve—the patients or the health care industry?" As one participant remarked, "it is often more stressful to deal with the insurance company than the disease." Review of the evidence suggests that what is driving health care costs may not be as simple or easy to fix as many people have come to believe. But the problems are very real and there is clear support for initiatives to tackle the issues surrounding efficiency and quality of health care in America.

The public saw a connection between quality and cost. For example, many agreed that greater investment in health information technology and moving to an integrated system of electronic health records could improve administration and treatment while reducing medical errors. More than two-thirds of respondents to the Internet poll supported more investment by doctors, hospitals, and other providers in health information technology as a means to improve quality and increase administrative efficiency. Furthermore, many participants in the community meetings discussed the desirability of using medical evidence to decide which services are covered and provided. Similar results have been found in national polls.

Individuals have the ability and the desire to be informed health care consumers and a positive influence in efficient treatment decisions. On the one hand, people expressed a need to have more information about how to use health care better and more effectively. This is a sentiment found in national polls which show that many Americans believe they do not have enough information about hospitals and other health care facilities to make educated health care choices. One participant suggested that Americans "would be willing to pay for some of the cost of their care if they could understand up front the risks, costs, and benefits of different treatments for their medical maladies." On the other hand, concerns were voiced about a family's difficulty making informed medical decisions in times of crisis.

The Cost of Poor Quality Care

Above all, it is clear that the economic cost of poor quality health care and medical errors is high. These costs are in addition to the pain and suffering – and in some cases, the loss of life – resulting from overuse, underuse, and misuse of medical services.

Waste in the health care system can take many different forms. Examples include: unnecessary care induced by excess capacity (e.g., using hospitals, diagnostic equipment, physicians simply because they are available), a failure to avoid preventable complications (such as reactions to medications and some hospital-acquired infections) and the associated costs of additional care delivery, and inefficiencies, especially those resulting from a fragmented delivery system. These examples do not include costs associated with the underuse of proven diagnostic and preventive protocols that can forestall treatment of preventable medical conditions. Additionally, one must take into account the indirect costs to individuals and employers of lost productivity and earnings.

Experts who testified at Working Group hearings estimated that the total costs of health care for the nation could fall by 32 percent, and survival rates increase by 2 percent, if all communities were to utilize medical specialists, hospital beds, and ICU beds at the same rate currently used by some leading integrated delivery systems in the United States. Additional cost savings may reasonably come from chronic disease management and reductions in care-associated injuries. A forthcoming report supported by the Agency for Healthcare Research and Quality of front-line inefficiency, as health care providers struggle with a massively complex, poorly coordinated, health care enterprise, categorized 35 percent of all efforts as waste. Taking the testimony and study together indicates that a significant portion of all health care expenditures produce no added health value. Fraud and abuse, while relatively small compared to the health care system's problems discussed above, still correspond to significant additional economic losses and represent opportunities for improved care at a lower cost.

Concentrated efforts in some integrated health care systems have demonstrated care can be improved and waste eliminated. Continuous improvement methods have reduced costs by optimally managing chronic conditions, reducing preventable care-associated patient injuries, and designing

coordinated systems of care delivery that reduce hassle and rework.

However, continuous improvement efforts rest on fundamental change in underlying medical practice and professional culture – a difficult, long-term, proposition. Widespread improvement will require a much better understanding of how to "do it better" (investment in health care delivery research), restructured training programs, significant organizational restructuring, and investment in aligned health information technologies and systems. To date, most early successes have come in integrated delivery systems, which have the concentrated resources and organizational structures to address these needs.

The ramifications are clear—improvements in health care outcomes that produce significant cost reductions are achievable, but over the long run. Success will require fully integrated systems of care as well as committed management.

Building on Existing Models for Change

Important, innovative work in quality and efficiency improvement is under way in a number of local and regional private systems around the country as well as in government programs. New initiatives being tested—often with the private sector and federal government working together—allow doctors, clinics, and hospitals to share medical information safely and efficiently.

Health care providers, employers who purchase health care, and public programs are all working together to reduce preventable medical mistakes. These groups are testing ways to measure performance of physicians, hospitals, and other health care providers by using data available to the public. They are trying out ways to use information on provider performance to reward high-quality providers and to reward consumers for using more efficient, higher quality providers. Some employers are introducing innovative practices to enhance employee health that may also reduce costs. For example, some support wellness centers and physical fitness facilities. Others are using financial incentives to encourage employees to stop smoking or lose weight.

The federal government has also been active in this field. The Veterans Health Administration has been developing performance measures as a basis for improving care and efficiency in clinical settings. The Centers for Medicare and Medicaid Services participates with several private and public groups to promote quality care and measurement and has introduced a number of its own initiatives in the areas of nursing homes, home health, hospitals, physicians, and end-stage renal disease care. Development of quality measures, especially when these can be related to evidence-based medical practice, is a key component of any strategy to improve quality and reduce unwarranted practice variation. In August of 2006, the Secretary of Health and Human Services announced a new initiative to facilitate and promote wider and more effective use of quality measurement tools and health information technology.

Efforts in both the public and private sectors can also help to ensure the benefits of ground breaking biomedical

research that hold great potential for prevention and treatment of disease are, in fact, used effectively.

Federal Government Leverage

In the Working Group's Internet poll, participants overwhelmingly supported the view that both the public and private sector play a role in improving efficiency.

With this in mind, it is crucial to consider the implications of the federal government's role as a dominant purchaser of health care. It also plays a significant role in the research and evaluation of the delivery of health care services. Therefore, it is well positioned to provide leadership in this field.

A variety of federal programs could be used for development, demonstration, and dissemination of reform efforts. These programs run the full range of design possibilities, making them particularly useful for "beta testing" of new ideas.

Health care researchers and practitioners are well aware of the practical difficulties of replicating these improvements on a wide scale. To do so will take concerted public/private effort and strong leadership. The federal government should work with private sector organizations to ensure that these programs are evaluated fully and fairly.

As noted earlier, there are federal agencies like the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services (within the Department of Health and Human Services) that already support evaluations. However, in order to fully realize this advantage, they may need to broaden the scope of their demonstrations and experiments and, perhaps, seek expanded authority to do so. If successful quality improvement efforts can be adopted by significant numbers of providers, the cost savings and improved health outcomes might spur a truly fundamental reform of the nation's health care system.

6. Fundamentally Restructure the Way End-of-Life Services Are Financed and Provided

End-of-life care should be fundamentally restructured so that people of all ages have increased access to these services in the environment they choose.

- **Public and private payers should integrate evidence-based science, expert consensus, linguistically appropriate and culturally sensitive end-of-life care models so that health services and community-based care can better handle the clinical realities and actual needs of patients of any age and their families.**
- **Public and private programs should develop and support training for health care professionals that emphasizes proactive, individualized care planning and clear communication between providers, patients and their families.**
- **At the community level, funding should be made available for support services, including nonmedical services, to assist individuals and families in accessing the kind of care they want for the last days of their lives.**

Context

End-of-life care surfaced as an issue at virtually every community meeting held by the Working Group. Americans clearly agree that alternatives to medical and surgical interventions of questionable value for people with advanced incurable illnesses and for those nearing the end of life should be encouraged. Many argue that current end-of-life care is expensive, that it often does not improve the patient's quality of life, that it is too often based in hospitals or nursing homes and that it may not be consistent with the wishes of the patient or family.

In place of those interventions, the people we heard from expressed preferences for providing at-home and comfort care. There was a desire for individuals nearing the end of life and their families to receive support from the health care system in understanding their options, making their choices about care delivery known, and having those choices honored. Greater emphasis on providing palliative care met with strong support in the Internet poll and community meetings, with 61 percent and 63 percent, respectively, agreeing or strongly agreeing.

End-of-life care is not restricted to the elderly. At some community meetings, participants expressed concerns about the difficult issues surrounding the care of other populations with terminal medical conditions, including very low-birth-weight babies.

Discussions at all community meetings underscored the importance of this issue to Americans. A community meeting was held in New Hampshire that focused specifically on end-of-life issues. Values expressed by meeting participants included honoring personal choices, providing adequate pain relief, and ensuring that health professionals treat persons nearing the end of life with dignity and respect. Importantly, it was noted that payment incentives for end-

of-life care are currently misaligned with these values. The current system encourages heroic interventions in hospitals and care in nursing homes in lieu of low technology care, support, and time spent with health care providers.

Also playing an important role in end-of-life care are nonmedical services, such as transportation, personal care, and assistance with meal preparation. New models of care delivery must do better at taking into account language barriers and cultural differences. However, it is most essential that care is focused on maintaining the dignity of patients in their last days.

Cost, Quality and Efficiency

A major fear for many people as they approach death is the financial burden their care may place on their families. It has been estimated that expenses in the last year of life constitute 22 percent of all medical expenditures. New models of care delivery should do a better job of knitting together community-based services—often nonmedical—to meet the needs of people nearing the end of life and their families.

A new model of care becomes even more critical as people live longer with chronic conditions. A stronger focus on knowing both what works and when medical intervention serves no good purpose, coupled with more consumer-friendly information and better provider-patient communication, will help seriously ill people and their families make informed choices about care. More information on quality and efficiency will also begin to address the current substantial regional variations in intensity and cost of health services used by the elderly, aligning these variations to outcomes.

When developing a new model of care, there is much to learn from leaders in the field of palliative care such as the Hertzberg Palliative Care Institute at the Mount Sinai School of Medicine in New York City. Also, the demonstration projects funded by the Robert Wood Johnson Foundation from 1998 through 2004 in its "Promoting Excellence in End-of-Life Care" initiative offer examples of new care delivery models that emphasize coordination and continuity of care.

Helping Americans have the "good death" they desire will require change. At the policy level, new care models must address the extended periods of fragility many Americans experience. Payment policies and professional medical training programs must be adjusted accordingly. For example, Medicare reimbursement for hospice services needs to better account for the most common patterns of death and dying while accommodating the differing trajectories of common causes of death. Payment for providers needs to be less procedure-driven and take into account essential time-intensive services such as provider-patient counseling and guidance. End-of-life care must become a central training component for all health professionals who have direct patient contact.

Serious illness and death can occur at any age. As new models for care delivery and patient and family support mechanisms develop, the special problems faced by terminally ill newborns or children and their families must be considered as well.

Areas of Need Extend Beyond the Health Care System

A comprehensive system of care for the dying extends beyond the health care system. Here are a few areas that must be considered when restructuring end-of-life care:

- Professional and family caregivers: More attention needs to be given to professional caregivers as well as to family members who become caregivers. Direct-care workers usually receive low wages and few benefits. They often work part-time and are themselves uninsured. As the number of elderly Americans increases and more caregiver services are required, the system will need to offer better pay, improvements in training, and opportunities for professional growth in order to meet the increasing demand.

- Objective, useful information on needs: Policy development is currently hampered by a lack of useful information about patients, their needs, and their use of services. The development and use of standardized instruments for collecting demographic, epidemiological, and clinical information, careful evaluation of emerging care models, and the dissemination of best practices are all needed to improve care for the dying.

The concerned and thoughtful attention to end-of-life issues that emerged through the public dialogue made clear to the Working Group that change is needed. The passion expressed by participants emphasized the importance of such change. The Working Group acknowledges that end-of-life issues are often difficult, painful, and complicated and thus not conducive to quick or easy fixes. One person commenting on the Working Group's web site said, "When one is reaching the end of life, it's hard and unimaginable to think that you and your loved ones are not getting the proper support." This recommendation seeks to better define, communicate, and make available at individual, family, community, and societal levels the support needed and wanted in one's last days.

Paying for Health Care for All Americans

No plan to address the serious shortcomings in today's health care system would be complete without considering how to pay for it. In doing so, the Working Group members considered the discussions at community meetings, citizens' comments received in its web-based polls, and public opinion expressed in national polls. Members also discussed a number of proposals put forth by government agencies, think tanks, and scholars.

The Working Group arrived at three guiding principles to financing new initiatives:

- The financing methods should be fair. Fairness is evaluated using three factors. First, financing methods should not have the effect of creating a disproportionate increase in the financial burden on the sick; second, responsibility for financing of health care should be related to a household's ability to pay; and third all segments of society should contribute to paying for health care.
- The financing methods should increase incentives for economic efficiency in the health sector and the larger economy.
- The methods should be able to realize sufficient funds to pay for the recommended actions.

As noted above, everyone – government, families, and businesses – must be involved in improving health care. The Working Group heard over and over again that everyone has a stake and everyone must contribute.

Overview of Approach

The Working Group believes that a number of the recommendations made in this report force a difficult choice of finding sources to pay for these actions or contributing to sizable budget deficits.

The Working Group believes that some of its proposed actions would result in opportunities to reallocate existing funds spent by state and federal governments. These would include payments by Medicaid under disproportionate share (DSH) provisions, high-cost risk pools, and uncompensated care payment programs.

Some of the actions proposed in this report may also yield savings to the health care system in the long term (as noted in the discussion on quality and efficiency). Since these recommendations call for immediate action to develop protection against high health care costs and investment in further development of integrated community health networks, some funds will be required right away. Based on the evidence and conversations with experts, the Working Group has concluded it is unlikely that health system improvements will yield sufficient savings over the next few years to pay for some of the reforms recommended in this document.

In addition to reallocating existing funds and harnessing savings, a third source of financing would stem from making changes in existing government subsidy programs that are at once inefficient and unfair. Based on recent reviews of federal subsidy programs by the Congressional Budget Office (including the Annual *CBO Budget Options*), the

President's Commission on Tax Reform and independent scholars from across the political spectrum, the Working Group believes that significant funds would be available by altering such public subsidy programs in a way that improves both economic efficiency and fairness.

Finally, if these sources were not sufficient to address the funding requirements of the six recommendations presented, new revenues would have to be considered.

The Working Group strongly believes that in order to gain the confidence of the American public it is critical that funds obtained from reallocations, savings, changes in subsidy arrangements, or new revenues be specifically dedicated to health care coverage.

Citizen Input on Financing Issues

Based on a review of national polls, the Working Group's own Internet polls and discussions at community meetings, it is clear that a very large segment of the American people believe there are sufficient funds associated with American health care to pay for health care that works for all Americans. As a result, there is a strong sense in the public that reallocation of existing public funds, changes in subsidy programs, and increased efficiency should take priority in funding the recommended actions.

Yet when posed questions about the possible need for new revenues, we found, across the board, that majorities of the population were willing to pay more to ensure that all Americans are covered. This has also been found consistently in national polls. The specific option raised most often in meetings and comments was some form of progressive, or "sliding scale" income or payroll tax (like the Medicare payroll tax) specifically dedicated to supporting health care for all. Some who supported this approach to financing indicated that they personally could not afford to pay any more; health care costs have strained their budgets to the limit. A smaller group of respondents expressed strong opposition to any form of taxation at all.

We also heard other specific proposals for raising revenues to support health care for all Americans. Some examples follow.

"Some sort of a general consumption tax (sales tax) adjusted for the product based on factors such as its healthfulness and use to low vs. high income consumers (e.g., 1% on grocery products, 10% on fast food, 2% on a used car, 5% on a new car, 1% on a canoe, 8% on a power boat, etc.) could be the fairest."

"I believe this can be financed with greater (and enforced) corporate income taxes, graduated enrollee contributions, and the like. Fairness demands that the revenue not come from sales tax or any tax that has the greatest impact on the Americans who have the least income."

"Short-term security for Americans at risk should be from the federal and local tax bases. I say yes to a "sin" tax."

"It seems to me that fairest, least complicated way to fund an affordable, accessible health care system for everyone is through an income tax deduction or a value-added tax. How

about a 5% tax on every soft drink sold in America?"

The Cost of Inaction

If the United States Congress decides that fundamental change in health care is either too disruptive to the economy, too complex, or too controversial and defers further action at this time, the Working Group fears that the cost of this inaction to American families goes beyond dollars and cents.

The problem of medical providers charging the insured more to cover costs of the uninsured will become even more prevalent. Public budgets will continue to feel the pressure of both the growing numbers of uninsured people and of the aging population, as long-term care costs consume an even greater share of Medicaid funds. Additionally, uncompensated care costs—now estimated to be more than $40 billion annually—will continue to rise, placing huge burdens on hospital providers and even forcing many safety net providers to close.

Furthermore, health care premiums will continue to rise. These increases will make it more difficult for many businesses to continue coverage for their workers and retirees; they will continue paring down coverage and shifting costs to employees. Individuals and families will find it more difficult to purchase coverage from their employers or the individual market and may not be eligible for public programs. States will continue to explore ways to provide coverage to their residents, but finding the revenue to pay for these programs could threaten budgets or lead states to raise revenues in ways that drive out businesses. The uninsured will continue to receive less care and less timely care, to sustain more financial risk and to live, on average, shorter lives. The ramifications of the changes above will reach to every facet of American society, fundamentally altering the economy from what it is today.

A do-nothing response today will merely delay this impending crisis for others to tackle at a later date, at which time the size of the problem—the cost of inaction—will be much larger.

The Citizens' Health Care Working Group urges timely action on these recommendations for making health care work for all Americans.

Comments

TRANSFORMED U.S. HEALTH CARE SYSTEM
Alternative Perspectives to the Working Group Majority's Recommendations
Author: Randy Johnson, September 2006

Summary

The Citizens' Health Care Working Group (CHCWG) was appointed by the U.S. Comptroller General in accordance with provisions included in the Medicare Modernization Act, and charged with submitting recommendations to the President and Congress that would result in "Health Care that Works for all Americans."

"The Health Report to the American People," released by the Working Group in October 2005, indicates the **average annual health care cost per person** in 2004 was $6,300 and projected to be $11,000 by 2014. Despite the increasing cost, patients receive only 55 percent of the care recommended by experts, and, according to the Institute of Medicine, there are as many as 98,000 deaths annually due to medical errors in hospitals. The U.S. Census Bureau has reported that 84 percent of us in the U.S., more than 247 million, have health insurance (approximately 175 million in employer-based programs, 40 million in Medicare, 38 million in Medicaid, 27 million in direct purchase programs, and 11 million in military programs with some having coverage under more than one type of program). Yet, approximately 47 million people (about 16 percent) in the United States do not have health insurance. So, reducing costs, improving quality, reducing waste and errors, and ensuring coverage are the critical elements required to fix our health care system.

This paper provides alternative recommendations to those of the Working Group majority due, in part, to concerns related to the "dialogue with American citizens" (see "Process" section below).

1. The following recommendations are based on expert testimony from the hearings, input from the community meetings, recent trends by employees who are covered by health plans today as well as my own experience in developing and implementing health care initiatives for 30-plus years.
2. Recognizing the current U.S. entitlement programs' obligations, the focus of "shared responsibility" rests more on individuals and less on the government.
3. The following depend more on private initiatives and less on government solutions.

Alternative Recommendations to Transform the U.S. Health Care System

The following illustrative recommendations are alternatives to those of the Working Group majority. They build on the strengths of the current U.S. health care system and are founded on two premises: 1) the U.S. has dedicated, expert, resourceful medical professionals, and 2) market-based systems have historically served the U.S. well. These recommendations are designed to improve quality and efficiency, and make coverage available to all Americans.

I. *Fundamentally, the U.S. Health Care System **Must** Be Transformed with Dramatically Improved Quality and Efficiency. Without improvements in these areas (expected by health care leaders from both the private and public sectors) from initiatives already being implemented, more citizens will likely move to the ranks of the uninsured, patients will continue to receive care that doesn't meet quality standards and lives will unnecessarily be lost.*

A. By 2007, provide legislation and regulations to fund the National Quality Forum's adoption of uniform nationwide measures of quality, and provide for the following in Medicare, Medicaid, FEHP, TRICARE and other federal and state health care programs:

1. Implement measurement, transparency and disclosure of outcomes.
2. Increase assistance for patients and other consumers in the following ways:
   a. Give them information and tools to make informed decisions.
   b. Focus on preventive care and protocols for chronic conditions.
   c. Give patients strategic financial discretion (not merely cost shifting for cost-shifting purposes).
3. Pay hospitals and providers based on their performance.

The Working Group heard testimony that taking these steps could result in a 40 percent quality improvement and 30 percent gain in efficiency (reduced costs). These steps could play a major role in offsetting the costs of expanded coverage.

B. By 2007, adopt legislation and regulations that provide for funding of a private and public collaboration to adopt uniform health information standards and terminology. Also, provide funding for the implementation of health information technology, including an electronic medical record in Medicare, Medicaid, FEHP, TRICARE and all other federal health care programs where such funding results directly in quality of care improvements.

The Working Group has received input that implementation of health information technology could result in a $70 – 90 billion annual cost reduction, PLUS improve patient quality and safety. Savings can assist coverage expansion.

C. By 2008, adopt legislation and regulations to facilitate patient and family education and election of palliative care, rather than primarily curative care, in private and public health programs during late stages in life. Expected results: quality improvements in patient and family care as well as costs savings.

D. With the consideration of input from a private/federal/state panel of experts, develop alternatives that simplify the design, funding and administration of Medicare, Medicaid and SCHIP so that citizens who are covered under more than one of these programs will be able to obtain coverage and care seamlessly, and the programs will be financed with increased transparency and efficiency.

Potential results: Patient satisfaction improvement and cost reductions.

II. *Retain the Strengths of the Current Employer-Based System and Expand Options so that Citizens Can Obtain Health Care Coverage when not Covered by Employer-Sponsored Plans.*

A. By 2008, adopt legislation to allow access through the Medicare system for citizens age 55 and older who do not have other insurance. Use age-based rates without adjustment for pre-existing conditions.

B. By 2008, adopt legislation to allow citizens under age 55 who do not have other insurance, access to the Federal Employees' Health Plan. Use age-based rates without adjustment for pre-existing conditions.

C. By 2008, enhance opportunities for citizens to invest funds for retiree medical coverage and purchase individual retiree medical coverage with preferential tax treatment similar to that of those covered by employer-sponsored plans.

D. By 2008, adopt legislation that allows individuals and small employers to join private health plan associations under the following provisions:

1. Enable citizens to choose coverage from insurance companies nationwide.
2. Fund government risk pools in a manner similar to stop-loss insurance.
3. Ensure that health care conditions do not result in rejection or increased premiums.

E. By 2009, require all U.S. citizens to have, at least, "basic/catastrophic health insurance coverage that includes preventive care and wellness initiatives. What is "basic/catastrophic health insurance" would be recommended by a multi-stakeholder group with representation similar to the National Quality Forum. It would be based on evidence-based design, and adopted by Congress using congressional rules that minimize the political forces that detract from best policy.

F. By 2009, increase the number of community health centers as one alternative to improve access to "basic/catastrophic coverage."

G. By 2009, adopt legislation that allows employers to "pass the sponsorship" of health plans to "qualified sponsors" that "elect" to serve in the sponsor role. This would result in a more consolidated, efficient purchasing entity, especially for small employers, to contract with health plans or other health delivery system vendors in behalf of employees.

H. By 2009, adopt legislation which provides for a private-public collaboration, similar to the MedPAC, to recommend the government subsidy to be provided to low income individuals enabling them to obtain coverage.

I. Consider potential revenue resulting from savings due to (1) minus the cost of (2) below:

1. Establish a "cap" on the value of health care coverage that is exempted from income of employees who are covered by employer-sponsored health plans.
2. Provide similar tax treatment for individuals who purchase their own insurance coverage as provided for those who are covered by employer-sponsored plans.

J. Consider potential cost reductions resulting from changes in Medicare reforms such as:

1. Gradual deferred eligibility age.
2. Gradual replacement of the current Medicare design with "basic/catastrophic coverage" discussed above.

The Process Used to Develop Recommendations

Nationwide experts provided testimony about both U.S. health care challenges and potential solutions. Citizens attended community meetings and provided their insights and perspectives. However, it became clear that the voices not as often heard were those who actually sponsor and/or are covered by employer-sponsored health plans (e.g., administrative assistants, nonunion production workers, tellers, engineers, accountants, chemists, supervisors, and managers).

There have been additional factors in the process that, if different, may have resulted in increased credibility for the basis of the Working Group recommendations:

1. The Working Group conducted hearings that resulted in significant input to improve quality and efficiency from very prominent purchaser and union organizations. Yet, the "Health Report to the American People" essentially omitted recommendations by the business community, unions and other organizations to improve the system.

This resulted in an incomplete report. It also apparently led some organizations to conclude that since the Working Group did not consider such perspectives in the "Health Report to the American People," it would likely omit these kinds of proposals in its final recommendations. Accordingly, some of these types of organizations concluded that their support of community meetings would not be valued.

2. The legislation called for "an informed national debate." Yet, comments at the Community Meetings often reflected the critical need to elevate the public's knowledge of basic facts rather than an informed discussion. Community Meeting attendees' comments reflected misunderstandings and factual errors regarding tax treatment related to health care, insurance company profits, health plan design, current initiatives to improve the system, etc.

Health care is such a difficult subject that many may not understand the complexity and resulting implications of system design changes. Public policies based upon such incorrect assumptions or factual errors are likely to be misdirected and fail.

Thus, it is imperative for public policy to respond to many real problems in the health care system while still following the well-known medical principle, "first, do no harm." All proposed solutions need to be very carefully considered to ensure that responding to certain points of view – however legitimate those concerns may be – does not inadvertently undermine the strengths of the current health care system.

Conclusion

"Health Care that Works for All Americans" is possible within the strengths of the current system: measurement, transparency and disclosure of health care outcomes; information, incentives and tools for consumers and purchasers to make informed decisions; payment of hospitals and clinicians based on their performance; implementation of health information technology; and new coverage option.

Health Care That Works For All Americans

Dialogue With The American People

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

Table of Contents: Dialogue with the American People

How We Did Our Work

Hearings

In the summer and early fall of 2005, the Working Group held hearings in Crystal City, Virginia; Jackson, Mississippi; Salt Lake City, Utah; Houston, Texas; Boston, Massachusetts; and Portland, Oregon to learn about the nation's health care system. At the first hearings, health policy experts provided a common foundation on topics including employer-based and other private insurance, public programs including Medicare and Medicaid, health care costs, and public and private initiatives to control costs and expand insurance coverage. At the subsequent hearings topics included: the uninsured and underserved, health care quality, geographic variation in health care utilization, health information technology, rural health issues, mental health, health care disparities, long-term care, end-of-life care, community-based care, and Oregon's experience in public engagement on health care issues.

We also heard of many private and public programs trying to expand access to care, improve quality, and reduce costs. Some of the programs we heard about were state and local programs to expand health insurance coverage; employees and employers working together to expand access by holding costs down and getting the right care at a good price; using health care technology to reduce medical errors, monitor patient care, and choose the most appropriate care for patients; providing more information to providers and patients for making choices about health care; encouraging people to use less expensive but equally effective care such as generic drugs; adjusting payments to doctors, hospitals, and other health care providers based on the quality of care they provide; and improving people's access to care and insurance coverage through more effective use of current programs or new programs that will allow small business and self-employed individuals to obtain coverage.

Many of the programs are new, so we don't know yet how well they will work over the long term. And, because these programs were designed to work in particular places, we don't know whether the programs would fit, or work successfully, in other locations or settings. However, the hearings reinforced our conclusion, as stated in the *Health Report to the American People*, that we need to address the entire health care system, not just specific problems in cost, quality, or access, no matter how urgent they may seem from our different perspectives. Ideally, savings gained from improving efficiency and quality in the system could be used to make other needed changes. Some of the proposed health care initiatives could help to keep the amount and type of some health care services we receive the same, while controlling costs and improving quality. But we also concluded that none of the initiatives that we reviewed could provide all the answers to our health care system's problems. Rather, the hearings helped lay the groundwork for the search for solutions described in this report.

A complete list and brief description of the 61 presentations made by experts at these hearings is found in Appendix E.

Public Dialogue

The Working Group conducted community meetings throughout the United States to hear from, and begin a dialogue with, the American people. As stated in the statute, these meetings constitute the primary source of input that the Working Group has used in developing its preliminary recommendations. In addition, however, a variety of complementary forms of input (described below) have been important. These different types of input were designed to engage a broad segment of the American public in an informed discussion, using formats that allowed both

- free expression of all views, and
- sufficient structure to allow the Working Group to characterize and compare different views in order to reach conclusions based on the dialogue.

Working Group Community Meetings

The Working Group conducted 31 Community Meetings in 28 states between January and May 2006 (see Appendix A). These meetings ranged in size from about 35 to approximately 500 participants. At least one Working Group Member attended each meeting. Each meeting was organized using one of a set of formats designed for meetings of different lengths, but all were based on discussion of the four questions to the American people posed in the legislation. The discussion guides, as well as other background materials developed for the meetings (videos, slides, etc.), were all based on the analysis of issues confronting the American health care system presented in the Working Group's publication, *The Health Report to the American People*, with some updated facts and figures. Audience generation for the community meetings consisted of outreach through both earned and paid media, involvement of national and local organizations, associations, and other groups, and the participation of various leaders and government officials at the local, state and national levels. Professional meeting facilitators led the meetings.

The basic structure of the meetings involved discussion among participants sitting in small groups, and a structured process for reporting the views of the groups. At the 31 Community Meetings, electronic devices allowed individuals to provide responses to all or some of the same questions included in the poll posted on the Working Group Internet site (see Appendix C), and used in other polls and surveys. The responses to each question were then displayed on a screen, providing immediate feedback to the participants. As discussed in "The Dialogue" (below), there was some variation in the wording of the "standard" questions from meeting to meeting, in response to the preferences of the groups. The format therefore allowed participants to alter the discussion when they felt it was important to do so, while providing enough consistency to allow for comparisons on key issues. Attendees were also encouraged to provide written comments, and many did so. Staff of the Working Group also considered these comments in their review of the meetings.

Additional Meetings

Another important set of discussions took place at the University town hall meeting sponsored by the Big Ten Conference and the Association of Schools of Public Health, and hosted by the University of Michigan on March 22, 2006 (see Appendix D). This virtual town hall provided a forum for individuals gathered at 22 separate public meetings organized by the participating universities, along with the webcast of the meeting from the University of Michigan, as well as people viewing the live webcast across the country. Interactive technology allowed various locations to call in with questions and comments, and individuals submitted their feedback about health care in America through e-mail to be read to participants during the live event.

Still other meetings organized by individual Working Group Members and staff in collaboration with community based health, advocacy, and business groups provided additional insights and opportunities to hear from people with perspectives that might not have been well represented at the other community meetings (see below). Some of these were directly related to issues that were raised in the hearings held by the Working Group (see Appendix E). These special meetings included sessions focusing on mental health, health care at the end of life, chronic illness and disability, a series of meetings in rural areas of Mississippi, a meeting co-hosted with Native American organizations, and a meeting organized by a national association representing realtors.

The Working Group also reviewed data from additional meetings that members as well as other people throughout the country conducted on their own, using materials developed by the Working Group and made available to the public in the "Community Meeting Kit" available on the web site. A listing of meetings that have provided data to the Working Group is included at the end of this section. Other organizations have also provided us with information. Among these are: The National Health Care for the Homeless Council (NHCHC), which conducted a nationwide outreach effort to gather the input of homeless persons; data from the responses of 446 homeless persons in 12 cities were provided to the Working Group.

Other Direct Citizen Input

The Working Group solicited input from people across the country via the Internet, at www.citizenshealthcare.gov, and by mail.

The Working Group Public Comment Center on its web site solicited both structured and unstructured comments from the public.

- "What's Important to You" sought responses to four broad questions about people's concerns about health care in America, views on changing the way health care is delivered or paid for, trade-offs that people would be willing to make to improve health care, and recommendations that people would make to improve health care for all Americans. The responses submitted by over 4,600 people from across the United States were coded into response categories and

analyzed. The full text of close to 2,200 hand written responses was also provided to the Working Group for review. The United Church of Christ provided us with about 1,500 hand-written responses from people in about 10 percent of its 5,700 churches across the country to the open-ended questions posted on our Internet site; these are included in our analysis.

- Close to 600 people wrote to the Working Group, via the CHCWG Internet "Share Your Experience" page or in handwritten letters, to tell us about their own stories. Many of these described problems obtaining or paying for adequate health insurance or quality health care; some described very positive experiences with the health care system.
- The Health Care Poll posted on the web site drew over 13,000 responses from January through August 31 (see Appendix C). The Catholic Health Association (CHA) also provided over 1,000 poll responses that were submitted directly to CHA's web site. These are included in the analysis of poll data; the responses are also presented in Appendix C. A number of organizations, including Communication Workers of America (CWA), Starbucks Coffee Company, The National Health Law Program, the National Assembly on School Based Health Care, Wheaton Franciscan HealthCare, and the American Nurses Association also provided information and links to encourage people to provide input to the Working Group. Many people affiliated with these groups participated in community meetings and via the Internet. More than 500 members of the CWA responded to the Internet poll (see Appendix C). Additionally, many of the organizations that conducted their own meetings sent us paper polls. The Area Agency on Aging in Florida provided about 50 poll responses from seniors in Florida. Written input mailed to the Working Group was coded and analyzed using the same protocols as the electronic data submitted over the Internet.

Analysis of the Data

Methods

The Working Group reviewed summaries of all the sources described above. The Community Meetings were considered, for analytical purposes, as case studies. In addition to the data on demographics and the votes recorded at each meeting, staff reviewed background information on each location and, in the course of planning each meeting, obtained a great deal of information on the health care, resources, and policy issues in each community. Senior staff members who attended the meetings used a structured format when preparing the meeting reports. The individual reports, including the data recorded at each meeting, are being made available to the public on www.citizenshealthcare.gov. The Working Group compared data across meetings only when it was truly comparable, that is, questions were asked in the same context during the meetings, in the same form. (See Appendix B for more information.)

Staff coded and analyzed data from open-ended, on-line polls, and Interim Recommendation responses using standard statistical software. The Working Group reviewed summary data, as well as the results of analyses that reflected possible

differences in response patterns related to demographic differences. The Working Group also reviewed data from relevant national polls and surveys.

Public Comments

The Interim Recommendations posted on the web site received over 8,000 responses, mostly via the Internet, but also by mail, from June 1 through August 31. These public comments were classified into response categories and analyzed; comments were also posted on the web site. Official feedback from advocacy organizations and professional associations were reviewed by the Working Group members as well as staff, and posted on the Working Group web site. A summary of the comments and the Working Group's response to the comments is presented in Appendix G.

Limitations

People attending the Working Group Community Meetings or providing input in writing are more likely than others to be especially interested in health care, either because they, or their family members, have had concerns about their health care or insurance coverage, or because they work in the health care field. The people we heard from were, on average, more likely to be female and in or on the edges of the Baby Boom generation (age 45-64), and the proportion having bachelor degrees or advanced graduate degrees was much higher than in the population as a whole. And, while participation in Community Meetings by minority group members was fairly close to national percentages, representation of people who identified themselves as Latino or as African American among those submitting comments or poll data was lower. The proportion of people who were not covered by any form of health insurance, and the proportion receiving benefits through Medicaid, was also lower than the nation as a whole. Some of these limitations were addressed by holding meetings specifically designed to reach underrepresented populations (see above). And, as noted above, analysis of the data was performed to assess the extent to which demographic factors may have accounted for some of the findings.

A more serious issue is the inability to ensure that people providing input represent the full spectrum of views of all Americans, given that people who are sufficiently interested or motivated to provide input on health care and policy issues may not be typical of the population as a whole. The consistency of findings across many communities and between the poll data obtained through both the Working Group Internet site and the community meetings provides support for the view that we have heard from a significant segment of the American people. The consistency between findings from recent national polls and surveys provides even stronger support for the findings. However, the meetings, as well as the www.citizenshealthcare.gov data were designed to offer information to help frame discussion and responses to questions, whereas national polls and surveys generally do not serve this purpose. Therefore, the responses we have analyzed are not exactly comparable to other national poll data, even when the same, or very similar, questions are asked. Consequently, we do not claim that we know, with great certainty, the values and preferences of all Americans. Rather, we are basing our recommendations

on a careful assessment of input from as many sources as feasible, from tens of thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in the data to the best of our ability.

Citizens' Health Care Working Group Meetings through August 31, 2006

Working Group Community Meetings

Kansas City, MO	January 17, 2006
Orlando, FL	January 24, 2006
Baton Rouge, LA	January 26, 2006
Memphis, TN	February 11, 2006
Charlotte, NC	February 18, 2006
Jackson, MS	February 22, 2006
Seattle, WA	February 25, 2006
Denver, CO	February 27, 2006
Los Angeles, CA	March 4, 2006
Providence, RI	March 6, 2006
Miami, FL	March 9, 2006
Indianapolis, IN	March 11, 2006
Detroit, MI	March 18, 2006
Albuquerque, NM	March 20, 2006
Phoenix, AZ	March 25, 2006
Hartford, CT	April 6, 2006
Des Moines, IA	April 8, 2006
Philadelphia, PA	April 10, 2006
Las Vegas, NV	April 11, 2006
Eugene, OR	April 18, 2006
Sacramento, CA	April 19, 2006
San Antonio, TX	April 19, 2006
Billings, MT	April 21, 2006
Fargo, ND	April 22, 2006
New York, NY	April 22, 2006
Lexington, KY	April 25, 2006
Cincinnati, OH	April 29, 2006
Little Rock, AR	April 29, 2006
Tucson, AZ	May 4, 2006
Sioux Falls, SD	May 6, 2006
Salt Lake City, UT	May 6, 2006

University Town Hall Meeting, March 22, 2006

Participating Institutions*

Boston University	Boston, MA
Drexel University	Philadelphia, PA
Emory University	Atlanta, GA
George Washington University	Washington, DC
Indiana University	Indianapolis, IN
Johns Hopkins University	Baltimore, MD
Louisiana State University	Baton Rouge, LA
Michigan State University	East Lansing, MI
Northwestern University	Evanston, IL
Ohio State University	Columbus, OH
Penn State University	Harrisburg, PA
Purdue University	West Lafayette, IN
Tulane University	New Orleans, LA
University at Albany	Albany, NY
University of Arkansas	Fayetteville, AR
University of Illinois	Urbana, IL
University of Iowa	Iowa City, IA
University of Louisville	Louisville, KY
University of Michigan (Host)	***Ann Arbor, MI***
University of Minnesota	Minneapolis, MN
University of South Carolina	Columbia, SC
University of Wisconsin	Madison, WI

* Not all meetings took place at main campuses.

Special Topic Community Meetings

Hanover, NH	Last Days	March 31, 2006
Redwood Valley, CA	Native Americans	April 20, 2006
Washington, DC	National Association of Realtors	May 16, 2006
Atlanta, GA	Mental Health	May 22, 2006

Meetings Organized/Facilitated by Individual Members

Washington, DC	Ascension Health CEOs	December 5, 2005
Daytona Beach, FL	Bethune-Cookman College	March 26, 2006
Deltona, FL	Florida CHAIN (Community Health Action Information Network) and MS-keteers Multiple Sclerosis Support Group	May 6, 2006
Palm Beach Gardens, FL	Area Agency on Aging	May 10, 2006
Boca Raton, FL	Area Agency on Aging	May 11, 2006
Lake Worth, FL	Area Agency on Aging	May 12, 2006
Thousand Oaks, CA	City of Thousand Oaks Conejo Recreation and Park District	May 18, 2006
Miami, FL	The Alliance for Human Services, The Human Services Coalition, Florida CHAIN, Miami-Dade County Health Department, Health Foundation of South Florida	August 22, 2006

Self-Initiated Meetings

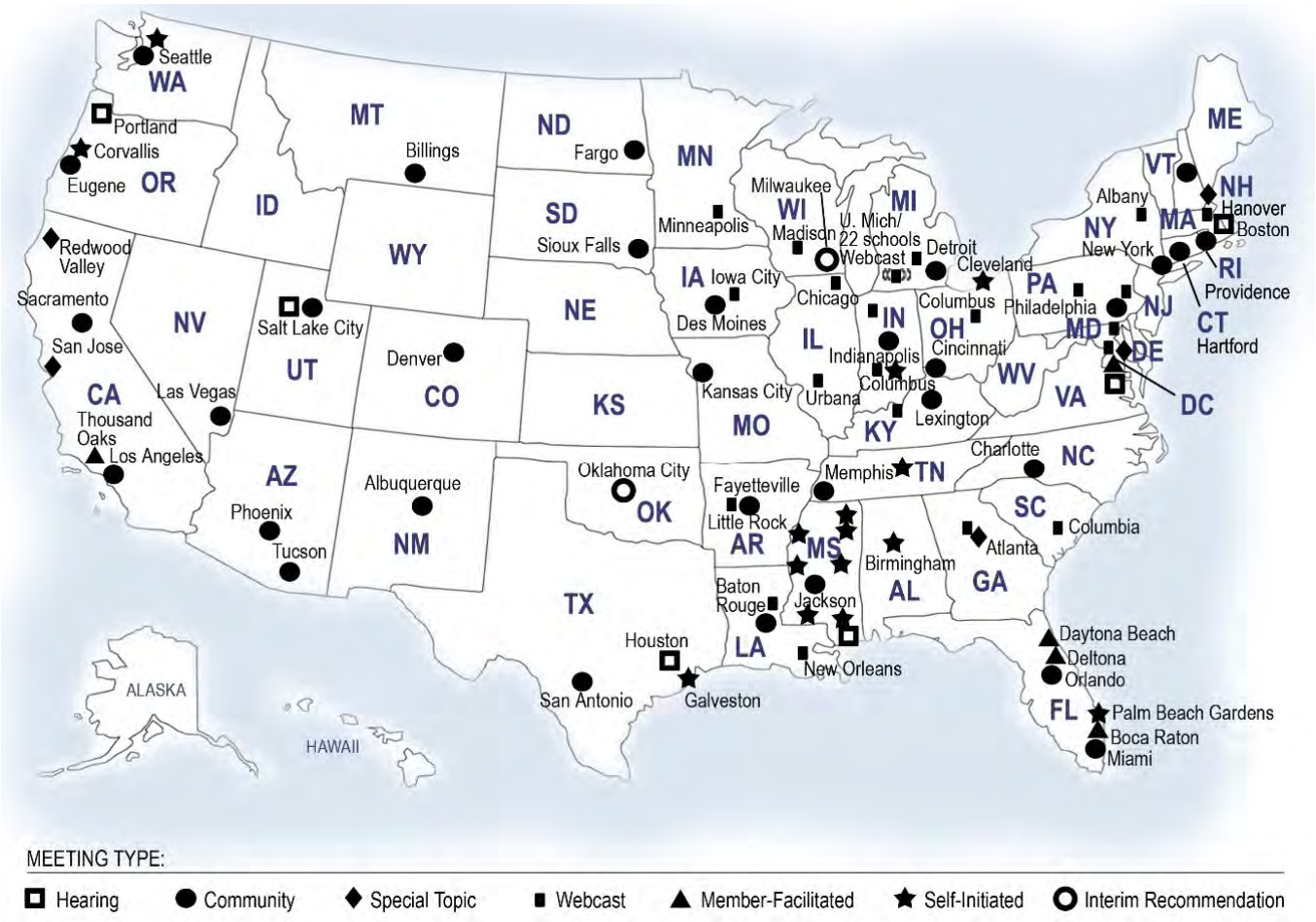
Crossville, TN	The Learning Community	January-March, 2006
Galena, IL	League of Women Voters	February 23, 2006
Starkville, MS	MSU Extension	March 21, 2006*
Verona, MS	MSU Extension	March 27, 2006*
Wesson, MS	MSU Extension	March 29, 2006*
Hattiesburg, MS	MSU Extension	March 30, 2006*
Clarksdale, MS	MSU Extension	April 11, 2006*
Palm Beach Gardens, FL	Human Resource Association of Palm Beach County	April 11, 2006
Greenville, MS	MSU Extension	April 18, 2006*
Newton, MS	MSU Extension	April 20, 2006*
Cloverdale, CA	United Church of Cloverdale	April 23, 2006
Eau Claire, WI	Chippewa Valley Technical College	April 29, 2006
Seattle, WA	Association of Advanced Practice Psychiatric Nursing	April 29, 2006
Alpena, MI	League of Women Voters	May 1, 2006
Galveston, TX	Center to Eliminate Health Disparities, University of Texas Medical Branch	May 1-3, 2006
Boulder, CO	Individuals	May 3, 2006
McKeesport, PA	Mon Valley Unemployed Committee	May 11, 2006
Muncie, IN	BMH Foundation and Partners for Community Impact	June 2, 2006
Birmingham, AL	Greater Birmingham PDA/DFA, UFCW Local 1657	June 22, 2006
Corvallis, OR	Mid Valley Health Care Advocates	July 20, 2006
Birmingham, AL	Birmingham Friends Meeting	July 16, 2006
Jackson, MS	MSU Extension	August 22, 2006*
Hattiesburg, MS	MSU Extension	August 23, 2006*
Greenville, MS	MSU Extension	August 24, 2006*
Cleveland, OH	North East Ohio Voices for Health Care	August 24, 2006
Columbus, IN	Columbus Regional Hospital Foundation (2)	August 29, 2006

* Held under the auspices of the Mississippi State University Extension Service.

Community Meetings on Interim Recommendations

San Jose, CA eBay/PayPal	July 20, 2006
Oklahoma City, OK	August 1, 2006
Milwaukee, WI	August 12, 2006

Locations of Community Meetings Across the United States



The Dialogue

This chapter highlights public input on the four questions Congress specified that the Citizens' Health Care Working Group ask the American people. The Working Group has reviewed all input it has received from community and other meetings, by Internet, by mail, in person, or by phone. Particular emphasis in this section has been given to information gathered in community meetings held throughout the nation, which Congress directed the Working Group to conduct before preparing its Interim Recommendations. Other survey data sources are discussed throughout this section, and they will also be highlighted in the Final Recommendations to Congress.

This chapter follows the organization of the "typical" meeting, which always began with a discussion of participants' underlying values. The 31 community meetings varied slightly from site to site, reflecting differences in the participants' interests and preferences. While the general structure of the meetings was similar, it evolved over time as the Working Group attempted to find more effective ways to gather the desired information. Meetings varied in length, with most meetings either three or four hours long, although some were shorter and a few longer. At all these meetings, discussions centered on the four legislatively mandated questions:

I. What health care benefits and services should be provided?

II. How does the American public want health care delivered?

III. How should health care coverage be financed?

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

Summary of Findings

The following common themes emerged from the community meetings and other sources of information collected from the American public by the Working Group:

Values

- Underlying the discussion of the four legislative questions is the belief by virtually everyone in attendance at each community meeting that the health care system has at least some serious problems.
- Over 90 percent of participants at community meetings and respondents to the Working Group's poll believed that it should be public policy that all Americans have affordable coverage.

I. What health care benefits and services should be provided?

- A clear majority of participants preferred that *all* Americans receive health care coverage for a defined level of services.
- People at the community meetings frequently expressed strong support for increased focus on wellness and prevention services as part of "basic" coverage, rather than focusing only on treating sickness.
- Participants at meetings continually emphasized the importance of a strong education component in health care and the management of health.
- Individuals voiced support for a fairly comprehensive basic benefit design.
- Although many participants recognized the need to do more to ensure that the health care provided is appropriate and delivered efficiently, they were also concerned about arbitrary limits on coverage and were not comfortable with bare-bones benefit packages.
- Despite the reluctance of many to limit benefits, participants at meetings supported limiting coverage to services that have proven medical effectiveness.
- Participants expressed some level of support for the idea that some people could pay for additional services outside the basic benefit package.
- People wanted consumers to play an important role in deciding what should go into a basic benefit package.
- Participants in some meeting sites discussed a potential role for a local board or other quasi-governmental entity in defining the basic level of services.
- Participants expressed the desire to be involved in the management of their own health care and were willing to accept some responsibility for their medical decision-making.

II. How does the American public want health care delivered?

- At the community meetings, individuals asked for a delivery system that is secure, transparent, easy to navigate, and treats the "whole person."
- Affordability of care is a primary concern among participants.
- Participants were troubled that many people did not have access to the health care they need.

- Many participants cited complexity of the system as a contributing factor to the problems with the health care system.
- Linked to confusion about the health care system was the lack of useful information to help individuals navigate the health care system.
- Participants mentioned that they or others were not always treated with respect or dignity.
- Participants frequently cited barriers to care related to their insurance coverage.
- Participants told the Working Group that they want to feel secure knowing that when they or their families need care, they can get it without becoming impoverished.
- Participants wanted all Americans to be able to get the right health care, at the right time, in a respectful manner.
- Participants noted that being able to choose and maintain a stable, long-term relationship with a personal health care provider was critical.

III. How should health care coverage be financed?

- Although the results differed across meeting sites, a majority of participants (ranging from 55 percent to 88 percent in the community meetings) believed that everyone should be required to enroll in either private or public "basic" health care coverage.
- In almost every community meeting, a majority of participants supported the notion that some individuals should be responsible for paying more for health care than others. The most commonly mentioned criterion for paying more was income, but varying payment by income was supported by the majority of participants in fewer than half of the meetings where this question was discussed.
- Views about employer-based coverage did not generally reflect a deep distrust of employers, but instead were intertwined with broader concepts of health reform.
- At most meetings, participants stressed the importance of preventive care to reduce health care costs.
- Participants at most meetings believed that individuals have a responsibility to manage their own care and use of services.
- In many meetings, participants mentioned that individuals have a social responsibility to pay a fair share for health care.
- Participants frequently stated that the problems of high costs rest with "price setters"—namely, prescription drug companies, insurers, and for-profit providers.
- A commonly expressed view was that a simpler system would result in lower administrative costs.
- Some support exists for investment by providers and the private sector in health information technology to increase system efficiency.
- Participants expressed general support for individuals playing their part in controlling utilization and costs.
- Individuals would like information about how to use health care better and more effectively.
- At some meetings, participants supported providing incentives to patients to engage in healthy behaviors.
- Participants expressed preferences for using medical evidence to decide which services are covered and provided.

- There was general support for controlling prescription drug costs by limiting direct-to-consumer advertising of prescription drugs and using more generic drugs, when medically appropriate.
- Support also existed for limiting expensive yet "futile" end-of-life care and instead providing palliative care.
- In almost all community meetings, participants expressed the belief that changing the culture from sick care to well care—namely, by focusing on prevention, wellness, and education (in general, and health education in particular)—will reduce health care costs.
- A commonly expressed view was that better use of advanced practice nurses and other non-physicians could save money and improve quality.
- Participants believed that investing in public health would pay dividends in terms of reducing health care costs.
- Support for limits on malpractice was expressed at some community meetings.

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

- In most meetings as well as on the Working Group poll, a majority of participants expressed a willingness to pay more to ensure that everyone has access to affordable, high-quality health care. Overall, about one in three (28.6 percent of poll participants) said they were willing to pay $300 or more per year.
- When asked to rank or choose among competing priorities for public spending on health, individuals—with few exceptions—were most likely to rank "*Guaranteeing that all Americans have health coverage/insurance*" as the highest priority.
- When asked to evaluate different proposals for ensuring access to affordable, high-quality health care coverage and services for all Americans, individuals at all but four meetings ranked "*Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance*" the highest. Three other options generally ranked in the top four choices at the community meeting locations: "*Expand neighborhood health clinics*"; "*Open up enrollment in national federal programs like Medicare or the federal employees' health benefits program*"; and "*Require that all Americans enroll in basic health care coverage, either private or public*."

Detailed Description of Findings

Values

Before focusing on the four legislative questions, all meetings began with a discussion of individuals' underlying values and perceptions that generally centered on three questions:

- When asked how they would describe the U.S. health care system today, 97 percent of attendees across all community meetings selected "*It is in a state of crisis*" (64 percent) or "*It has major problems*" (33 percent). In each of the 31 community meetings, at least 88 percent selected one of these options. Overall, only two percent said "*It has minor problems*," and one percent either said "*It does not have any problems*" or had no opinion. **Underlying the discussion of the four legislative questions is the belief by virtually everyone in attendance at each community meeting that the health care system has at least some serious problems.** This same concern has also surfaced in national polls. A January 2006 New York Times/CBS poll found that 90 percent of respondents said that our health care system needs fundamental changes or to be completely rebuilt (56 percent and 34 percent, respectively).[1] This finding has been fairly consistent over the past 15 years. However, the Employee Benefit Research Institute's annual Health Confidencet Survey has found from 1998 to 2004 the percent of respondents rating our health care system as poor has doubled from 15 percent to 30 percent. [2]

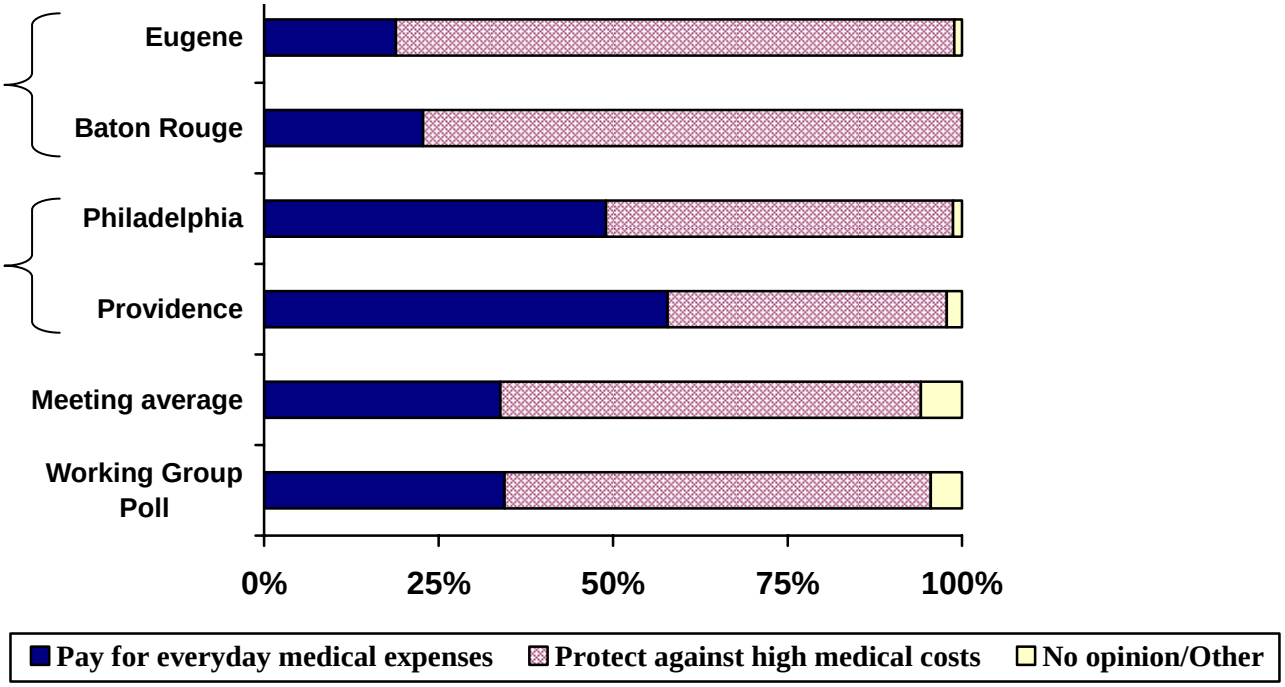
- When meeting participants at all meetings were asked, "Should it be public policy that all Americans have affordable health care coverage?", 94 percent overall said "yes." Similarly, in the Working Group's poll, 92 percent either strongly agreed (79 percent) or agreed (13 percent) with this statement. **Over 90 percent of participants at community meetings and respondents to the Working Group's poll believed that it should be public policy that all Americans have affordable coverage.** As stated by participants in the Orlando community meeting, "Health care is a right and not a privilege." Seattle, Denver, and Philadelphia meeting participants, among other locations, desired "cradle to grave" access to health care.

- At many of the community meetings, participants were asked what they believed was the most important reason to have health insurance. Although the results varied by meeting site, individuals were more likely to choose the response "To protect against high costs" than they were to choose the response, "To pay for everyday medical expenses."

Figure 1 illustrates how participants' responses varied across community meeting sites and the Working Group poll.

Figure 1:

Which do you think is the most important reason to have health insurance? (Lowest and highest rankings at community meetings, average, and Internet ranking)



Note: This question was not asked in Los Angeles, Albuquerque, Hartford, Las Vegas, San Antonio, Fargo, Lexington, Little Rock, or Sioux Falls. Eugene and Baton Rouge were the meeting sites where "Pay for everyday medical expenses" ranked as the lowest among the cities where the question was asked, while Philadelphia and Providence were the meeting sites where that option ranked as the highest. The meeting average reflects a weighted average of all meetings where this question was asked.

I. What health care benefits and services should be provided?

Some common themes have emerged from the community meetings regarding what health care benefits and services should be provided. In the community meetings, discussion of this question generally revolved around three core questions.

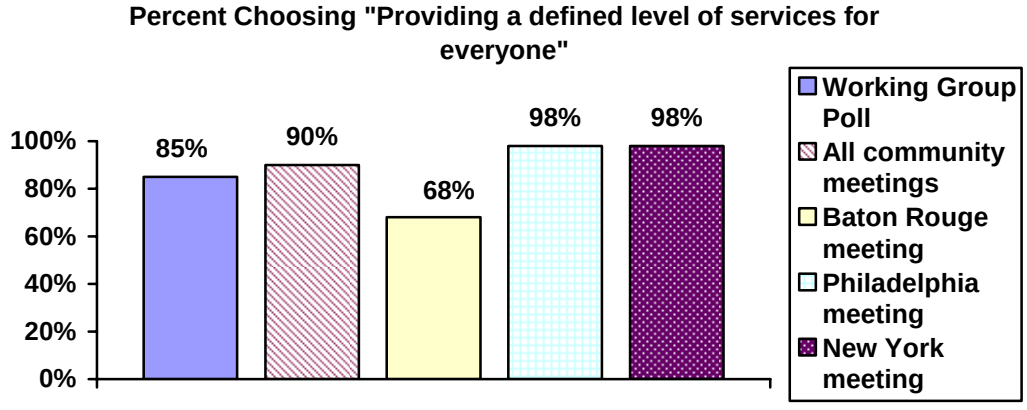
The first of these questions is discussed below:

"Health care coverage can be organized in different ways. Two different models are: (1) Providing coverage for particular groups of people (e.g., employees, elderly, low-income) as is the case now; (2) Providing a defined level of services for everyone (either by expanding the current system or creating a new system). Which of the following most accurately reflects your views?"

In response to this question, a strong preference emerged:

- **A clear majority of participants preferred that all Americans receive health care coverage for a defined level of services**. In response to the question, the vast majority (between 68 percent and 98 percent) of participants at all community meetings have said that we should provide a defined level of services for everyone. The highest level of support for a defined set of services was in the community meetings that were held in Philadelphia and New York, and the lowest in the Baton Rouge meeting (See Figure 2).

Figure 2:
Which statement best describes your views on how health care coverage should be organized?



In the Working Group poll, 84 percent of participants answered the question this way. These findings are also consistent with the results of other national polls asking similar questions. In surveys conducted by other organizations, a clear majority have expressed

the opinion that all Americans should have health insurance. For example, a *Wall Street Journal* poll regarding public support for a range of health practices in September 2005 found that 75 percent of U.S. adults somewhat favored (23 percent) or strongly favored (52 percent) universal health insurance.[3] More recently, a New York Times/CBS poll conducted in January 2006 found that 62 percent said that they think the federal government should guarantee health insurance for Americans; 31 percent said this was not the responsibility of the federal government, and 7 percent said they do not know.[4]

Discussions at community meetings teased out variations in how people conceptualize health coverage. For example, some participants indicated that it was hard to make a choice between the answers without knowing *who* was providing the coverage, or what would be covered. Many tended to view access to health care as a basic right, and they conveyed a willingness to contribute to the success of a system that would facilitate health care for all.

- In the Baton Rouge community meeting, where the smallest percentage of people opted for providing a defined level of services for everyone, participants still concluded that a defined level of services for everyone was "more fair and equitable" in the face of the current system that was "failing."

- In the Detroit community meeting, some participants worried that the issue of discrimination needed to be addressed, regardless of the system design. Just like the current system of providing coverage for particular groups of people (such as Medicare or Medicaid for elderly, disabled persons or low-income populations, or group coverage organized through employment), a system providing a basic level of care for everyone ran the risk of not providing sufficient levels of care for all. Participants expressed concern that any system reform must avoid creating different levels of care for different subsets of the population.

- At the two largest community meetings in Los Angeles and Cincinnati, fewer than 10 percent of participants favored the current system that provides coverage according to a person's affiliation with a particular group. These participants, like those at the other meetings, cited problems with the current system, including:

    - It excludes the unemployed and others who are not part of a particular group
    - The system is high cost, complex, and not uniform across groups
    - Mobility and flexibility are a problem.

- About 90 percent of participants supported the option of providing a defined level of benefits for everyone, rather than the current system of coverage for certain groups. The virtues of implementing a system of coverage for all that were mentioned included:

    - Reduced overall and administrative costs
    - Decreased hospitalization and emergency room use
    - Access for all

- Covered prevention and immunization, and
- Improved level of national health care.

However, participants also expressed potential concerns about such a system, such as: What is the defined level of services? Who will be denied access to care if costs are too high, and who will make these decisions? Who will pay?

- At all locations, participants emphasized the importance of involving consumers in the development of a basic benefit package. Because consumers can articulate what services are necessary at various stages of life, their participation in the development of the plan could help contain costs. In the Phoenix community meeting, for example, participants wanted a basic plan that would vary based on age and gender, and that could be added to if desired. Participants at most meetings recognized that the current system does work for some, and allows for a richer benefit than might be available otherwise, but that it does not work for everyone. They expressed a desire to build upon the current system, changing it into something that is more inclusive and provides a level of care for all Americans. Everyone would contribute to this system based on their ability to pay. However, for those people who are unable to afford the cost, government subsidies should be provided to allow access to a basic package.

- In the San Antonio community meeting, participants expressed interest in an approach that would provide a basic level of care for everyone combined with personal responsibility.

- In a number of community meetings, including Lexington, Eugene, Sioux Falls, and Cincinnati, participants commented that the United States should learn from other countries that have covered all or most of their citizens.

The second structured question delved into how to define the specific level of benefits:

"It would be difficult to define a level of services for everyone. A health plan that many people view as 'typical' now covers these types of benefits, many of which are subject to co-payments and deductibles: preventive care, physicians' care, chiropractic care, maternity care, prescription drugs, hospital/facility care, physical, occupational, and speech therapy, and mental health and substance abuse. How would a basic package compare to this 'typical' plan? Are there benefits that you would add or would take out?"

Although the discussion differed by meeting location, some common themes emerged:

- **People at the community meetings frequently expressed strong support for increased focus on wellness and prevention services as part of "basic" coverage, rather than focusing only on treating sickness**. According to participants at meetings throughout the country, individuals have a responsibility to be good stewards of their health and health care resources (preventive care/screenings/use of services). They also viewed an emphasis on wellness and prevention services as a

way to reduce health care costs, as discussed in the Financing section. According to these participants, disease management should also be a part of the focus. In the Working Group poll, over 90 percent of respondents indicated that annual physicals and preventive care should be part of a "basic" or "essential" benefits package, a level of support that was similar to that for hospital stays, prescription drugs, and lab tests.

- **Participants at meetings continually emphasized the importance of a strong education component in health care and the management of health**. To be good stewards of their health, individuals need to be educated about wellness and prevention. People thought information about how to use health care better and more effectively was important, but not information on cost. Broader issues of general education also came up in some meetings. Participants talked about the importance of beginning early, in grade school, to focus on basic skills that are prerequisites to literacy and health literacy. Fargo meeting participants expressed a preference for "school-based health promotion programs" for those in kindergarten through grade 12.

- **Individuals voiced support for a fairly comprehensive basic benefit design.** Benefits that a number of participants in meetings throughout the country viewed as important components of a basic benefit package included—but were not limited to—dental care, vision, hearing, care by non-physician providers such as nurse practitioners, long-term care, mental health, and hospice care. Some meeting participants also desired coverage of complementary and alternative medicine (for example, acupuncture).

- **Although many participants recognized the need to do more to ensure that the health care provided is appropriate and delivered efficiently, they were also concerned about arbitrary limits on coverage and were not comfortable with bare-bones benefit packages**. A participant in the Eugene community meeting made the point, "There's a need for definition because we can't afford it all." Still, when pressed to make decisions about what services to drop from basic coverage, many respondents told the Working Group "None," which was the most popular response in some locations.

"All people should have the same coverage that the President, Vice President, and Congress have…"
(Phoenix meeting)

"We agree that there should be a basic level of services for everyone-everyone has a right to that care. But our concern is that neither of those--what we have now, or a basic plan for everyone-- will work until it's a consumer-driven choice and not a corporate solution that values profits above everything else. The consumer should be driving the choices, not like the way the culture is now. There should be more of a balance."
(Charlotte meeting)

"Every citizen has a basic right to have basic health care, and it can't be based on the type of job they have."
(Salt Lake City meeting)

- **Despite the reluctance of many to limit benefits, participants at meetings supported limiting coverage to services to those that have proven medical effectiveness**. They expressed a certain level of comfort with decisions that could affect utilization, if they were based on medical evidence. Just over half of the Working Group poll respondents agreed (36 percent) or strongly agreed (14 percent) that health plans or insurers should not pay for high-cost medical technologies or treatments that have not been proven to be safe and medically effective, and nearly a quarter were neutral on the subject; responses in the March University town hall meeting were similar (see text box below), with 58 percent agreeing (36 percent) or strongly agreeing (22 percent).

University Virtual Town Hall Meeting:
"A National Conversation on Health Care"

On March 22, 2006, 22 universities participated in a simultaneous discussion on health care. Sponsored by the Big Ten Conference and the Association of Schools of Public Health, and hosted by the University of Michigan, this virtual town hall meeting provided a forum for individuals across the country to voice their opinions on health care.

Broadcast via satellite from the University of Michigan, individuals participated in this event either by gathering at various university sites, or by logging onto the forum through the Internet. Interactive technology allowed various locations to call in with questions and comments, and individuals submitted their feedback through e-mail to be read during the live event. The 21 simultaneous meetings held in addition to the host meeting were organized by their respective university communities, and followed the same format. Participants at these meetings received the standard Community Meeting Discussion Guide and a Health Care Poll, specific to this event, which included the majority of questions asked on the Working Group's own Internet poll (as well as in many of the Working Group Community Meetings). The separate meetings also had access to a local faculty expert who assisted in sending comments and questions to the national coordinator at the University of Michigan. After the event, the completed Health Care Polls were coded (772 from 22 of the webcast sites) and entered into a data set that was made available to the Working Group for analysis (See Appendix D for a complete summary of the results). Participating schools were:

Boston University
Drexel University
Emory University
George Washington University
Indiana University
Johns Hopkins University
Louisiana State University
Michigan State University
Northwestern University
Ohio State University
Penn State University
Purdue University
Tulane University
University at Albany
University of Arkansas
University of Illinois
University of Iowa
University of Louisville
University of Michigan
University of Minnesota
University of South Carolina
University of Wisconsin

- **Participants expressed some level of support for the idea that some people could pay for additional services outside the basic benefit package**. For example, in Kansas City, participants favored allowing individuals to purchase additional coverage of chiropractic care or fertility treatments. Charlotte participants were willing to pay more for an "a la carte" plan that would allow people to add services to the basic plan, which could vary by life phases and would be most cost effective for each age group. At virtually every meeting, attendees expressed concern about coverage for "futile" care at the end of life.

Results of the Working Group poll question about the importance of including each of 23 specific benefits can be found in Appendix C (Question 4 of the Working Group poll).

The next question in this section of the community meetings asked participants for their views on who should decide which benefits would go into the basic benefit package:

"How much input should each of the following groups have in deciding what is in a basic benefit package (federal government, state and/or local government, medical professionals, insurance companies, employers, consumers)?"

Some common themes emerged in response to this question:

- **People wanted consumers to play an important role in deciding what should go into a basic benefit package**. In meetings throughout the country, the majority of participants consistently answered that a combination of consumers, medical professionals, federal government, state and local governments—generally in that order—should be responsible for having input into these decisions. Some participants indicated that employers and insurance companies should also play a role, but one that is more limited.

  In the majority of meetings, participants were asked, "*On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?*" When participants were asked the question in this way, the highest rating was *always* for input from consumers, and it was *always* followed by "medical professionals."

> *"Some new entity or process needs to be created that includes all the relevant stakeholders, the foremost of which would be the consumer."*
>
> *"[There should be] a 'quasi-governmental' entity representing all groups, including us, the people."*
>
> *"One way to organize this would be to create an entity very much like the Federal Reserve Board with appointed individuals who are professionals in their field and whose activities are generally public so it has to come under the federal government but wouldn't be the government as we generally think of it."*
>
> (Orlando meeting)

Responses to this question are illustrated in Figure 3. In some meetings and on the Working Group poll, individuals were asked which party or parties they would prefer to make the decision regarding what services are covered in the basic health insurance plan. At least 60 percent of Working Group poll respondents and participants in the half dozen community meetings in which the question was asked this way chose the "some combination" option (of consumers, employers, government, insurance companies, and medical providers; the question did not identify which specific combination people preferred).

In the Sioux Falls meeting, participants were also asked to rate the "degree of involvement" government, medical professionals, insurance companies, employers, and citizens should each have in determining what is included in a basic health care package using the scale: major role, minor role, and no role. Consistent with other findings, 88 percent of participants voted that citizens should have a "major role," and 73 percent indicated that medical professionals should have a "major role." Participants generally believed that government (72 percent) and employers (64 percent) should play a "minor role;" insurance companies received a mixed response, with 55 percent saying they should play a "minor role" and 42 percent saying they should play "no role."

Figure 3:
On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?

Location	Federal Government	State/Local Government	Medical Professionals	Insurance Companies	Employers	Consumers
Jackson	3.6	3.0	5.7	1.8	3.6	7.8
Seattle	4.3	4.0	5.9	1.6	2.3	7.3
Denver	4.2	4.0	6.4	2.5	3.8	6.8
Providence	4.1	3.8	6.8	2.3	2.8	8.0
Miami	5.0	4.5	5.5	2.3	3.0	6.9
Indianapolis	4.9	3.9	6.1	2.2	3.3	7.6
Detroit	3.5	3.7	6.8	1.4	2.4	7.6
Phoenix	3.9	3.7	5.2	2.0	3.4	7.7
Des Moines	5.0	4.7	5.4	2.2	2.6	6.7
Philadelphia	4.4	4.4	6.0	1.5	3.1	6.7
Sacramento	3.8	3.8	6.4	2.5	2.9	7.4
Billings	5.1	4.7	6.0	2.4	4.0	6.3
New York	5.2	4.1	6.7	1.4	2.1	7.7
Tucson	3.9	3.4	6.2	2.6	3.2	6.6
Salt Lake City	4.6	4.7	4.9	2.6	3.1	6.8
Average	**4.4**	**4.0**	**6.0**	**2.1**	**3.0**	**7.2**

- **Participants in some meeting sites discussed a potential role for a local board or other quasi-governmental entity in defining the basic level of services**. For example, participants in the Memphis community meeting strongly supported the concept of defining the basic level of service using a "grass roots" method

through regional or state boards. In these discussions, participants emphasized the need for a publicly accountable body.

- **Participants expressed the desire to be involved in the management of their own health care and were willing to accept some responsibility for their medical decision-making**. Meeting participants felt that consumers played an important role in decision-making. This opinion was expressed both by individuals who sought a larger role for government and those who preferred that government have a limited role.

Mental Health Meeting

At its Boston meeting in August 2005, the Citizens' Health Care Working Group heard from a panel made up of the Director of Mental Health Services for Massachusetts, a representative from a managed behavioral health care plan and an advocate for the mentally ill. As members of the Working Group attended community meetings, they heard that access to mental health services was a significant issue to many participants. In order to delve more deeply into issues related to mental health, the Working Group sponsored a meeting focused on this topic in Atlanta, Georgia on May 22, 2006, at Skyland Trail, a mental health facility which offers long- and short-term residential care and community-based therapy, with the National Mental Health Association of Georgia as a host.

The participants at this meeting were knowledgeable about mental health. They included providers and consumers of mental health services, family members and advocates for the mentally ill and other health care providers. The meeting format was a mix of questions used at other community meetings and questions specific to mental health.

Attendees believed that the value most fundamental to a health care system "that works for all Americans" is universal access, with health care as a right. Other important values are affordability and equal quality of care for all. In considering what was most important to the delivery of mental health care services, universal access was also the most important value, accompanied by integration of mental health into primary health care, parity for mental health care and eliminating the stigma attached to mental health.

The issue participants believed most important to address in getting mental health care services is the lack of parity in insurance treatment of mental illness. Other problems that are priorities for action include the need for more funding for mental health services, the stigma associated with mental health conditions, continuity of care and the need for education to help people "know what is wrong and where to go for help." The inappropriate criminalization of mental health behaviors was also identified as a problem.

When asked about the delivery of mental health services within the overall health care system, a majority of attendees embraced this vision which was developed by one table of participants:

> A comprehensive delivery system through primary care to include addictive disease, mental illness and all other physical illnesses with:
>
> - Education for all providers on mental illness
> - A robust referral system. and
> - Access to services driven by consumer choice.

Ultimately, attendees wanted a system of "any door" access to services where dollars follow the consumer, and there is a focus on wellness recovery and resiliency.

II. How does the American public want health care delivered?

In general, community meeting discussions of how the public wants health care delivered have been structured around two central questions. The first is discussed below:

"What kinds of difficulties have you had in getting access to health care services?"

Individuals at the community meetings discussed a number of problems they or their family members have had in getting access to health care services. Some common themes emerged that are summarized below.

> *"When you change insurance, you should be able to keep your doctor."*
>
> *"Primary care doctor—I like that relationship and I don't want to see that go away."*
>
> (Charlotte meeting)
>
> *"It is an accident of history that medical insurance is attached to the place of employment, only to be lost or changed if jobs change or are lost."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- **At the community meetings, individuals asked for a delivery system that is secure, transparent, easy to navigate, and treats the "whole person."** Having a continuing relationship with a personal physician is just one component of a stable system, according to the participants. Confidentiality of medical records was mentioned as another important component of a good health care system. Individuals expressed a desire for a system that is holistic, treating the whole person rather than just treating "a bundle of symptoms," as described in the Denver community meeting.

- **Affordability of care is a primary concern among participants**. At meetings throughout the country, individuals discussed how costs had prevented them or others from getting needed care. Costs of care generally referred to *their* (or their family's) costs, including co-payments, deductibles, and health insurance premiums, rather than system-wide costs. Participants in different cities indicated that the high costs of prescription drugs were a particular concern. Participants in the Salt Lake City meeting discussed how "people are being priced out."

  National polls have shown that the cost of health care overshadows concerns about quality. In fact, almost three-quarters (73 percent) of those surveyed in a 2005 Gallup Poll said they were greatly concerned

> *"More than anything at our table we have been talking about the cost of the health care – cost is keeping people from getting the care."*
>
> (Phoenix meeting)
>
> *"We want health care delivered equitably at the community level by people we trust."*
>
> (Memphis meeting)
>
> *"We have rural areas here in Indiana where you can't even get a paramedic."*
>
> *"We have lost time-intensive care. Providers right now don't have time to spend with us! You only get two minutes with your doctor."*
>
> (Indianapolis meeting)

about cost; less than half rated other items such as medical errors or avoidable complications, privacy of health information, or availability and access to services as great concerns.[5] The EBRI 2004 Health Confidence Survey found that 34 percent of respondents were not at all confident (23 percent) or not too confident (11 percent) in their ability to afford health care today. The figure rose to 44 percent (25 percent not at all confident and 19 percent not too confident) when the respondents were asked about being able to afford care ten years out.[6] For the last twenty years, a variety of survey findings consistently showed that approximately one in four Americans reported problems paying medical bills in the previous year.[7] Surveys have continued to describe that burden Americans are feeling as it relates to the costs of medical care. According to a 2006 CBS/New York Times Poll, 61 percent of adults said they were concerned a lot about the health care costs they are facing now or will face in the future,[8] A Pew Center for the People and the Press Survey found that 54 percent of U.S. adults reported that the costs of paying for a major illness was a major problem and 38 percent said even routine care was a major problem. Moreover, 70 percent of respondents said that the government spends too little on health care, while 65 percent thought that the average American spends too much.[9]

"Culturally competent care-funding to encourage more minority physicians and providers. If I want an African American dermatologist, I have to search high and low."
(Indianapolis meeting)

"You can't get through this system without luck, a relationship, money, and perseverance."
(Salt Lake City Meeting)

"Care should be delivered at the most local level possible."
(New York Meeting)

- **Participants were troubled that many people did not have access to the health care they need**. Access to care includes access to both facilities and health care providers, including specialists. Participants in community meetings nationwide highlighted problems with access to health care in rural areas, including lack of transportation to providers or facilities located far away. The lack of public transportation was brought up as an issue not only for rural areas, but for urban areas as well. Others described problems finding an accessible provider who was willing to accept their insurance, particularly Medicaid. Providers and facilities tend to be concentrated in suburbs and more populated areas. For example, in the Phoenix community meeting, individuals noted that most providers and specialists were concentrated in the Phoenix area, and it was difficult to access care in other areas of the state. According to a national Wall Street Journal/Harris Interactive survey 56 percent of adults agree that people who are unemployed and poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes.[10]

Consolidated Tribal Health Project, Redwood Valley, California

"I don't have money to get my kids milk and you want me to take them to the dentist?"

"Society preaches prevention—but a doctor isn't going to see this young lady's kids for preventive care. She might get in at a walk-in clinic, but what's the quality of care? Is the waiting room safe? Is the provider credentialed? Are they culturally sensitive to your needs? We get referred to the outside world where they assume you can read and write and just have you signing forms and don't take the time to explain it to you."

Native Americans (both tribal and non-tribal members) met in Redwood Valley on April 20, 2006, at the Consolidated Tribal Health Project to provide an open, honest, and often emotional insight into the barriers they face in accessing even basic primary medical, mental and dental health care. Participants expressed their desire for everyone to have access to health care, both in terms of geographic distance and ability to access providers.

They felt that "health care is not a privilege, it's a right and we don't receive that right…not only as Native Americans, but as rural citizens." Individuals addressed the issue of access as a multi-pronged problem. One woman said, "When they can afford to purchase gasoline, their tires are in good shape, and they aren't in too much pain, they can make the long drive for care." If the primary care reveals a need for specialty services, they face an even greater hurdle.

Individuals talked about how they valued culturally competent care with providers who took the time to explain medical terminology and did not assume literacy. One person noted that "[health] professional people are so professional that they don't know how to relate to us nobodies. They don't know how to tell us the simple things." Participants at this meeting emphasized the importance of the government recognizing its duty to the Native American population and honoring the trust relationship that is established in law.

Mississippi Listening Sessions

Eleven listening sessions organized by faculty of the Mississippi State University Extension Service were conducted between March 21, 2006 and April 20, 2006. These sessions were held across the rural areas of the state and included a diverse mix of geographies and cultures. Altogether, 138 people participated in the sessions. The majority of participants were college graduates, many with post-graduate education, and most had some form of health coverage. Many of the participants were health care providers or administrators, or business people actively involved in their communities, and most were knowledgeable about the problems facing low-income and underserved rural Mississippi communities. A major thought expressed across the rural sessions was that many problems with the health care system in rural areas are distinct from those found in more urbanized areas. Lack of physicians and other health care professionals, distances to services, transportation issues, high cost, and lack of insurance were strongly recurring themes across the state.

Across the sessions, values regarding affordability and quality of care ranked highest among participants. Accessibility ranked third in urgency, but the total number of specific issues related to this concept dominated the discussion. Choice of care rounded out the list of values articulated at the sessions.

Those observing the sessions noted that there were marked differences in the views expressed in the meetings, reflecting at least in part, differences in culture, but also the recent major devastation caused by Hurricane Katrina. Participants from the state's southern regions, hardest hit by the storm, talked about problems they still face getting health care. Doctors left and patient records were destroyed or disappeared. And when some doctors attempt to return, they are finding that their patient base is scattered and possibly gone for good. Concerns were also expressed in the other regions of the state focused on the influx of Katrina and Rita evacuees (many of these evacuees are either uninsured or are covered by Medicaid) and the accessibility barriers that these people faced. Other storm concerns involved the lack of generators for respirators and difficulty accessing medication. One person who became the guardian after the storm of a 3-year old child who is covered by Medicaid seemed overwhelmed: "I don't know what to do or how to access the system." Another left the same session highly distressed contending that, in light of this system's inability to quickly respond to Katrina, we had no business focusing on health care issues that will take years to address, and that we should instead focus our attention on the possibility of other natural disasters, a potential pandemic, or a bioterrorist attack.

In other sessions, people talked about more pervasive problems, including delays in the ability to schedule an appointment, and physicians who are unwilling to accept Medicaid or Medicare patients. Problems related to communicating with the system led one participant to advocate the establishment of patient navigators. One session in Hattiesburg focused on small businesses' and independent contractors' inability to secure reasonable group rates; it was mentioned that 28 percent of National Association of Realtors members have no health care coverage.

Most participants (78 percent) agreed with the statement, "It should be public policy that all Americans have affordable health care." Compared to other meetings, however, participants expressed a stronger interest in focusing on personal responsibility (including taking advantage of educational opportunities) to improve health care and control health care costs, investing in public health infrastructure, and expanding safety net programs in order to ensure access to care. There was also a greater emphasis on expanding existing public programs and bolstering the employer-based health care system to address gaps in coverage, rather than initiating new programs or making fundamental changes to the health care system. The most resounding dialogue the group facilitators recalled at all the sessions focused on the availability of health care services.

- **Many participants cited complexity of the system as a contributing factor to the problems with the health care system**. A number of issues related to complexity were discussed. Some participants noted that a lack of transparency in insurance coverage and reimbursement policies contributed to the problems. In the Memphis community meeting, the discussion of the complexity of the insurance system emphasized the problems created by multiple payers. Related to the concept of multiple payers, participants in the Denver community meeting discussed how the "labyrinthine scheme of Medicare and Medicaid" sets up a system especially hard to navigate by or on behalf of elderly patients. In the Providence, Philadelphia, and Sacramento community meetings, the new Medicare prescription drug benefit (Part D) was cited as an example of the complexity of the health care system.

  > *"It's so complex. You wake up one day and your contract has been renegotiated, your numbers have changed, and your providers have changed. There are too many rules and too much bureaucracy."*

- **Linked to confusion about the health care system was the lack of useful information to help individuals navigate the health care system**. Individuals wanted to have access to understandable medical information to help them make educated decisions about their health care. Many participants discussed their desire to partner with their health care provider in making health care decisions. Participants noted that sometimes it was very hard to find any information, although we also heard from some participants that information was available if one knew where to look. People often were not sure where to go to find what they needed. The desire for information is not unique to Working Group community meeting participants. According to a 2005 Gallup Poll, a slim majority (51 percent) of individuals said they do not have enough information about hospitals and other health care facilities to make educated choices for health care services.[11]

- **Participants mentioned that they or others were not always treated with respect or dignity.** Examples of problems people encountered included a lack of effective communication, discrimination by race or ethnicity, long wait times, and overcrowded emergency rooms. In a number of locations, meeting participants discussed how they had encountered or knew of barriers due to race or ethnicity, language, lack of cultural sensitivity, and lack of health insurance.

- **Participants frequently cited barriers to care related to their insurance coverage**. People in community meetings mentioned that they have experienced problems getting care due to health insurance rules. For example, some services were not covered due to pre-existing conditions. Participants also discussed problems related to needing to go through an insurer's gatekeeping requirements to receive referrals that sometimes were denied. A number of participants spoke of problems with the portability of health insurance under the current system.

Within the employer-based health insurance system, someone who changes jobs might be forced to switch insurance and could lose access to their health care provider if that provider is not in the new network. Participants in the Billings community meeting noted that limited provider networks created access problems in Montana, a large but lightly populated state. In the Baton Rouge community meeting, participants noted that the experience from the hurricanes in the summer of 2005 brought to the forefront the need for major emergency preparedness in all aspects of the health care system, including among insurance providers.

> *"It's often more stressful to deal with the insurance company than it is to deal with the disease."* (Des Moines meeting)
>
> *"There should be no waiting period before becoming eligible for coverage."* (Lexington meeting)

The second question asked of community meeting participants about health care delivery relates to their priorities for getting needed care:

"In getting health care (choosing a physician, health care provider, or health plan), what's most important to you?"

The responses to this question built on the answers to the previous question about problems getting care. The primary themes related to affordability, accessibility, and forming mutually respectful relationships with providers.

- **Participants told the Working Group that they want to feel secure knowing that when they or their families need care, they can get it without becoming impoverished**. Discussants frequently mentioned that it was important that their out-of-pocket costs for health care not be unreasonably high. Participants said people should have to pay some amount, but they generally also said that patients of all income levels should be able to receive needed care without costs being a barrier.

  > *"I feel like we are only as good as our weakest link, and so many people can't afford care."* (Fargo meeting)

- **Participants wanted all Americans to be able to get the right health care, at the right time, in a respectful manner**. Access for everyone emerged as a common theme across meeting sites. Some meeting participants said that receiving "the right health care" meant that medical decisions would not be based on factors such as a person's age. Many participants decried making medical decisions on the basis of cost rather than medical need, but did want the care they receive to be delivered in a cost-effective manner. Participants expressed the need to have care received in a coordinated and timely manner. Among other factors, getting the right care in a respectful manner involved having a provider who was courteous and could communicate well. As stated in meetings from

Charlotte to Seattle, participants believed that care should be sensitive to the needs of different cultures. The desire to be treated with respect has also been shown to be highly valued in other national surveys. A 2004 Wall Street Journal/Harris Interactive poll asked what qualities people believed were extremely important from the doctors who treat them; some of the most popular responses related to the medical provider's interpersonal skills—such as being respectful (85 percent) and listening carefully to health care concerns and questions (84 percent).[12]

- **Participants noted that being able to choose and maintain a stable, long-term relationship with a personal health care provider was critical**. Individuals at meetings throughout the nation reiterated the importance of the provider-patient relationship that they believed should not be affected by whether a person switches jobs or changes health insurance. In the Phoenix community meeting, participants valued being able to choose a provider that would listen to them and provide "true" care, rather than just writing out a prescription. They wanted to be able to keep their health care provider even if they changed insurance carrier. In a number of locations (such as at the meetings in Orlando and Detroit), participants also discussed the importance of choosing a specialist. Participants at the community meetings told the Working Group that they placed a high value on having a "medical home" in which they can spend individual time with a provider. On the other hand, some participants at other meetings, such as San Antonio, expressed a willingness to forego some choice of primary care physician in exchange for lower costs or higher quality care.

III. How should health care coverage be financed?

Community meetings tended to devote a substantial amount of time to questions related to financing health care and controlling health care costs. The first of five questions that were commonly used in community meetings asks participants their opinion on whether everyone should be required to enroll in basic health care coverage:

"Should everyone be required to enroll in basic health care coverage, either private or public?"

Meeting participants had interesting discussions in response to this question:

- **Although the results differed across meeting sites, a majority of participants (ranging from 55 percent to 88 percent in the community meetings) believed that everyone should be required to enroll in either private or public "basic" health care coverage**. Support for some form of mandated coverage is displayed in Figure 4. Fewer than half (47 percent) of the Working Group poll respondents agreed or strongly agreed with requiring everyone to enroll in health coverage, and another 21 percent said they were "neutral." Over 80 percent in the University town hall meeting said everyone should be required to enroll in basic (public or private) health care coverage.

Figure 4:
Should everyone be required to enroll in basic health care coverage, either private or public?

Percent Saying "Yes":		
Less than 70%	**70-79%**	**80% or More**
Kansas City (60%)	Orlando (74%)	Memphis (83%)
Baton Rouge (65%)	Jackson (74%)	Charlotte (80%)
Albuquerque (62%)	Seattle (77%)	Indianapolis (88%)
Des Moines (55%)	Denver (75%)	Philadelphia (82%)
Las Vegas (56%)	Providence (76%)	Sacramento (81%)
Eugene (65%)	Miami (75%)	Lexington (80%)
	Detroit (75%)	Cincinnati (86%)
	Phoenix (79%)	Little Rock (85%)
	San Antonio (73%)	Tucson (88%)
	Billings (74%)	Sioux Falls (82%)
	Fargo (74%)	Salt Lake City (81%)

Note: Los Angeles, New York, and Hartford are not included in this table. In the Los Angeles meeting, the responses were modified based on participants' comments in the meeting. As a result, only 16 percent answered "yes" to the question, while 78 percent of the participants chose a third option that was offered by participants—that everyone automatically would have coverage under a national system, so, according to participants, the question was not applicable. For the same reason, the question was not completed in the New York meeting. In the Hartford meeting, the majority of participants abstained.

Several common themes emerged when individuals discussed why they supported requiring everyone to have health care coverage. Some participants expressed the opinion that those who are able should pay their fair share. At meeting sites throughout the country, individuals made the analogy to the law that requires everyone who drives to have automobile insurance. They believed that health coverage should be treated similarly since everyone uses health services. Additional analogies included laws requiring seat belt use and vaccinations, as expressed by meeting participants in Miami. Participants in community meetings in places such as Jackson and Denver that supported an "individual mandate" (in other words, a law requiring all individuals to have health insurance coverage) said it would be consistent with the philosophy of individual responsibility.

"Enrolling everyone in a single pool would spread costs and yield savings."

(Providence meeting)

"There should be progressive rates for health care, based on ability to pay, through income taxes, as part of a single- payer system."

(Hartford meeting)

"*All individuals should carry their own health insurance as they do for car and property. Insurance companies should be forced to insure individuals rather than corporate entities and employer groups*."

(Comments submitted to CHCWG Internet "What's Important to You?")

Younger Americans Weigh in on the Issues

Over 100 students in an undergraduate public health class at Purdue University participated in the University town hall meeting as part of a class assignment. They completed the University town hall poll, and explained their responses to questions about policy options in essay questions.

Compared to older respondents, the students were less likely to describe the health care system as being in a state of crisis (6 percent) or having major problems (61 percent). Most (88 percent) agreed or strongly agreed that it should be public policy that all Americans have affordable health care insurance or other coverage, and most (72 percent) said coverage should be provided for everyone, for a defined level of benefits. The students also opted, by a majority of 70 percent, for mandatory enrollment in some form of public or private coverage.

The majority (57 percent) thought some people should be responsible for paying more for coverage than others, with respondents most likely to state that the criteria for paying more should be either health behaviors or income. The most important priorities identified by the students for public spending on health and health care in America were guaranteeing that all Americans get health care when they need it through some sort of private or public program and investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics and disasters.

Although strong support for an "individual mandate" was found at each of the meetings, some participants disagreed. Others objected to the way the question was worded since they said it assumed implicitly that a national health care system would not exist. In fact, at the community meeting in Los Angeles, the vast majority of participants supported a new "third" option: that everyone automatically would have health coverage and access to care under a new national system. Participants who disagreed with the individual mandate concept expressed concerns that it would give greater power to the government and would undermine concepts of individual freedom. Someone at the Billings meeting noted, "[Montanans] don't like to be told what to do." Meeting participants also expressed uncertainty about how undocumented persons or non-citizens would be treated in the individual mandate system, with some saying these individuals should receive care, others maintaining that non-citizens should not be entitled to coverage.

The next commonly asked question related to whether people should pay more for health care and, if so, whether the amount they should be required to pay should be influenced by income or other factors:

"Should some people be responsible for paying more than others? What criteria should be used for making some people pay more?"

- **In almost every community meeting, a majority of participants supported the notion that some individuals should be responsible for paying more for health care than others**. The most commonly mentioned criterion for paying more was income, but varying payment by income was supported by the majority of participants in fewer than half of the meetings where this question was discussed. (See Figure 5.)

However, in many community meetings, no consensus emerged regarding who should pay more, as shown in Figure 6.

- The most popular choice of criteria was *income*. In other words, those with higher incomes should pay more than those with lower incomes. Some participants argued that those with very low incomes should not have to pay anything for their care. A July 2006 Wall Street Journal Online/Harris Interactive Poll found that 39 percent of adults agree that the higher someone's income is, the more he or she should expect to pay in taxes to cover the cost of people who are less well off and are heavy users of medical services.[13]

- The next most popular criterion often was health behaviors. Such a system could be structured either by reducing health insurance costs for those who practice healthy lifestyles (for example, exercising regularly, not smoking, wearing seat belts, etc.), or by increasing health care co-payments or premiums for those who practice unhealthy behaviors, such as smoking. (*In three of the community meetings, the choice "other" was changed to "other/combination of factors,"*

which could include both income and health behaviors, as well as other factors.) According to a Wall Street Journal Online/Harris Interactive Poll conducted in July 2006, more than one in three agreed (35 percent) but another 35 percent disagreed that it is unfair to require the majority of people who are healthy to pay for most of the cost of treating those who are sick and heavy users of hospitals and doctors.[14]

Figure 5:
Should some people be responsible for paying more than others?

Percent Saying "Yes":		
Less than 60%	**60-69%**	**70% or More**
Indianapolis (58%) Sacramento (43%)	Orlando (64%) Baton Rouge (60%) Memphis (66%) Jackson (60%) Denver (66%) Miami (63%) Phoenix (65%) Tucson (61%)	Kansas City (72%) Charlotte (72%) Seattle (77%) Providence (79%) Detroit (81%) Des Moines (73%) Philadelphia (83%) Billings (76%) Salt Lake City (80%)

Note: This question was asked only in the above cities. In most meetings where this question was asked, participants were also asked which criteria should be used. In some meetings, however, *only* the question about criteria was asked. See the next question below.

Over 80 percent of respondents in the University town hall meeting said that some people should be responsible for paying more for coverage than others, and about 71 percent said income should be used as a criterion for making people pay more.

Figure 6:
What criteria should be used for requiring some people to pay more?

Location	None—everyone should pay same	Vary by Family size	Vary by health behaviors	Vary by income	Other	Other/ Combination
Orlando	21%	6%	15%	41%	17%	Not asked
Baton Rouge	6%	15%	27%	44%	8%	Not asked
Memphis	15%	3%	11%	58%	14%	Not asked
Charlotte	12%	1%	27%	32%	27%	Not asked
Jackson	26%	4%	19%	38%	13%	Not asked
Denver	16%	4%	16%	57%	8%	Not asked
Los Angeles	20%	4%	11%	51%	15%	Not asked
Providence	20%	2%	27%	45%	6%	Not asked
Indianapolis	16%	4%	29%	47%	5%	Not asked
Detroit	12%	7%	7%	69%	7%	Not asked
Phoenix	26%	2%	12%	52%	8%	Not asked
Des Moines	17%	4%	16%	61%	3%	Not asked
Philadelphia	8%	5%	7%	70%	10%	Not asked
Billings	12%	7%	29%	44%	8%	Not asked
Fargo	6%	1%	11%	21%	--	61%
Little Rock	11%	5%	6%	15%	--	62%
Tucson	18%	0%	18%	50%	13%	Not asked
Sioux Falls	13%	3%	23%	10%	--	52%
Salt Lake City	9%	4%	23%	59%	6%	Not asked

Note: Figures may not add up to 100 percent due to rounding. Question was not asked in Kansas City, Seattle, Miami, Albuquerque, Hartford, Las Vegas, Eugene, Sacramento, San Antonio, New York, Lexington, or Cincinnati.

On the Working Group poll, there were multiple questions about how higher income people might pay more for coverage. About 40 percent (38 percent) of respondents agreed or agreed strongly that everyone should pay the same for health insurance, while **44 percent disagreed or strongly disagreed**. When asked whether people with higher incomes should pay higher premiums for employer-sponsored health insurance, 37 percent agreed or strongly agreed, while **43 percent** of respondents **disagreed or strongly disagreed**. Moreover, about one-third (34 percent) of respondents agreed or strongly agreed that higher income people should pay higher premiums for health insurance they buy themselves, compared to 45 percent who disagreed or strongly disagreed.

The level of support for higher-income people paying more for health insurance they purchase themselves was similar across education levels of the people responding to the Working Group poll. A **large share of respondents disagreed or strongly disagreed.** These findings may reflect the view, also heard at many meetings and in comments submitted via the Working Group poll, that there is some support for higher contributions from higher-income people, but there is less support for direct income-related cost-

sharing or premiums than there is for contributions to a national coverage system through some form of progressive tax, as discussed below.

According to a recent Los Angeles Times/Bloomberg survey 34 percent of adults believe that it is the government's responsibility to ensure that all citizens have health insurance and income for retirement, while 28 percent believe that it is the employer's responsibility and 28 percent believe that it is the individual's responsibility. [15]

The following question generated substantial debate at many of the meetings:

"Should public policy continue to use tax rules to encourage employer-based health insurance?"

As shown in Figure 7, the percent of individuals who agreed with this question varied greatly from meeting site to meeting site. In the Detroit community meeting, only 23 percent of participants supported a continuation of the use of tax rules to encourage employer-based health insurance, while 87 percent of those at the Baton Rouge community meeting agreed with the policy. In a number of meetings, some participants abstained from answering the question, in many cases because of frustration with the way the question was worded, as was the case with the previous two questions. In five of the community meetings, an "abstain" option was provided to participants.

A different question, focusing on whether employers should be given additional incentives to *expand* coverage, was asked in both the Working Group's poll and the University Internet town hall meeting. Support for tax incentives for employer-sponsored coverage as a means of expanding coverage was relatively high. Almost 70 percent (69 percent) of Working Group poll respondents and 61 percent of University town hall meeting respondents agreed or strongly agreed with the strategy.

Figure 7:
Should public policy continue to use tax rules to encourage employer-based health insurance?

Percent Saying "Yes":		
Less than 30%	**30-49%**	**50% or More**
Memphis (29%)	Kansas City (36%)	Orlando (60%)
Providence (27%)	Seattle (32%)	Baton Rouge (87%)
Detroit (23%)	Denver (39%)	Charlotte (62%)
Hartford* (15%; 41% abstained)	Los Angeles (37%)	Jackson (72%)
Des Moines (24%)	Indianapolis (31%)	Miami (67%)
Las Vegas (25%)	Albuquerque (39%)	Phoenix (53%)
San Antonio* (14%; 48% abstained)	Philadelphia (32%)	Lexington* (63%; 18% abstained)
	Eugene (32%)	
	Billings (46%)	Cincinnati (50%)
	Fargo* (44%; 27% abstained)	Tucson (50%)
	Little Rock* (42%; 23% abstained)	Salt Lake City (53%)

Note: Question was not asked in Sacramento, New York, or Sioux Falls. * "Abstain" option provided.

- **Views about employer-based coverage did not generally reflect a deep distrust of employers, but instead were intertwined with broader concepts of health reform**. The extent to which participants at a meeting may have been more heavily focused on fundamental reform, like a single-payer system, affected the group discussions about employer-based coverage. An analysis of Internet and mailed-in, open-ended responses to the question about changing the way health care is financed, as well as comments from participants at some community meetings, revealed at least four—sometimes overlapping—categories of responses.

- ***"The current system should be maintained or bolstered, either on an ongoing basis or as part of a more comprehensive system***." Some meeting participants supported a clear role for employers and a continuation of the current tax rules for employers. Some participants who supported retention of these tax rules argued that they needed to be applied fairly, with small businesses needing additional incentives. Meeting participants who supported comprehensive reform through some type of national plan told the Working Group that, in the absence of a national plan, employers would need to be responsible, with tax breaks provided to assist small businesses. Without a national plan, participants worried that people across the country would lose coverage through employers dropping insurance. In the community meeting in Los Angeles, participants who supported continuing the current tax system did so because they believed it encourages employers to provide

"I do believe all employers large and small should give their workers insurance. There should be programs or better tax cuts for those employers."

"[Expand] tax incentives for companies that provide health care benefits for their employees. Small companies should be able to join together to take advantage of group rates. Corporations like Wal-Mart should be penalized for not providing decent health care benefits for its employees."

"If employers are to continue to provide coverage, all employers must participate, nationwide."

"I think that placing the burden of health care on employers makes American businesses less competitive in the global market. At the same time, I think that placing the burden of paying for health care on individuals will ultimately drive up the cost of care by forcing the poor and middle-income among us to rely on costly emergency services that hospitals cannot ethically deny based on inability to pay, rather than cheaper preventive care which they can."

"We must sever the relationship between health insurance and employment. Employers should not bear the cost; it is impacting our competitiveness in the global market and it leaves huge gaps in which persons not employed in a company providing health insurance, are forced to bear huge costs of non-group insurance or, most likely, go without insurance at all. The rising percentage of uninsured is a tragedy in itself because these people frequently go without needed health care until they reach crisis. In addition, we all pay for the uninsured through higher and higher insurance premiums. Our system must be completely overhauled and redesigned to provide universal coverage with buy-in by all who have the means and a safety-net for those who can not."

(Comments submitted to CHCWG "What's Important to You?")

coverage that they might otherwise not have an incentive to provide. They also felt that the system leads to higher employer productivity and helps promote shared responsibility.

- ***"Employer-based insurance is not sustainable and is too expensive."*** Many participants felt the nation should move away from current tax rules that favor employer-sponsored coverage. Even with the current tax breaks, health care costs continue to rise rapidly, and both businesses and employees are footing ever larger and unsustainable expenditures. Some meeting participants believed that the system of employer-based health insurance needs to be replaced to make U.S. industries more competitive. At least one person noted that the employer subsidies were invisible to the average citizen, unlike Medicare or Medicaid, whose costs are frequently cited. Other participants noted that they were afraid to leave their jobs because of fear of losing health insurance or paying higher premiums. Those who opposed the current tax breaks cited a lack of equity in the current employer-based insurance system, a system that, as long as it exists, means that health care, as stated by someone at the Indianapolis meeting, will be, "an imperfect patchwork full of gaps."

- ***"The whole system should be changed fundamentally, but employers should contribute through some form of taxation or contributions to a pool."*** Other participants indicated an interest in a non-employer based system, but one in which the employers are still involved. For example, in the Des Moines community meeting, a participant referred to the employment-based system as "…outdated and the money saved from not having an employer-based system could go towards higher salaries and/or taxes to create a new system." Some participants at different meetings supported fundamental change to the system, but believed that a transition period should be implemented during which employers would still contribute to the system.

> *"We need to have one single pool of Americans who are insured. This would help spread their risk and everyone could be covered. Employers could contribute to the costs, but individuals should be able to contribute on their own."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- ***"Employer-based insurance is unfair, inequitable, and inadequate."*** A number of participants discussed other aspects of the employer-based system that were not working. For example, participants brought up the fact that some employers are going around the current tax system by hiring only part time employees, to whom they are not required to offer full benefits. In the Los Angeles meeting, many participants supported a government-run universal health care system because they felt that the current employer-based system is unfair. They expressed concerns that it excludes self-employed, unemployed, and part-time workers, and favors large corporations. These participants supported replacing the employer tax

> *"Employer-sponsored insurance worked when it was a perk, an extra offered by employers. But now coverage is a necessity, not a privilege."*
>
> (Billings meeting)

incentive with another type of tax (such as an income or payroll tax). At several meetings and in Internet comments, some called for a national value added tax[1] or national sales tax. A large number of participants expressed the opinion that access to care should not be tied to insurance coverage.

At some meetings, participants were asked what the responsibilities of individuals and families should be in a health care system. Although some of these topics will be discussed under the next question typically asked in community meetings ("What can be done to slow the growth of health care costs?"), the following section provides a brief summary of three of the most common responses to the question:

"What should the responsibilities of individuals and families be in the health care system?"

Three of the most common answers heard by the Working Group in response to this question were the following:

- **At most meetings, participants stressed the importance of preventive care to reduce health care costs**. Preventive care includes getting important screenings, exercising regularly if possible, and following a healthy diet. Some individuals said that practicing preventive care would lower health care costs.

- **Participants at most meetings believed that individuals have a responsibility to manage their own care and use of services**. Participants told the Working Group that doing so involves educating oneself, possibly through attending health education classes. It also involves being proactive in seeking better care and becoming wise, informed consumers of health care services and following treatment regimens. However, a number of participants noted that some people are better equipped to be informed consumers than others.

- **In many meetings, participants mentioned that individuals have a social responsibility to pay a fair share for health care**. Participants in the Memphis and Las Vegas meetings, among others, mentioned that, in a universal health system, this would include paying appropriate and possibly additional taxes.

The Working Group poll also shows some support for strategies that focus attention on the costs and appropriate use of health care. A majority of respondents either agreed (37 percent) or strongly agreed (19 percent) that we should all pay for part of our health care costs so that we will be more careful about how we use health care services.

[1] A value added tax is a tax, levied at each stage of production, on the added value in each stage as firms produce goods or services. It is similar in some respects to a sales tax. Many industrialized nation employ various types of value added taxes. (See Bickley, James M. CRS Report for Congress Value-Added Tax: A New U.S. Revenue Source? Washington D.C: Congressional Research Service, August 22, 2006. Accessed at http://opencrs.cdt.org/rpts/RL33619.pdf.)

Hearing from self-employed small business owners

The National Association of Realtors hosted a community meeting during their annual legislative conference on May 16, 2006, in Washington, DC, to enable the Citizens' Health Care Working Group to hear from these self-employed small business owners from around the country. Participants at this meeting sought to identify solutions for the problems specific to self-employed small business owners. They recognized that more than one in four of the nation's 1.2 million realtors have no health care coverage, while many others are only a single health incident away from having their livelihood destroyed by high health care costs.

Recurring themes in this meeting included a desire to have protection from financial ruin, having access to affordable care, and increasing the information available for patients on cost and quality to enhance their decision-making capabilities. They emphasized the need for a level of security in the health care system, saying that "we need something that ensures that if we become very ill, it doesn't take away our livelihood or what we've worked so hard to earn all our lives." While most participants agreed that everyone should have access to basic health care services, they were rather evenly divided on whether or not people should be required to have health care coverage. One participant said that "at first I was going to say no (to a requirement), but then I thought, if they aren't required to sign up for it then the only time they will get in the system is when there is emergency care and that will cost us more." Desiring to keep health care "in the competitive arena," participants talked about the need to have greater transparency in costs, standardization of forms, and understandable information to enable them to be better patients. There was a clear sentiment at this meeting to limit government involvement, with participants asking "has it ever improved anything if the government gets involved and standardizes it?"

The next "typical" meeting question asked participants about ideas for reducing the growth of health care costs in this country:

"What can be done to slow the growth of health care costs in America?"

Participants had a variety of ideas about how they would slow the growth of health care costs. Throughout the meetings, common themes emerged:

- **Participants frequently stated that the problems of high costs rest with "price setters"—namely, prescription drug companies, insurers, and for-profit providers**. In meetings throughout the country, participants mentioned the desire to limit profits in the health care sector. Some participants also noted that allowing the government broader authority to negotiate prices with pharmaceutical companies would reduce Medicare costs. The Working Group poll showed strong support for government setting limits on prices for health care products such as prescription drugs or medical devices; just over 70 percent of respondents strongly agreed (39 percent) or agreed (32 percent) with these

government-set limits. The general lack of trust of for-profit health care expressed in the community meetings is consistent with other national survey findings. For example, a December 2003 Wall Street Journal Online Health Care Poll found that most of the public do not view health care as a business that should be driven by the profit motive, and only 22 percent would prefer that for-profit insurance provide most health insurance; the findings indicated a preference for government (31 percent) or non-profit organizations (25 percent).[16]

- **A commonly expressed view was that a simpler system would result in lower administrative costs**. Participants believed that a more straightforward health care system would reduce administrative costs by eliminating duplication of services. At a number of meetings throughout the country, many individuals advocated a single-payer system to eliminate the middleman, possibly one structured like Medicare or similar to the public school system. Under this type of system, everyone would pay taxes to support the system, even though, as with education, they might not use the services. Participants advocating the single payer concept said it would be the most efficient way to organize health care.

> *"I paid over $12,000 in expenses (not including legal fees) to collect $12,500 in medical expenses because insurers were arguing about who was responsible. Everyone wants to avoid paying. It would be vastly cheaper to adopt any of the European systems."*
>
> *"I think we'll finally, inevitably, follow the lead of every other Westernized nation and institute some form of extensive public health care system – I think it's the most efficient system, and the one that gives the best care to the most people. The biggest problem I see with the system as it now stands is that we as a society spend a huge amount of money putting a profit in the pockets of the 'middleman' in the system—the insurance companies. That's why we spend 50% more of our GNP on health care than other nations do while getting worse care, and it's absurd."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- **Some support exists for investment by providers and the private sector in health information technology to increase system efficiency**. At a number of meetings, participants supported increasing the availability of electronic medical records. Greater investment in health information technology and moving to an integrated system of electronic medical records could improve administration and treatment and reduce medical errors, according to views commonly expressed at the meetings. More than 70 percent (71 percent) of respondents to the Working Group poll supported more investment by doctors, hospitals, and other providers in health information technologies as a means to improve quality and increase administrative efficiency. (By comparison, a 2005 Wall Street Journal Online/Harris Interactive poll found that 78 percent of the public supported doctors' use of electronic medical records.)[17]

A concern discussed at some meetings was privacy of the electronic medical records, which is highlighted in recent national surveys. For example, a 2005 Harris Interactive poll found that 70 percent of Americans are very or somewhat concerned that personal medical information might be leaked due to weak data security, and the public was evenly divided on whether the potential benefits of electronic medical records outweigh the potential risks to privacy.[18]

Public investment in health information technology was not identified as among the priorities for public spending on health and health care by most Internet poll respondents (see Appendix C).

- **Participants expressed general support for individuals playing their part in controlling utilization and costs**. Individuals have a responsibility to be informed health care consumers and comply with recommended treatments. To this end, participants suggested several related ideas:
    - **Individuals would like information about how to use health care better and more effectively**. For example, those with chronic diseases could use more information to properly manage their treatments.
    - **At some meetings, participants supported providing incentives to patients to engage in healthy behaviors.** Some participants supported the idea of rewarding people who practice healthy behaviors (for example, not smoking, or getting recommended health screenings). On occasion, participants also discussed the notion of penalizing people who engage in unhealthy lifestyles. The type of unhealthy behavior in question affected participants' opinions, consistent with other national surveys. According to a 2005 Wall Street Journal Online/Harris Interactive poll, the majority of Americans supported the idea of smokers, those who do not wear seat belts, and those who drink alcohol heavily paying more in health insurance costs; however, the same poll found strong opposition for charging more to those who are overweight or who do not exercise regularly.[19] According to a 2006 Wall Street Journal Online/Harris Interactive poll that compared results from the same poll in 2003 to the results in from the 2006 poll, in 2006 53 percent of adults agreed that it is fair to ask people with unhealthy lifestyles to pay higher insurance premiums than people with healthy lifestyles; while in 2003 only 37 percent of adults agreed. [20]
    - **Participants expressed preferences for using medical evidence to decide which services are covered and provided.** Many participants discussed the importance of focusing on evidence-based medicine.
    - **There was general support for controlling prescription drug costs by limiting direct-to-consumer advertising of prescription drugs and using more generic drugs, when medically appropriate.** Participants at many meetings expressed the desire to limit or prohibit direct-to-consumer advertising of prescription drugs, which could reduce the over-use of heavily-advertised drugs and slow the growth of health care costs. Some people mentioned ideas to make generic drugs available more quickly in

the market; for example, Orlando community meeting participants suggested reducing the length of time of the exclusive patent rights of pharmaceutical companies.

- **Support also existed for limiting expensive yet "futile" end-of-life care and instead providing palliative care.** Participants at meetings generally recognized the high costs associated with certain end-of-life services, some providing little value to the patient despite their high costs. At the same time, they stressed the importance of pain management, hospice care, and other support services to improve the quality of the last days of life. Better communication with patients near the end of life was considered to be an important step in controlling these costs. Participants in some meetings stressed the importance of living wills and medical directives that detailed people's wishes for treatment if they were too ill to communicate. At many meetings, similar concerns were expressed about the effectiveness and costs of care for very fragile newborns.

> "*We should have the decency to honor end of life by not pumping millions into the last days but rather encouraging high quality comfort care."*
> (Sioux Falls meeting)

- **In almost all community meetings, participants expressed the belief that changing the culture from sick care to well care—namely, by focusing on prevention, wellness, and education (in general, and health education in particular)—will reduce health care costs**. Participants broadly supported greater emphasis on prevention as part of a "culture of wellness" in the health care system. A number of participants in community meetings across the nation (including Des Moines, Fargo, Salt Lake City, Las Vegas, and others) emphasized the need for education of both children and adults to make this culture possible.

> "*If we want to bring the cost of health care down, then ultimately, we need to reduce the burden of disease. We need to reduce the need to spend money rather than figuring out how to redistribute the money. Otherwise the system will remain broken regardless of how we want to pay for it."*
> (Indianapolis meeting)

- **A commonly expressed view was that better use of advanced practice nurses and other non-physicians could save money and improve quality**. In some meetings, participants supported the increased use of care provided by health professionals other than physicians including greater use of home-based care.

- **Participants believed that investing in public health would pay dividends in terms of reducing health care costs.** Some people discussed providing more funding for community health centers and for public health more generally. They believed that doing so could reduce racial differences or disparities in health care, and could effectively reduce overall system costs.

- **Support for limits on malpractice was expressed at some community meetings.** Some participants discussed decreasing malpractice costs.

End-of-life care has surfaced at virtually every community meeting as an issue that encapsulates many of the frustrations with health care in America. Sometimes meeting attendees discussed the need for hospice care in the basic benefit package. Sometimes participants talked about exchanging expensive measures of questionable efficacy for the dying for general improvements in access to care. Usually, the speaker raising the issue has been a bit tentative. "I'm not sure how to phrase this…" or "This sounds clumsy…" Death is a difficult topic among family and friends; it's also difficult in a policy context.

At its Boston hearing, the Working Group heard a panel of experts on end-of-life care. This discussion was compelling, and members asked that a community meeting be held on the topic (information on the presentation can be found in Appendix E). This special topic meeting was held March 31, 2006 in Hanover, New Hampshire. About 120 people attended. "Living Well through the End-of-Life" was the theme of the meeting. The last chapter of many people's lives requires support and assistance, but often what is needed to live well is not medical in nature. Transportation, personal care, and help with meals and cooking are all needed. What people attending the meeting feared most about their final days (or those of someone close to them) were intractable pain, "prolongation of death," and losing personal control. They identified potential challenges related to "getting the system to work for you when you are dying" or "graceful surrender." What people wanted most from the medical system was to have their choices honored, good pain relief, and respect from health professionals so they could maintain their dignity.

The majority believed that family and friends are the primary sources of such help, but that some paid assistance should also be available. People would like respite services for the principal care provider and a contact person for coordination of community help. "Care has to be taken out of the medical system and accommodate what happens in the community." Most people (69 percent) wanted to die at home. Close to 85 percent believed that other choices could be acceptable if certain elements of care were well managed.

When asked what policy advice they'd give their Senators, participants had many specific suggestions, such as realigning financial incentives so that physicians could be encouraged to spend more time talking to patients and a request to revisit Medicare hospice payment practices. However, suggestions quickly began to mirror what has been heard in other meetings. *"As a health care consumer, I want appropriate, timely, comprehensive care from conception to death and I would be willing to pay an additional modest percentage of income across my working life to achieve this.*"

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

The last of the four questions that the legislation directed the Working Group to ask the American people is about trade-offs they are willing to make so that everyone has access to affordable, high-quality care. In community meetings, the "typical" structure was to ask participants to discuss their willingness to pay to achieve this goal, evaluate the most important priorities for public spending on health care, consider specific trade-offs the public would be willing to make, and then to evaluate potential approaches for improving access to affordable, high quality health care for all Americans. In many meetings, time constraints or the desire by participants to reiterate their support for broad system reform precluded discussion of some of these questions.

Many comments submitted to the Working Group via the poll provide additional context for understanding what we heard about trade-offs. Although worded in a variety of ways, the single most common response to the question about trade-offs can be summarized as "no trade-offs." The discussions at the community meetings provided context for what people really were saying, which is far more complicated.

The discussion at meetings was divided into several parts. One set of deliberations at the meetings focused specifically on paying for expanded coverage.

"*That is too broad a question. There is the wealthy American public who have lots of options right now. There is the less wealthy American public who have enough income to take some of the available options. There is the working American public who can just barely afford any available options. And there is the American public who can not afford any of today's health care options. And each group will have very different ideas about what they are willing to give up or 'trade-off' to get affordable, good quality health care. Even the concept of 'quality' health care is a relative term -- any reasonably trained and mostly competent doctor looks good when your choice is that doctor or no treatment at all. What all Americans should want is at least the quality and availability of care that countries like Canada, France, England, etc. offer.*"

(Comments submitted to CHCWG "What's Important to You?")

"Eliminate profits in the health care system to pay for universal coverage."

(New York City meeting)

"Eliminate medical middlemen (insurance companies) and direct-to-consumer advertising by pharmaceutical companies in exchange for universal health care."

(Hartford meeting)

"How much MORE would you be willing to pay (taxes, premiums, co-payments, or deductibles) in a year to support efforts that would result in every American having access to affordable, high quality health care coverage and services?"

- **In most meetings as well as on the Working Group poll, a majority of participants expressed a willingness to pay more to assure that everyone had access to affordable, high quality health care. Overall, about one in three (29 percent) said they were willing to pay $300 or more per year.** Sizable shares of participants expressed a willingness to contribute *some* additional amount each year toward the stated goal. (See Figure 8.) Although the size of the groups varied, some participants at all meetings said they would be willing to pay an additional $1,000 or more in a year. The Working Group poll indicated that 12 percent would be willing to pay $1,000 or more per year (in taxes, premiums, or deductibles) to support efforts that would result in access to affordable, high-quality health care services and coverage for all, and 17 percent would be willing to pay an additional $300 to $999. Another 19 percent said they did not know, and 13 percent said they would not be willing to pay anything extra.

"For those that already have health care, I believe many are willing to pay a little more for that benefit if they can be guaranteed that the extra would be put towards providing health care for those less fortunate; most of us have been in the position of having no health care at one time or another in our lives. For those that don't currently have health care, there can't be much they can trade".

"I think that most people would be willing to accept a national value added or national sales tax to fund a nationalized medical system that treats all legal citizens fairly and equally, without financial or any other kind of discrimination."
"Phase it in. Universalize a small sector of health care--for example, preventive care--before trying to redo the entire system. If the public learns to trust a small sector of tax-financed health care, it will be more open to greater change."
"It should be underwritten by the government, with sliding scale of payments made by individuals through taxes - people who make the most should pay the most to insure that health care is available for all; employers should also contribute through the taxes they pay."
Comments submitted to CHCWG "What's Important to You?")

In the Working Group poll, the amount they were willing to pay was fairly consistent across age; however, persons with the highest levels of education (those with graduate degrees) were more likely to be willing to pay $1,000 or more than those with less education, a finding that could indicate that those likely to have more money are willing to pay more. It may also reflect that those with higher levels of education typically have richer employer-sponsored insurance packages, face lower out-of-pocket payments, and therefore have not already reached their limit in terms of willingness to pay. At the meeting with realtors (see "Hearing from self-employed small business owners**"** text box

presented earlier), where few have any employer-sponsored insurance and face high premiums in the individual market, a large percentage were not willing to pay anything more, even though they earn relatively high incomes. Even so, in the 28 meetings where the question was asked, at least 43 percent of participants indicated some willingness to pay more to achieve this goal.

Figure 8:
Amount Willing To Pay in a Year So That Every American Has Access to Affordable, High-Quality Health Care

Location	$0	$1-$99	$100-$299	$300-$999	$1,000+	Don't Know
Kansas City	7%	12%	19%	24%	25%	14%
Orlando	18%	11%	20%	15%	17%	20%
Baton Rouge	9%	20%	20%	26%	20%	7%
Memphis	31%	2%	4%	13%	31%	19%
Charlotte	45%	8%	11%	10%	16%	11%
Jackson	34%	16%	15%	13%	5%	18%
Denver	12%	16%	17%	24%	25%	6%
Los Angeles	38%	14%	9%	10%	11%	19%
Providence	24%	8%	21%	16%	24%	8%
Indianapolis	12%	15%	15%	16%	22%	20%
Detroit	10%	13%	15%	21%	33%	8%
Albuquerque	22%	8%	18%	18%	24%	10%
Phoenix	19%	15%	20%	19%	20%	7%
Hartford	20%	10%	13%	27%	22%	8%
Des Moines	14%	12%	15%	31%	20%	9%
Philadelphia	9%	12%	12%	13%	28%	25%
Las Vegas	15%	18%	21%	20%	16%	11%
Eugene	13%	12%	12%	18%	33%	12%
San Antonio	8%	15%	23%	20%	19%	15%
Billings	15%	16%	19%	19%	21%	10%
Fargo	11%	16%	30%	16%	13%	14%
New York	25%	3%	6%	13%	36%	16%
Lexington	11%	15%	18%	29%	20%	6%
Cincinnati	24%	19%	15%	10%	12%	19%
Little Rock	14%	26%	23%	18%	7%	12%
Tucson	23%	19%	0%	29%	13%	16%
Sioux Falls	6%	16%	16%	25%	28%	9%
Salt Lake City	23%	14%	20%	25%	11%	6%
AVERAGE	**19%**	**14%**	**16%**	**17%**	**19%**	**14%**
Working Group Poll	***13%***	***17%***	***21%***	***17%***	***12%***	***20%***

Notes: Figures may not add up to 100 percent due to rounding. The "don't know" data for the Working Group poll includes the one percent that did not respond. Question was not asked in the Seattle, Miami, or Sacramento community meetings.

The next question asked the public about its views on what should be the most important priority for public spending for health care:

"Considering the rising cost of health care, which of the following should be the most important priority for public spending to reach the goal of health care that works for all Americans?"

At community meetings throughout the country, participants were asked to consider a list of possible priorities for public spending to reach the goal of health care that works for all Americans. In some of the meetings, participants were asked to give the most important priority of those listed, while in other meetings participants were asked to rate each priority on a scale from 1 (low) to 10 (high). The list presented at the meetings generally included the following items: guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas; investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters; guaranteeing that all Americans have health insurance; funding the development of computerized health information; funding programs that eliminate problems in access to or quality of care for minorities; funding biomedical and technological research; guaranteeing that all Americans get health care when they need it, through some form of public or private program, including "safety net" programs for those who cannot afford care otherwise; and preserving Medicare and Medicaid.

Although the phrasing of the question and the options given were not exactly the same across the community meeting sites and the Working Group poll, the top priorities were consistent:

- **When asked to rank or choose among competing priorities for public spending on health, meeting participants—with few exceptions—were most likely to rank *"Guaranteeing that all Americans have health coverage/insurance"* at the top of the list.** In the Working Group poll, 64.6 percent chose this as among the top three priorities for public spending on health.
- Other spending priorities in the list that tended to score high included:
    - Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters
    - Guaranteeing that all Americans get health care when they need it, through some form of public or private program, including "safety net" programs for those who cannot afford care otherwise
    - Guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas , and
    - Funding programs that eliminate problems in access to or quality of care for minorities.

It is important to note that each of the eight options provided by the Working Group likely would receive support from the public if polled separately, even if it did not rank as the *highest* priority among the group. For example, "funding the development of computerized health information" and "funding biomedical and technological research" generally did not rank among the highest priorities, though discussions at Working Group meetings frequently emphasized their importance. Similarly, individuals selecting other options as most important (such as "guaranteeing that all Americans have health

insurance") would likely be in favor of strengthening Medicare and Medicaid as part of the broader health care structure that would cover all Americans.

It is also important to note that support for *any* of the particular proposals could change dramatically when the list of potential priorities was modified, as occurred in two meetings. In the Hartford meeting, where participants were asked, "Which is your first priority?" discussants there added a ninth priority to the list: "*Guaranteeing that all Americans have quality health care*." When this option was included in the list of options, a full 80 percent of participants selected it rather than the options ranked highly elsewhere. For example, although the option, "Guaranteeing that all Americans have health coverage" ranked as the second highest priority in the list, it was selected by only 8 percent of participants. "Guaranteeing that all Americans get health care when they need it" also was selected by 8 percent of respondents, and no other option generated more than one vote. Similarly, in the Billings meeting, audience members requested a word change of one of the choices to include "*Guaranteeing that all Americans have health care*." In this meeting, participants were asked to rate each priority on a scale from 1 (low) to 10 (high). When this option was added, it ranked higher than any other option.

Paying More Taxes for Health Care for All:
Evidence from Other National Polls

- A poll conducted in December 2004 by The Pew Research Center for the People and the Press found that 65 percent of Americans favor or strongly favor the U.S. government guaranteeing health insurance for all citizens, even if it meant raising taxes (Pew); an earlier poll conducted in August 2003 also by Pew from the same polling group also found that 67 percent favored guaranteeing health insurance to all citizens even if it meant raising taxes.[21]
- A 2003 CBS News/New York Times poll showed that 81 percent of respondents favored using potential tax cut money to ensure all Americans have access to health insurance, whereas 14 percent indicated a tax cut should be a higher priority.[22]
- A 2003 poll found that 79 percent of Americans believed it is more important to provide health care coverage for all Americans, than to hold down taxes. (ABC/Washington Post).[23]

The next question often asked at community meetings was met with resistance at most meetings, sometimes by many of the participants:

"Some believe that fixing the health care system will require trade-offs from everyone—for example, hospitals, employers, insurers, consumers, government agencies. By 'trade-off' we mean reducing or eliminating something to get more of something else. On a scale from 1 (strongly oppose) to 10 (strongly support), please rate your support of each of the following trade-offs. What are some other examples of trade-offs that you would support?"

In many of the meetings, the Working Group provided a list of specific trade-offs for participants to evaluate:

- Accepting a significant wait time for non-critical care to obtain a 10 percent reduction in health care costs
- Paying a higher deductible in your insurance for more choice of physicians and hospitals (or paying a lower deductible with less choice)
- Paying more in taxes to have health care coverage for all. This could mean limiting coverage to high deductible/ catastrophic care or, if you were willing to pay more, a more comprehensive package
- Expanding federal programs to cover more people, but providing fewer services to those currently covered in those programs
- Limiting coverage for certain end-of-life care of questionable value in order to provide more at-home and comfort care for the dying
- Having government define benefits and set prices versus relying on free market competition by doctors, hospitals, other health care providers, and insurance companies.

> *"I would be more willing to pay more in taxes to assure that everyone has access to good healthcare if I could be assured that the medical care system was based on fair practices and was not influencing politics. I would be thrilled to see Americans embrace a healthier lifestyle. That is a trade-off that doesn't cost much. People seem to believe that they can just take a pill or wait for some breakthrough to solve their health problems. Public schools need to bring back physical education and increase activity, cities need to become more pedestrian/bicycle-friendly. This country can help provide the opportunity to MAINTAIN good health instead of fixing the problems of poor health; - it would be a lot cheaper. I'd be willing to pay more in taxes for things like that."*
>
> (Comments submitted to CHCWG "What's Important to You?")

In a number of meetings, participants voiced support for limiting coverage for end-of-life care of questionable value in order to provide more at-home and comfort care for the dying. This option received strong support in both the Working Group poll and the University town hall meeting—59 percent and 63 percent, respectively, agreed or strongly agreed with the proposal. The proposal generally receiving the lowest level of support was "expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs." In the Working Group poll, for example, only 17 percent of respondents agreed or strongly agreed with this proposal. In the University town hall meeting, 24 percent agreed or strongly agreed.

Individuals at many, if not all, community meetings argued that there were enough resources in the system already to achieve a goal of health care that works for all Americans, that resources just need to be redistributed. Most, however, did not think that the resources needed to be redistributed away from services provided to them; rather, they wanted to see reductions in waste, fraud, and (unnecessary) profit. In other cases,

participants thought that the trade-offs should come from outside the health arena. For example, at the Los Angeles community meeting, participants developed and voted on their own list of specific trade-offs they would be willing to support. The only two choices that garnered majority support were: (1) No trade-offs—the American people already pay more than enough to fully fund a single-payer universal plan; and (2) Trade war for health care—cut from defense and homeland security budgets. In Las Vegas, the participants opted for "re-evaluating federal spending priorities."

Despite the resistance to this particular question, the meeting participants did discuss various trade-offs (without using that term) in previous sections of the meeting. For example, as noted above, many participants expressed a willingness to pay more so that everyone had care. Many participants also told the Working Group that individuals should play a larger role in their health and health care. More than one in three people filling out the Working Group's Internet poll said they would be willing to pay a higher deductible in exchange for more choice of providers and services. This level of support for a trade-off of out-of-pocket costs for choice was actually slightly higher than the 2004 National Opinion Research Center at the University of Chicago (NORC) national survey finding that 27 percent of respondents would be willing to accept a higher deductible in exchange for fewer restrictions on use. The NORC results varied by income: 40 percent of Americans with household income of $75,000 or more would accept a higher deductible, compared with 23 percent with income below $25,000.[24] The Working Group was not able to analyze the relationship of income to its participants' responses.

The final substantive question at meetings asked people for their opinions on a range of fairly specific yet broad proposals for ensuring access to affordable, high quality health care coverage and services for all Americans:

"If you believe it is important to ensure access to affordable, high-quality health care coverage and services for all Americans, which of these proposals would you suggest for doing this?"

As with the previous question, participants at the community meetings were asked to evaluate a list of proposals. In this case, participants were asked to evaluate ten proposals on a scale from 1 (low) to 10 (high). Proposals included: offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own; expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program (SCHIP), to provide coverage for more people without health insurance; rely on free-market competition among doctors, hospitals, other health care providers, and insurance companies rather than having government define benefits and set prices; open up enrollment in national federal programs like Medicare or the federal employees' health benefits program; expand current tax incentives available to employers and their employees to encourage employers to offer insurance to more workers and families; require businesses to offer health insurance to their employees; expand neighborhood health clinics; create a national health insurance program, financed by taxpayers, in which all Americans would

get their insurance; require that all Americans enroll in basic health care coverage, either private or public; and increase flexibility afforded states in how they use federal funds for state programs—such as Medicaid and SCHIP—to maximize coverage.

As with the question on priorities for public spending, preferences varied somewhat in different meetings and on the Working Group poll. Once again, however, a clear consensus emerged among these options:

- **When asked to evaluate different proposals for ensuring access to affordable, high-quality health care coverage and services for all Americans, individuals at all but four meetings ranked "*Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance*" the highest.**
- Three other options almost consistently ranked in the top four choices:
    - Expand neighborhood health clinics
    - Open up enrollment in national federal programs like Medicare or the federal employees' health benefits program, and
    - Require that all Americans enroll in basic health care coverage, either private or public.

These options received high levels of support, in the community meetings as well as the Working Group poll. The support for neighborhood health clinics and for opening up enrollment in Medicare or the federal employees' health benefits program was consistently high and in line with the strong support for the Medicare program that was expressed in meetings across the country. The responses to both the Working Group poll and the University town hall meeting were similar to each other, as shown in Figure 9 below. There was, however, stronger support for expanding state programs such as Medicaid or SCHIP in the poll and the University town hall meeting than in the 31 community meetings. The level of support in the Working Group poll and University town hall meeting for opening enrollment in national programs such as Medicare or the federal employees' health benefits program was in line with a 2005 national survey by the Employee Benefit Research Institute that found 76 percent strongly or somewhat favor allowing uninsured people to buy into government programs such as Medicare and Medicaid, or into the one in which members of Congress participate.[25]

In the community meetings, the individual mandate (in other words, requiring that all Americans enroll in basic health care coverage, either private or public) was included as one of the options. Regardless of when in the meeting the question was asked, this option had a fairly high level of support, although the explanation of the concept differed from discussion to discussion. This option ranked third in popularity in the University town hall meeting and, in several community meetings, it ranked higher than all other options. However, its support in the Working Group Internet poll was below 50 percent.

Figure 9:
Responses to Trade-off Questions on Working Group Poll and from University Internet Town Hall Meeting

How much do you agree or disagree with the following options to assure coverage for all Americans? % who "Agree" or "Strongly Agree"	Working Group Poll	University Town Hall Meeting
Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own	42%	35%
Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance	68%	71%
Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices	23%	16%
Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program	64%	63%
Require businesses to offer health insurance to their employees	56%	47%
Expand neighborhood health clinics	73%	79%
Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance	70%	78%
Require that all Americans enroll in basic health care coverage, either private or public	47%	74%
Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage	55%	58%
Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families	69%	61%

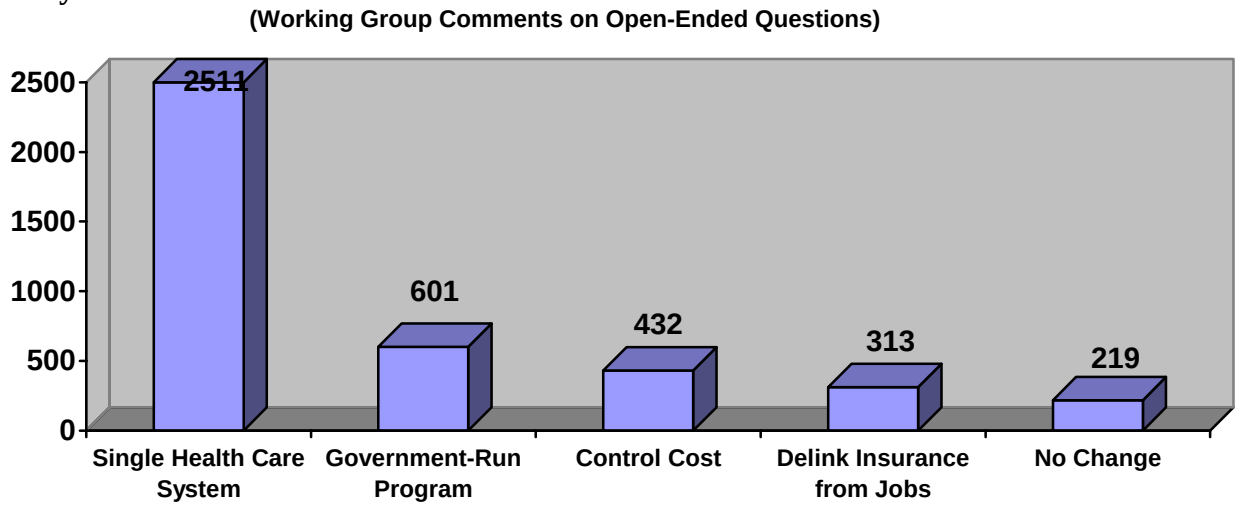
The open-ended comments submitted to the Working Group provide some additional insight into how people view the health care system, how they want it changed, and what trade-offs they are willing to make. More than 6,000 people (6,224) wrote responses, sometimes fairly long, to the general questions on both the Internet as well as on paper forms sent to the Working Group.

In general, responses to the open ended question about paying for health care were very similar to responses to the questions regarding trade-offs and recommendations. There are comments from a small number of individuals who are strongly opposed to major changes to the current system or to any changes that would increase the government's role in health care, but these were not the typical comments we received or what we heard in meetings or from the Internet poll.

As illustrated in Figure 10, analysis of the comments shows that when asked about what kinds of changes should be made to the way we currently pay for care, most wrote about the need for a single health care system. We know from the comments submitted as well as the discussions at the meetings that the notion of a single health care system means a number of different things to different people. For some, the most important issue clearly was the need for a government-run program. For others, it was an administratively

simple program that would be available to everyone but provided in the public and private arenas. Among the 2,511 respondents who wrote about the need for a single health care system in response to an open-ended question about how health care should be financed, 43 percent recommended a single-payer system, while 24 percent discussed national health care and 18 percent discussed universal health care. The remainder discussed the ideas of universal Medicare, universal coverage, universal basic care, or universal access.

Figure 10:
Our current way of paying for health care includes payments by individuals, employers, and government. Are there any changes you think should be made to this system?

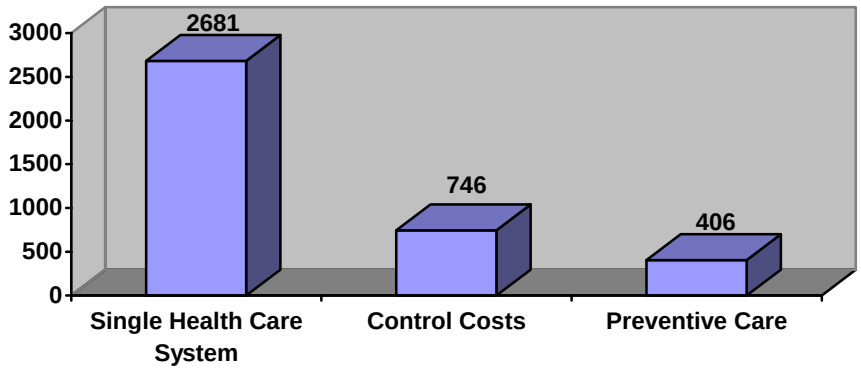


And, while a minority expressed the view that market reforms and advancements in technology could help to control costs and lead to better access to care, most of the people we heard from want more fundamental change.

The same notion—the need for a single national health care system—dominated the responses to the final question that asked people for the single most important recommendation for improving health care for all Americans. See Figure 11.

Figure 11:
What is your single most important recommendation to make to improve health care for all Americans?

(Working Group Comments on Open-Ended Questions)



There is a great deal of diversity in the ways people envision a reformed system. They believe this can be accomplished, and most believe that the resources are already there in our current system to achieve this goal. A selection of sample comments is provided below.

The Working Group Heard Many Views about How to Make Health Care Work for All Americans: Examples

"We need a single-payer system to control costs and promote efficiency, and it has to be universal."

"I think the only thing that will work is creating a system that includes everyone at a basic level of care with significant incentives for preventive care. It could be done through a system of clinics located near grocery stores (or WalMart-type stores), in schools and community heath centers."

"Let's just do Medicare for everyone. And establish a universal standard of electronic record keeping. Then everybody can go to the doctor of their choice, when they need to, and nobody falls through the cracks. And our health care system can focus on getting the right treatment to people the best way, and the health care database can track what treatments work best for whom, in the most cost effective way. Until we have a system that guarantees universal, complete coverage, we will never be able to track what basic, effective health care really costs or establish mechanisms --or even rationing (which I don't think we need)-- that does what is best for all;"

"Everyone pays a fair share, everyone has health care benefits."

"A non-profit single payer system that covered everyone would be the best solution. This would save billions in the total cost of health care in America. This plan could buy drugs with huge bulk discounts like Medicare & congressional, & veterans plans do."

"Require all Americans to choose a health care option and allow health care choices. Then let the free market reduce the costs. The default option is a free Medicaid type program that only provides emergency and preventative care."

Examples (Continued)

"I believe if Americans see that financing is more fair (rich paying more than the poor, the young contributing to the care of the elderly, the healthy paying for the sick) and all according to their level of income, this would be the first step in Americans accepting financial trade-offs. If the financing is not transparent and fair, there will be perpetual resistance. Second, I believe there must be set up a public infrastructure for setting standards of coverage and the availability of services that we are willing to fund. Such a public commission would include both citizens and representatives of all health care professions meeting apart from state or federal government. Such commission governance should be on the state, not federal, level so that local management is undergirding the system. Health resource management is local. When American citizens see that a public entity is taking the time and expertise to decide transparently what should and will be covered according to some stated ethic and philosophy of health care goals, trade-offs become more easily acceptable because the public is involved (not private corporations or remote federal agencies making such decisions). And finally, the public and local health care professionals should have the right and access to express their opinions and desires to such a public commission. There is a decision-making infrastructure that carries real authority and control but that is also permeable and open to citizen and professional input."

"All insurance should be tax deductible whether employer provided or individually purchased, as well as health expenses should be deductible below the 7.5 percent threshold. More transparency in both quality and cost so that people can truly become health care consumers. Government plans need to provide BASIC coverage and support care through community health centers as most efficient way for free care to be administered."

"I believe people should have a choice in selecting and paying for their healthcare. However, I believe the government should provide catastrophic coverage for all people. It will pay for itself in reduced neglect and dependency on government welfare and other programs."

"Put everyone in one risk pool and have a publicly financed, privately delivered system instead of paying high administrative costs for private insurance companies."

"Develop a coordinated system through the government that assures access for all, including focusing on preventive care. Health care should be regulated -- like utilities are regulated. The private sector system is not working for the US. Every other developed country has figured out a system; why can't we?"

"A single-payer system with a massive investment in information technology that provides universal access to patients as well as providers."

"Enact a single payer system of national health insurance with national standards and a global budget in which inequalities in health care delivery would be monitored and reported by race, ethnicity, income, and disability status at the state and community levels to identify inefficiencies that could be reduced by incorporating non-discrimination standards into the regulatory structure at the federal and state levels."

Examples (Continued)

"We need to set up a system like Social Security, where all working people pay into it, but all get equal coverage. We also need to tax not-for-profit institutions and systems that are currently acting very much like for-profit systems to cover insurance costs for the uninsured, the elderly, and disabled. If these systems are competing with one another, and they are, they must contribute to the community need through tax dollars, since they are duplicating services and keep building facilities that are not needed."

"Medicare and the VA are and have been working. They are cheaper than other options already in place and are more efficient in administrative costs than many other options."

"A non-mandatory, semi-private, semi-government run health insurance/free (or at least affordable, possibly based on income levels) health care program to everyone in the country. A health care program completely run by the government wouldn't work, but neither would one that was privately run - something comparable in theory to the FEHBP. And it should be either free service (paid for by taxes) for the patron, or be priced according to income and possibly 'risky' behaviors."

"In addition, we need a system where health care is provided by those best able to do it most efficiently including the highest quality. There is too much reliance on physician specialists and not enough on family physicians and nurse practitioners, nurse-midwives, nurse anesthetists, etc."

"I like the idea of the health savings accounts -- but the people that need the help can't afford the cost of the high deductible insurance, so how can they afford to put $2500 or so a year in the savings portions? Paying medical expenses from an account that they manage, might make people monitor their health care costs. I do believe that people on SSI - Medicaid overuse the system. But -- how can they not. They don't have any experience with the health care system, having put off all but the most critical care all of their lives. They only know the emergency room, because they have only sought medical care in extreme emergency in the past. To make the health savings account work, I think the government should put the $2500 into the health savings account, for all individuals below a certain income level."

"Create a system that seamlessly covers individuals from birth to death. Health care is about the individual, not whether they work, or have a disability, or fall within a certain age range. We keep everything in this country piecemeal and segregated by false categorization and because of that ensure a fragmented system with lots of individuals falling through the cracks. Get rid of the fractured system based on the private market. It doesn't work. It is costly and creates too many gaps in care."

"There needs to be some combination of these things to allow coverage for all Americans. Maybe we could expand Medicare/Medicaid, or allow people without coverage to enroll in the federal employees' plan, with a premium based on a sliding fee scale, so all pay something."

Endnotes

[1] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[2] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. 1998-2004 Health Confidence Surveys. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey" EBRI Issue Brief No. 275. November 2004. See Figure 5: Rating of Health Care System in America Today, 1998-2004.
[3] Wall Street Journal Online/Harris Interactive Poll of 2,242 U.S. adults, conducted online by Harris Interactive September 6-12, 2005. See The Wall Street Journal Online (October 20, 2005), "Poll Shows Strong Public Support For Range of Health Practices."
[4] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[5] Gallup Poll of national random sample of 1,010 U.S. adults age 18+, conducted in September 2005. See The Gallup Poll (November 1, 2005), "Healthcare Panel: Costs More Troubling Than Quality."
[6] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. 1998-2004 Health Confidence Surveys. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey" EBRI Issue Brief No. 275. November 2004. See Figure 19: Confident in Selected Aspects of the Health Care System, 2004.
[7] USA Today/Kaiser Family Foundation/Harvard School of Public Health: Health Care Costs Survey (August 2005) conducted by telephone by ICR/Harvard University between April 25 and June 9, 2005, with 1,531 adults age 18 and over responding. See Chart 6: Trends in Ability to Pay for Health Care. Additional survey sources include The Gallup Organization and Pew Research Center.
[8] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[9] The Pew Research Center for the People and The Press Poll of 1,405 U.S. adults from March 8-12, 2006. "March 2006 News Interest Index."
[10] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See the Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[11] Gallup Poll of national random sample of 1,010 U.S. adults age 18+, conducted in September 2005. See The Gallup Poll (November 22, 2005), "Healthcare Panel: More Information, Stat."
[12] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,267 U.S. adults conducted online by Harris Interactive between September 21 and 23, 2004. See The Wall Street Journal Online (October 1, 2004), "Doctors' Interpersonal Skills Valued More than Their Training or Being Up-to-Date."
[13] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[14] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[15] Los Angeles Times/Bloomberg Press of 2,563 adults conducted by Roper Center for Public Opinion Research between February 24 and March 5, 2006.
[16] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,587 U.S. adults conducted online by Harris Interactive between November 13 and 17, 2003. See The Wall Street Journal Online (December 4, 2003), "Most People Uncomfortable with Profit Motive in Health Care."
[17] Wall Street Journal Online/Harris Interactive Health Care Poll of 2,048 adults conducted online by Harris Interactive between September 30 and October 4, 2005. See The Wall Street Journal Online (October 7, 2005), "Poll Indicates Strong Support for New Medical Technologies."
[18] Harris Interactive telephone survey of 1,012 Americans age 18+ between February 8-13, 2005. See Alan F. Westin testimony at the hearing on privacy and health information technology (February 23, 2005) www.patientprivacyrights.org, under News Room.
[19] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,007 U.S. adults conducted online by Harris Interactive between December 12-14, 2005. See The Wall Street Journal Online (January 6, 2006), "Kicking a Bad Habit Could Pay Off."

[20] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[21] The Pew Research Center for the People and the Press (May 10, 2005) "Beyond Red vs. Blue." The 2005 Political Typology Survey is a national telephone interview sample of 2,000 adults age 18 and over. The Typology Callback Survey conducted in March 2005 obtained 1,090 respondents from the initial December 2004 survey. The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates between July 14 and August 3, 2003.
[22] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006. See CBS News Online (May 13, 2004) "Poll: Economy Remains Top Priority."
[23] ABC News/Washington Post Poll, with a national sample of 1,000 adults, was conducted from October 9-13, 2003.
[24] NORC at the University of Chicago survey, implemented by International Communications Research (ICR), with random sample of 2,024 respondents between August 4-10, 2004. Schur, CL, Berk, ML, and Yegian, JM. (November 10, 2004), "Public Perceptions Of Cost Containment Strategies: Mixed Signals For Managed Care." *Health Affairs* Web Exclusive: W4-516 – W4-525.
[25] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. (August 9, 2005) "2005 Health Confidence Survey: Wave VIII, June 30-August 6, 2005."

Appendix A:
Local Demographics and Health Resources:
Citizens' Health Care Working Group Community Meetings

Table of Contents

Introduction

The Citizens' Health Care Working Group held meetings across the country to hear what people had to say about health care. A core set of 31 Community Meetings were held between January and May 2006. These were structured similarly, and each included the use of electronic devices allowing individuals to provide responses to questions that were the same as, or very similar to, questions also asked on the Working Group's Internet Poll. In addition to these meetings, about 40 other meetings, organized either by the Working Group, individual members, or other groups across the United States, provided input to the Working Group.[1]

Because the structure of the 31 Community Meetings allows us, with appropriate cautions, to compare what we heard from meeting to meeting, the meetings were the focal point of the Working Group's efforts to engage in a national dialogue. The main criterion for selecting locations for these meetings was reaching as wide a spectrum of communities as possible in the time available. This Appendix provides profiles of these communities to illustrate diversity amongst them. The measures included are population demographics, population health status, and the availability of various health resources. The data represent the Metropolitan Statistical Area (MSA), except where such level of analysis would be inappropriate. For readability, data are summarized and highs and lows are presented. The source of the data is the 2005 Area Resource File data set provided by the Health Resources and Services Administration, Department of Health and Human Services, unless noted otherwise.

• Albuquerque, New Mexico	• Little Rock, Arkansas
• Baton Rouge, Louisiana	• Los Angeles, California
• Billings, Montana	• Memphis, Tennessee
• Charlotte, North Carolina	• Miami, Florida
• Cincinnati, Ohio	• New York, New York
• Denver, Colorado	• Orlando, Florida
• Des Moines, Iowa	• Philadelphia, Pennsylvania
• Detroit, Michigan	• Phoenix, Arizona
• Eugene, Oregon	• Providence, Rhode Island
• Fargo, North Dakota	• Sacramento, California
• Hartford, Connecticut	• Salt Lake City, Utah
• Indianapolis, Indiana	• San Antonio, Texas
• Jackson, Mississippi	• Seattle, Washington
• Kansas City, Missouri	• Sioux Falls, South Dakota
• Las Vegas, Nevada	• Tucson, Arizona
• Lexington, Kentucky	

[1] In addition to these meetings, several other types of meetings expanded the scope of the Working Group's outreach. Special Topic Community meetings were held to explore several issues of special concern, and a national webcast hosted by the University of Michigan included town hall meetings held at 22 participating universities; members conducted meetings; and a variety of organizations held their own meeting using materials developed by the Working Group.

Population Characteristics

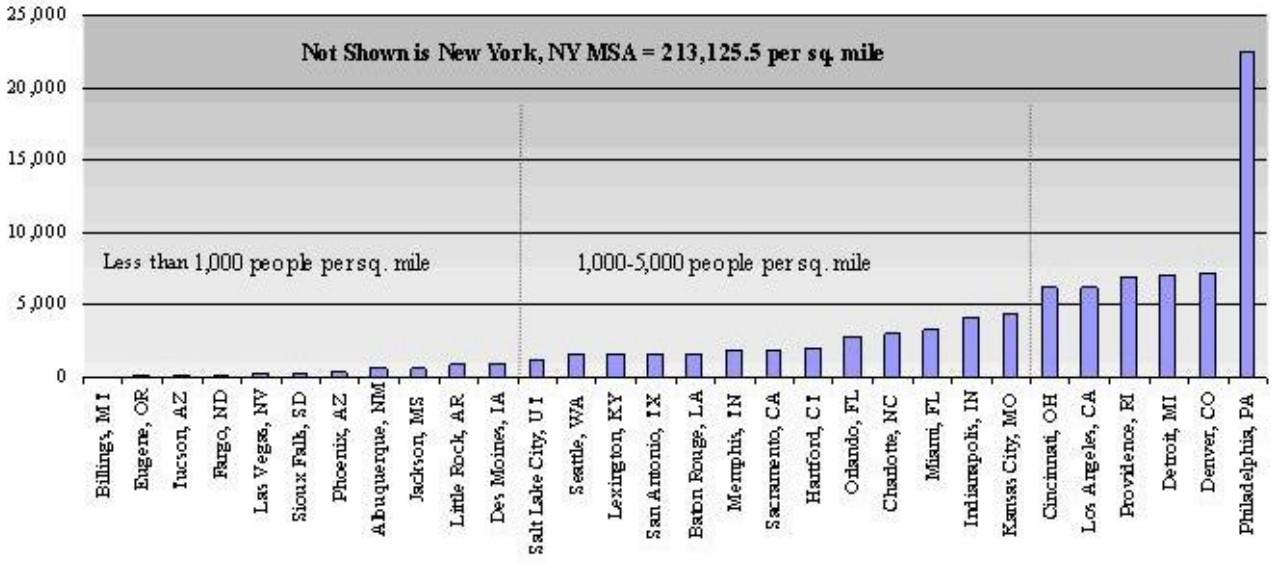
The meeting sites were diverse on several measures, including their population size, rural populations, racial composition, and population age. The following figures provide some insight on these and other characteristics of the communities visited. Just as there is no "typical" U.S. community, there was no "typical" site for a community meeting.

Population Size and Population Density

– The areas visited ranged in size from 144,472 in Billings, MT to over 18 million in the New York metropolitan statistical area (MSA). Of the 31 areas visited, 11 had fewer than one million people, 16 had between one and five million people, and four had over five million people.

– In 2004, the population per square mile also had a tremendous range, from 55.9 people per square mile in Billings, MT to 213,125.5 people per square mile in the New York, NY MSA. As shown in Figure A1, 11 of the areas visited had population densities less than 1,000 people per square mile. Thirteen areas had between 1,000 and 4,999 people per square mile, and seven areas had 5,000 or more people per square mile.

Figure A1:
Population Per Square Mile for Meeting Sites, 2004



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– The meeting sites included both rural and urban MSAs. Five areas had more than 20 percent of its population living in rural areas (Baton Rouge, LA, Billings, MT, Jackson, MS, Little Rock, AR, and Sioux Falls, SD). Six areas had less than 5 percent of their population in rural areas, including Los Angeles, CA, New York, NY, Miami, FL, Las Vegas, NV, Salt Lake City, UT, and Phoenix, AZ.

Racial and Ethnic Diversity

– In 2000, 75 percent of the U.S. population was White, 12 percent was Black/African-American, and 13 percent was of another race or combination of races. Of the 31 meeting sites, five had Black/African-American populations greater than 20 percent (see Figure A2), nine had between

10 and 20 percent of the population as Black/African-American, and 17 had 10 percent or less of this population group.

Figure A2:
Prevalence of Black/African-American Populations in Meeting Sites, 2000

MSAs with Black/African-Americans as a Share of the Population:			
Less than 10%		**10-20%**	**More than 20%**
Albuquerque, NM	Phoenix, AZ	Charlotte, NC	Baton Rouge, LA
Billings, MT	Providence, RI	Cincinnati, OH	Detroit, MI
Denver, CO	Sacramento, CA	Indianapolis, IN	Jackson, MS
Des Moines, IA	Salt Lake City, UT	Kansas City, MO	Little Rock, AR
Eugene, OR	San Antonio, TX	Lexington, KY	Memphis, TN
Fargo, ND	Seattle, WA	Miami, FL	
Hartford, CT	Sioux Falls, ND	New York, NY	
Las Vegas, NV	Tucson, AZ	Orlando, FL	
Los Angeles, CA		Philadelphia, PA	

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– Of the 31 areas visited, 11 had Hispanic populations (of any race) greater than the U.S. average of 12.5 percent in 2000 (see Figure A3). In San Antonio, TX half of the population was of Hispanic or Latino descent while Albuquerque, NM and Los Angeles, CA both had populations of 41 percent Hispanic.

Figure A3:
Prevalence of Hispanic Populations in Meeting Sites, 2000

MSAs with Persons of Hispanic/Latino Origin as a Share of the Population:			
Less than U.S. Share (12.5%)		**12.5-20%**	**More than 20%**
Baton Rouge, LA	Jackson, MS	Denver, CO	Albuquerque, NM
Billings, MT	Kansas City, MO	New York, NY	Las Vegas, NV
Charlotte, NC	Lexington, KY	Orlando, FL	Los Angeles, CA
Cincinnati, OH	Little Rock, AR	Sacramento, CA	Miami, FL
Des Moines, IA	Memphis, TN		Phoenix, AZ
Detroit, MI	Philadelphia, PA		San Antonio, TX
Eugene, OR	Providence, RI		Tucson, AZ
Fargo, ND	Salt Lake City, UT		
Hartford, CT	Seattle, WA		
Indianapolis, IN	Sioux Falls, SD		

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Age and Gender

– The age distributions of the areas visited varied. Salt Lake City, UT had the largest proportion of persons under age 25 (43.3 percent); Miami, FL had the smallest percent (31.5 percent). In Indianapolis, IN, 17.3 percent were age 65 and older while in Salt Lake City, UT only 8 percent were seniors. Figure A4 gives examples of age distributions for nine small, medium, and large communities visited by the Working Group.

Figure A4:
Summary of Age Distributions, by Population Size, 2000

MSA	2000 Population	Percent Age 0-24	Percent Age 25-44	Percent Age 45-64	Percent Age 65+
Fargo, ND	174,367	40.2%	29.7%	19.5%	10.6%
Eugene, OR	322,959	34.8%	27.5%	24.4%	13.3%
Des Moines, IA	481,394	35.1%	31.5%	21.8%	11.5%
Little Rock, AR	610,518	35.5%	30.7%	22.4%	11.3%
Salt Lake City, UT	968,858	43.3%	30.7%	18.1%	8.0%
Charlotte, NC	1,328,839	34.7%	35.2%	20.3%	15.0%
Indianapolis, IN	1,524,707	35.5%	32.9%	21.0%	17.3%
Miami, FL	5,007,564	31.5%	30.2%	21.8%	16.4%
New York, NY	18,323,002	33.4%	31.7%	22.3%	12.6%
U.S.	281,421,906	35.3%	30.2%	22.0%	12.4%

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

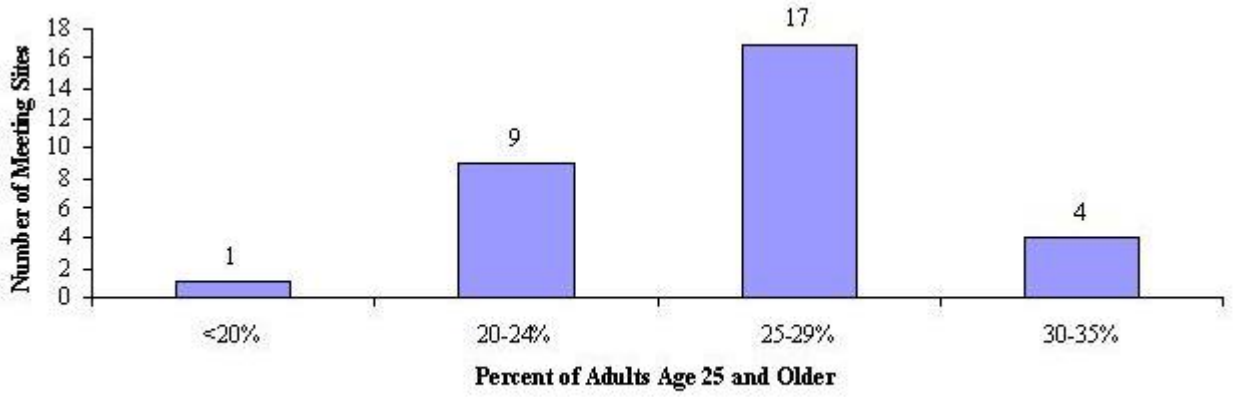
– For the most part, the meeting sites were evenly split in terms of the percentages of men and women, just like the U.S. as a whole (49.1 percent men in 2000). Jackson, MS had the lowest percentage of men (47.7 percent); Las Vegas, NV had the largest (50.9 percent).

Education and Employment

– In 2000, the majority of adults age 25 and older in each of the communities had achieved at least a high school diploma, although there was some variation across geographic areas. In the Los Angeles, CA area, 72.2 percent of adults had completed at least high school while in the Fargo, ND area, 89.7 percent had completed high school education or above that level. In the U.S. as a whole, 80.4 percent of adults age 25 and older had at least a high school diploma.

– As shown in Figure A5, in 21 of the meeting sites, more than 25 percent of adults age 25 or older had completed four or more years of college in 2000. In the United States, 24.4 percent had completed four or more years of college.

Figure A5:
Adults Age 25 and Older with 4 or More Years of College, 2000



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– Unemployment rates also varied across sites. While the unemployment rate in the Sioux Falls, SD area was 2.8 percent in 2000, Los Angeles, CA faced unemployment of 7.4 percent. The national unemployment rate in 2000 was somewhere in between, at 5.8 percent. The Working Group visited 12 places with unemployment rates of 5.8 percent or higher and 19 with rates lower than the national average.

– In 2004, 8.4 percent of the U.S. population were veterans of the military. Of the 31 sites hosting Community Meetings, the Charlotte, NC area had the largest portion of veterans (22.5 percent), while Los Angeles, CA had the smallest percentage (4.7 percent). Twenty-one of the meeting sites reported veteran populations less than 10 percent of their populations. The other 10 areas had veteran populations of 10 percent or higher.

Income and Poverty

Per Capita Income

– In 2003, the per capita income for the U.S. was $31,472.[2] Of the 31 MSAs visited, 14 had per capita incomes less than the U.S. average, 17 had per capita incomes greater than the U.S. figure. Per capita incomes in the meeting sites ranged from $25,853 in Tucson, AZ to $40,963 in the New York, NY MSA (see Figure A6).

[2] The Area Resource File uses income data from the U.S. Department of Commerce, Bureau of Economic Analysis. Income figures from this source differ from those reported by the U.S. Bureau of Census.

Figure A6:
Per Capita Income for Meeting Sites, 2003

MSAs with Per Capita Income *Less* Than U.S. Average $31,472		MSAs with Per Capita Income *More* Than U.S. Average $31,472	
MSA	**2003 Per Capita Income**	**MSA**	**2003 Per Capita Income**
Tucson, AZ	$25,853	Memphis, TN	$31,665
Eugene, OR	$26,316	Providence, RI	$31,742
Baton Rouge, LA	$26,878	Lexington, KY	$32,012
San Antonio, TX	$27,315	Cincinnati, OH	$32,974
Orlando, FL	$28,103	Miami, FL	$33,023
Jackson, MS	$28,143	Sioux Falls, SD	$33,272
Albuquerque, NM	$28,584	Charlotte, NC	$33,289
Billings, MT	$29,181	Los Angeles, CA	$33,324
Phoenix, AZ	$29,589	Kansas City, MO	$33,356
Salt Lake City, UT	$29,779	Des Moines, IA	$33,695
Little Rock, AR	$29,975	Indianapolis, IN	$33,732
Fargo, ND	$30,767	Detroit, MI	$36,000
Las Vegas, NV	$30,938	Philadelphia, PA	$37,055
Sacramento, CA	$31,436	Hartford, CT	$38,196
		Seattle, WA	$39,012
		Denver, CO	$39,215
		New York, NY	$40,963

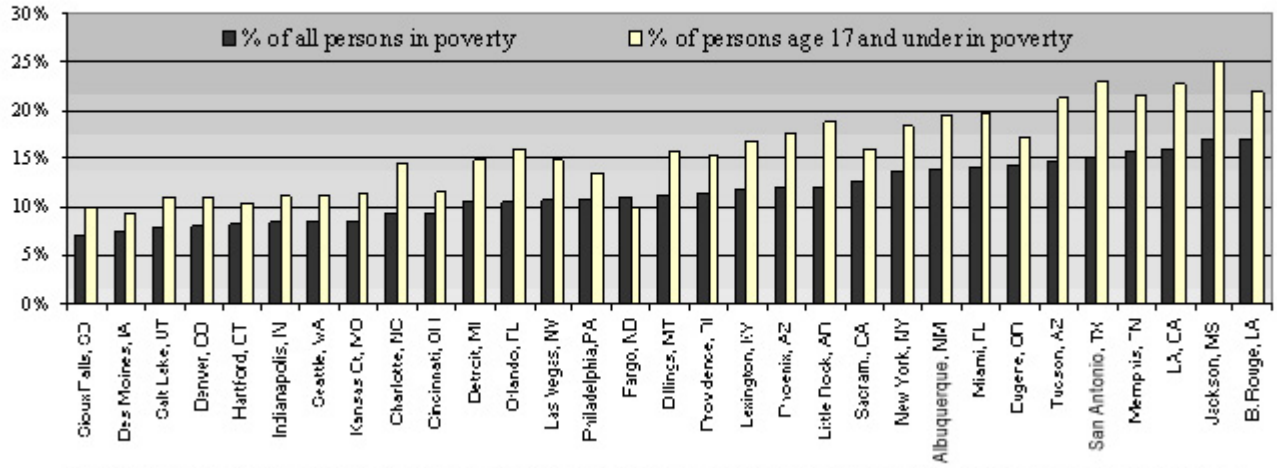
Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration. Note: The Area Resource File uses income data from the U.S. Department of Commerce, Bureau of Economic Analysis. Income figures from this source differ from those reported by the U.S. Bureau of Census.

Poverty

– The percentage of persons living with incomes below the federal poverty level (FPL) in 1999 ranged from 7.1 percent in Sioux Falls, SD to 17.1 percent in Baton Rouge, LA (see Figure A7). Twenty-two areas had 12.7 percent of the population (the national average) or less living in poverty.

– For children age 17 and under, the percentage living with incomes below poverty ranged from 9.3 percent in Des Moines, IA to 25 percent in Jackson, MS.

Figure A7:
Percent of All Persons and Those Age 17 and Under Living in Poverty, 1999



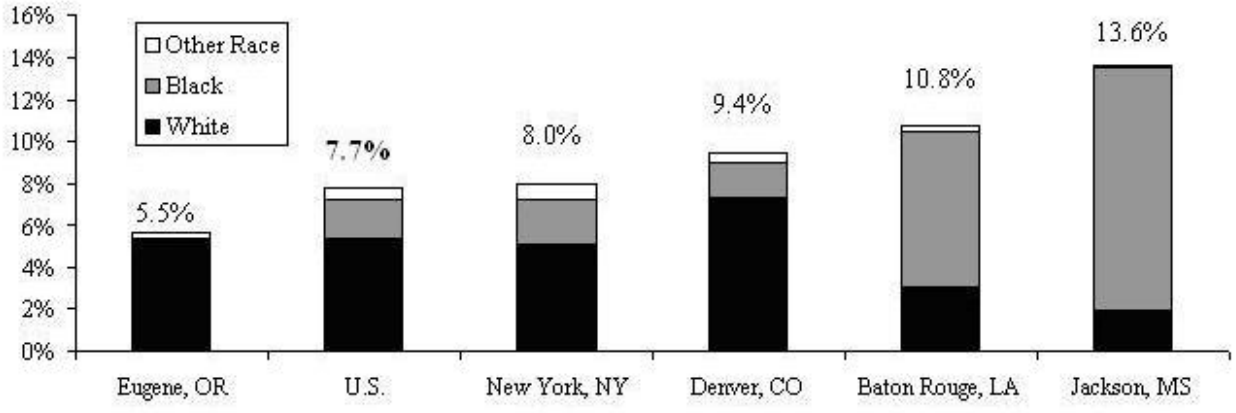
Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Health Status

Births

– Figure A8 shows a summary of the average percentage of births for 2000-2002 that were low birth weight by race of the birth mother. Eugene, OR had the smallest proportion of low-weight births with 5.5 percent, and Jackson, MS had the largest proportion with 13.6 percent. The other counties highlighted show the variation for highly populated areas like New York, NY as well as smaller areas like Baton Rouge, LA. The counties of the community meetings also showed diversity in the percent of births receiving early prenatal care. On average in the U.S., 81.5 percent of births got early prenatal care between 2000 and 2002. Philadelphia, PA had the lowest percentage of births for early prenatal care (67.2 percent), Des Moines, IA the highest (89.3 percent).

Figure A8:
Summary of Low Birth Weight Percentages for Meeting Site Counties, by Race, 2000-2002

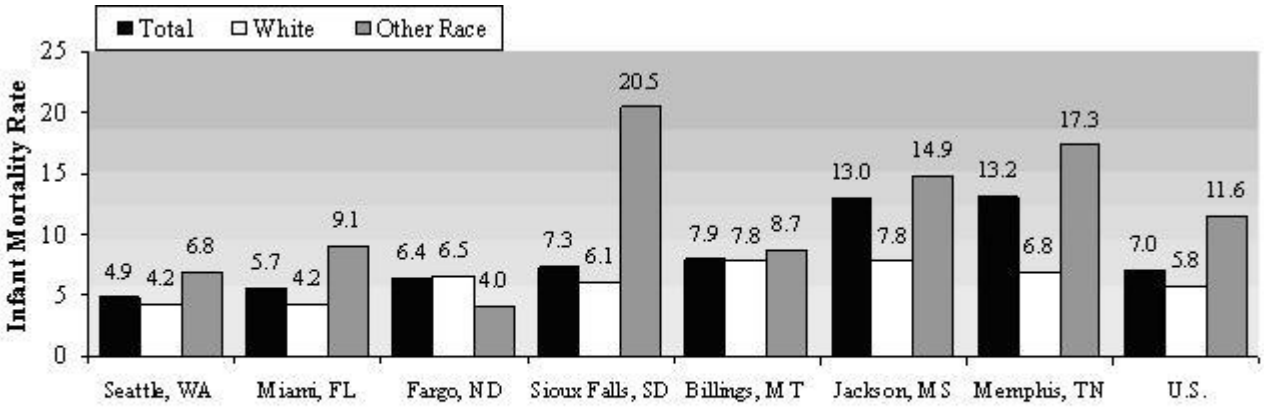


Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Deaths

– The infant mortality rates (infant deaths per 1,000 births) in the counties visited ranged from 4.9 in Seattle, WA to 13.2 in Memphis, TN (average for 1998-2002). Racial disparity for infant mortality is also evident across the counties visited. The infant mortality rates for births to White mothers ranged from 4.2 in Miami, FL and Seattle, WA to 7.8 in Billings, MT and Jackson, MS. In contrast, the range in mortality rates for births to mothers of other races was 4.0 in Fargo, ND to 20.5 in Sioux Falls, SD. Figure A9 summarizes the infant mortality rates for the counties with highest and lowest rates for each racial category.

Figure A9:
Summary of Average Infant Mortality Rates in Meeting Site Counties, by Race, 1998-2002



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– For most counties visited, close to half of all deaths were due to one of four major diseases—heart disease, cancer, chronic lower respiratory diseases, or diabetes, on average between 2000 and 2002. Four counties had less than 45 percent of deaths from these major diseases (with the lowest being 38 percent in Salt Lake City, UT), 22 counties had 45 to 55 percent of deaths from these diseases, and five counties had more than 55 percent of deaths due to major disease (with the highest being 57 percent in Providence, RI).

Figure A10:
Percentage of Deaths Due to Major Disease in Meeting Site Counties, 2000-2002

Percentage of Deaths from Heart Disease, Cancer, Chronic Respiratory Disease, or Diabetes				
Less than 45%	**45-55%**			**More than 55%**
Charlotte, NC	Albuquerque, NM	Indianapolis, IN	Philadelphia, PA	Des Moines, IA
Denver, CO	Baton Rouge, LA	Kansas City, MO	Phoenix, AZ	Los Angeles, CA
Jackson, MS	Billings, MT	Las Vegas, NV	Sacramento, CA	Miami, FL
Salt Lake City, UT	Cincinnati, OH	Lexington, KY	San Antonio, TX	New York, NY
	Detroit, MI	Little Rock, AR	Seattle, WA	Providence, RI
	Eugene, OR	Memphis, TN	Sioux Falls, SD	
	Fargo, ND	Orlando, FL	Tucson, AZ	
	Hartford, CT			

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Resources Available

Physicians

– In 2004, there were over 760,000 nonfederal physicians who were actively practicing in the U.S. This figure averages to about 26 physicians per 10,000 people. Of the 31 areas visited, nine MSAs had 26 or fewer nonfederal active physicians per 10,000, and 22 areas had more than 26 physicians per 10,000 people. The highest ratio of physicians was in Lexington, KY, where there were 48 physicians per 10,000 people. The smallest ratio was in Las Vegas, NV, where there were 17 physicians per 10,000 residents.

– The vast majority of physicians in almost every MSA visited were specialists. In 2004, the range of general practitioners, including general practice, general family medicine, and family medicine subspecialties, was from two per 10,000 residents in eight different meeting sites to six per 10,000 in Sioux Falls, SD. In contrast, the range of all types of specialists was between 14 per 10,000 residents (in Las Vegas, NV) and 36 per 10,000 residents (in New York, NY).

Hospitals and Other Health Care Facilities

– Figure A11 gives a snapshot of the diversity in hospital resources available in a few of the MSAs visited. The sites chosen demonstrate the often noted relationship between the size of the area and the number of short-term general hospitals, ambulatory surgery centers, and hospices. Larger areas tend to have more of these types of facilities. However, population size is less related to the number of rural health clinics, community mental health centers, and federally qualified health centers.

– Veterans Administration (VA) hospitals were present in 24 of the MSAs visited. Twenty areas had one VA hospital. Figure A11 shows the four areas that had more than one VA hospital available—Miami, FL, Philadelphia, PA, Los Angeles, CA, and New York, NY.

Figure A11:
Summary of Number of Hospitals and Other Health Facilities in Meeting Sites

MSA	Population (2004)	Short-Term General Hospitals (2003)	Veterans' Hospitals (2003)	Ambulatory Surgery Centers (2004)	Hospices (2004)	Rural Health Clinics (2004)	Community Mental Health Centers (2004)	Federally Qualified Health Centers (2004)
Billings, MT	144,472	3	0	4	2	1	0	2
Sioux Falls, SD	203,324	7	1	3	3	7	0	2
Eugene, OR	331,594	4	0	9	3	5	1	3
Salt Lake City, UT	1,018,826	10	1	16	13	2	1	8
Cincinnati, OH	2,058,221	21	1	26	11	2	3	24
Detroit, MI	4,493,165	37	1	23	16	0	1	8
Miami, FL	5,361,723	54	2	61	11	4	68	31
Philadelphia, PA	5,800,614	58	3	66	45	0	14	34
Los Angeles, CA	12,925,330	117	2	229	59	0	3	40
New York, NY	18,709,802	143	5	151	56	1	22	63

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Medicaid

– Each state had its own income thresholds for Medicaid eligibility for working parents. In 2005 it ranged from 19 percent of the federal poverty level (FPL) in Arkansas to 200 percent of the FPL in Arizona. About half (15) of the areas visited had state-wide income eligibility levels for working parents that were below the national average (67 percent of FPL), eight areas had state levels at or above 100 percent of the FPL.[3]

– State residents may also enroll in Medicaid if they qualify for Supplemental Security Income (SSI). Again, each state sets its own levels for being eligible for SSI. Over half of the areas visited (19) were in states that established SSI eligibility at 73.8 percent of the FPL. The two areas visited in California (Los Angeles and Sacramento) had SSI eligibility of 100.2 percent of the FPL.[4]

Medicare

– The federal Medicare program provides vital health coverage for seniors age 65 and over and certain disabled workers under the age of 65. The percentage of the non-elderly population eligible for Medicare because of disability, 14.7 percent of the U.S. Medicare population in 2003, varied considerably. In Miami, FL, 9.9 percent of Medicare beneficiaries were disabled beneficiaries, while in Kansas City, MO, 14.6 percent were disabled and in Jackson, MS and Little Rock, AR, over one-fifth were disabled (22.0 percent and 20.5 percent, respectively).

– Medicare adjusted average per capita costs (AAPCC) for aged beneficiaries serve as an additional marker of the diversity in the areas of the community meetings. Three counties had the lowest AAPCC of the sites visited—$555.42; fifteen counties were at $613.89; and seven counties had rates above $700. The highest payment rate was $904.51 in Miami, FL. While the average per capita costs reflects differences in the prices of services, it also reflects variation in the amount of services and the intensity of care used.

Uninsured

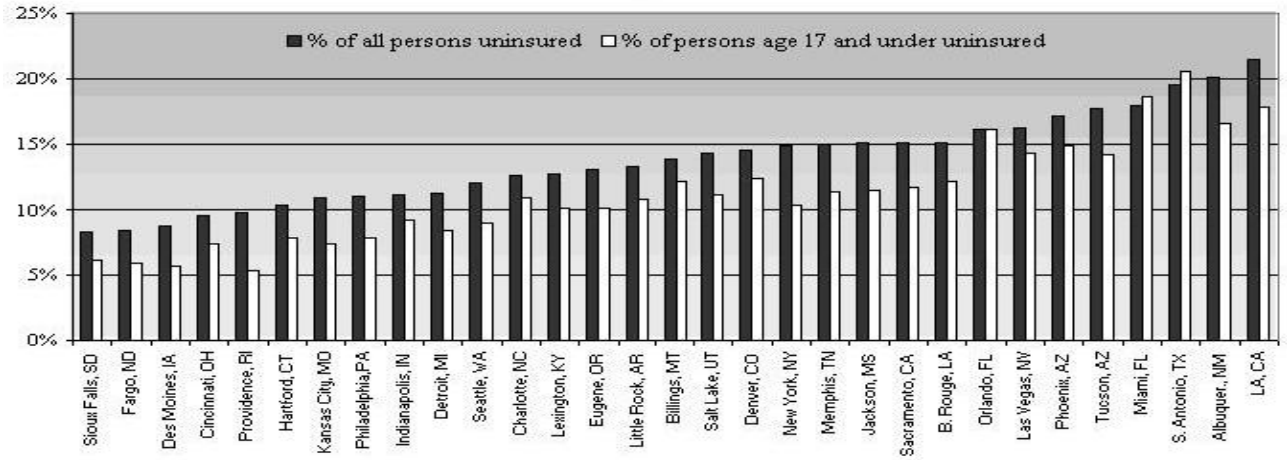
– In 2000, 14.2 percent of the U.S. population did not have health insurance. About half of the areas visited (16) had uninsured rates less than the national average. Sioux Falls, SD had the smallest percent of uninsured persons (8.2 percent) and Los Angeles, CA had the largest percentage (21.5 percent).

– Figure A12 below shows that in all but three areas (Orlando and Miami, FL and San Antonio, TX), a larger percentage of children age 17 and under were uninsured, compared with the percentages for all people.

[3] Kaiser Family Foundation website www.statehealthfacts.org.

[4] Lynda Flowers, Leigh Gross, Patricia Kuo, Shelly-Ann Sinclair, *State Profiles: Reforming the Health Care System 2005*, AARP Public Policy Institute, Washington, DC, February 2006.

Figure A12:
Percent of All Persons and Those Age 17 and Under Without Health Insurance, 2000



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Use of Services

– The areas visited by the Working Group also show variation in the rates of utilization of medical care services. In 2003, the rate of inpatient hospital visits in short-term general hospitals (per 1,000 persons) ranged from 404 in Eugene, OR to 1,378 in Sioux Falls, SD. Four meeting sites had inpatient visits rates of over 1,000—Billings, MT, Jackson, MS, Little Rock, AR, and Sioux Falls, SD.

– In 2003, the number of short-term general hospital outpatient visits per 1,000 persons ranged from 931 in Eugene, OR to 7,902 in Billings, MT.

– Emergency department visits in 2003 in short-term general hospitals ranged from 193 per 1,000 people in Sacramento, CA to 576 per 1,000 people in Jackson, MS. Figure A13 below summarizes the highs and lows for inpatient, outpatient, and ED visits.

Figure A13:
Summary of Visits per 1,000 Populations in Meeting Sites, 2003

MSA (Sorted by Inpatient Visits)	Inpatient visits per 1,000 pop.	Outpatient visits per 1,000 pop.	Short-Term General ED visits per 1,000 pop.
Sioux Falls, SD	1,378	2,887	276
Jackson, MS	1,317	2,163	576
Billings, MT	1,237	7,902	321
Little Rock, AR	1,194	2746	441
New York, NY	896	2,049	361
Philadelphia,PA	795	1,862	368
Detroit, MI	610	2,135	362
Los Angeles,CA	542	1,189	250
Sacramento, CA	462	1,183	193
Salt Lake City, UT	437	2,494	323
Eugene, OR	404	931	306

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Appendix B: Summary of Community Meeting Data

Demographic Characteristics (N=*Total Number of Respondents*)	Weighted Averages[1]: % of Meeting Attendees
Gender (N=*3,775*):	
Male	37.7%
Female	62.3%
Age in years (N=*3,824*):	
Under 25	6.0%
25-44	25.5%
45-64	53.2%
65+	15.3%
Hispanic Origin (N=*3,805*):	
Yes	9.1%
No	87.6%
Declined to answer[2]	3.3%
Race[3] (N=*3,810*):	
White	69.5%
Black/African-American	16.9%
Asian	2.6%
Native Hawaiian/Pacific Islander	0.2%
American Indian/Alaska Native	1.7%
Multiple races	1.8%
Other	3.8%
Declined to answer[2]	3.6%
Education (N=*3,856*):	
Elementary	0.9%
Some High School	1.3%
High School Graduate/GED	6.7%
Some College	17.1%
Associate's Degree	6.5%
Bachelor's Degree	23.9%
Graduate/Professional Degree	43.3%
Declined to answer	0.5%
Source of Coverage[4] (N=*3,662*):	
Employer	64.5%
Self-purchased	8.3%
Veterans' Administration	1.1%
Medicare	12.6%
Medicaid	2.6%
Other	3.6%
Uninsured	6.6%
Not Sure	0.7%
Employment[5] (N=*3,776*):	
Self-employed	11.6%
Full-time	50.2%
Part-time	8.1%
Looking for work	4.7%
Homemaker	1.7%
Other/retired	18.9%

[1] The weighted average was calculated as the total number of individuals providing a particular response to a question across all meetings divided by the total number of individuals who answered that question at all the meetings.
[2] The "decline to answer" option was not provided at all meetings.
[3] Classifications of race varied between meeting sites. In some meetings, the question of race was limited to one answer, whereas in other meetings, attendees were permitted to answer "multiple races." Also, attendees were allowed to decline to respond.
[4] The question on source of health coverage was not asked in two meetings.
[5] The question on employment was not asked in one meeting; the categories of full-time and part-time were combined in another.

% Who View The Health Care System as Being in Crisis or Major Problem		% that Believe Health Care Should:			% Who Think Affordable Health Care Should be Public Policy		% Who Believe that Health Care Should Cover:		
Meeting Sites Sorted from Lowest to Highest		**Meeting Sites Sorted by "Everyday Costs"**	**Pay Everyday Costs**	**Protect from High Costs**	**Meeting Sites Sorted from Lowest to Highest**		**Meeting Sites Sorted by Percent Answering "Certain Groups"**	**Certain Groups**	**A Level of Benefits for All**
Fargo, ND	87.5%	Eugene, OR	18.9%	80.0%[1]	Salt Lake City, UT	77.2%	Philadelphia, PA	2.0%	98.0%
Billings, MT	90.2%	Baton Rouge, LA	22.8%	77.2%	Baton Rouge, LA	85.5%	New York, NY	2.1%	97.9%
Little Rock, AR	90.8%	Salt Lake City, UT	25.6%	72.1%[1]	Las Vegas, NV	87.4%	Phoenix, AZ	2.8%	97.2%
Jackson, MS	93.5%	Billings, MT	26.4%	70.8%[1]	Fargo, ND	89.4%	Hartford, CT	3.2%	96.8%
Tucson, AZ	94.1%	Des Moines, IA	26.9%	71.0%[1]	Billings, MT	90.2%	Little Rock, AR	4.2%	95.8%
Salt Lake City, UT	94.5%	Seattle, WA	27.1%	36.2%[1]	Orlando, FL	90.4%	Eugene, OR	4.4%	95.6%
Lexington, KY	94.5%	Memphis, TN	27.5%	71.3%[1]	Albuquerque, NM	90.4%	Detroit, MI	4.8%	95.2%
Des Moines, IA	94.9%	Denver, CO	28.0%	71.1%[1]	Kansas City, MO	90.7%	Orlando, FL	4.9%	81.1%[1]
Orlando, FL	95.1%	Phoenix, AZ	28.0%	70.0%[1]	Eugene, OR	91.2%	Denver, CO	5.0%	95.0%
Las Vegas, NV	95.2%	Charlotte, NC	28.6%	70.2%[1]	Jackson, MS	91.4%	Seattle, WA	6.8%	93.2%
Providence, RI	95.9%	Miami, FL	29.4%	70.6%	Phoenix, AZ	91.5%	Tucson, AZ	6.8%	93.2%
Charlotte, NC	95.9%	Orlando, FL	30.1%	68.3%[1]	Miami, FL	91.7%	San Antonio, TX	7.1%	92.9%
Memphis, TN	96.1%	Tucson, AZ	31.1%	68.9%	Charlotte, NC	92.0%	Lexington, KY	7.2%	92.8%
Miami, FL	96.2%	Kansas City, MO	31.7%	57.4%[1]	Des Moines, IA	92.5%	Des Moines, IA	7.4%	92.6%
Kansas City, MO	96.8%	New York, NY	35.2%	46.6%[1]	Denver, CO	92.9%	Indianapolis, IN	7.5%	92.5%
San Antonio, TX	96.9%	Sacramento, CA	35.6%	62.2%[1]	Tucson, AZ	93.2%	Jackson, MS	8.3%	91.7%
Phoenix, AZ	97.0%	Indianapolis, IN	36.4%	62.1%[1]	Providence, RI	93.5%	Sacramento, CA	9.0%	91.0%
Sioux Falls, SD	97.0%	Jackson, MS	42.1%	57.9%	Lexington, KY	93.6%	Memphis, TN	9.6%	90.4%
Indianapolis, IN	97.5%	Cincinnati, OH	43.8%	48.0%[1]	Indianapolis, IN	94.9%	Kansas City, MO	9.7%	80.6%[1]
Baton Rouge, LA	98.2%	Detroit, MI	44.9%	50.0%[1]	Los Angeles, CA	95.4%	Cincinnati, OH	9.7%	90.3%
Eugene, OR	98.2%	Philadelphia, PA	49.0%	49.7%[1]	San Antonio, TX	95.5%	Los Angeles, CA	9.9%	90.1%
Sacramento, CA	98.4%	Providence, RI	57.8%	40.0%[1]	Memphis, TN	95.9%	Miami, FL	10.0%	78.9%[1]
Denver, CO	98.6%	Los Angeles, CA	NA	NA	Little Rock, AR	96.8%	Albuquerque, NM	11.0%	89.0%
Cincinnati, OH	98.9%	Albuquerque, NM	NA	NA	Sioux Falls, SD	97.0%	Billings, MT	13.0%	87.0%
Detroit, MI	99.0%	Hartford, CT	NA	NA	Seattle, WA	97.1%	Providence, RI	17.4%	82.6%
Albuquerque, NM	99.0%	Las Vegas, NV	NA	NA	New York, NY	97.1%	Salt Lake City, UT	18.7%	81.3%
Los Angeles, CA	100.0%	San Antonio, TX	NA	NA	Sacramento, CA	97.6%	Charlotte, NC	18.9%	81.1%
New York, NY	100.0%	Fargo, ND	NA	NA	Cincinnati, OH	98.2%	Baton Rouge, LA	19.6%	67.9%[1]
Hartford, CT	100.0%	Lexington, KY	NA	NA	Detroit, MI	98.7%	Las Vegas, NV	22.5%	77.5%
Philadelphia, PA	100.0%	Little Rock, AR	NA	NA	Philadelphia, PA	99.3%	Sioux Falls, SD	22.6%	77.4%
Seattle, WA	100.0%	Sioux Falls, SD	NA	NA	Hartford, CT	100.0%	Fargo, ND	23.3%	76.7%
Weighted average	**96.8%**	**Weighted average**	**33.9%**	**60.3%**[1]	**Weighted average**	**94.1%**	**Weighted average**	**8.9%**	**89.9%**[1]

[1] Some respondents selected "Other," "Unsure" or "No opinion," so the numbers shown here do not add up to 100 percent.

Who ought to decide what is in a basic benefits package? (SELECT ONE.)

Meeting Site	Consumers	Medical Professionals	Government	Employers	Insurance Companies	Some Combination
Baton Rouge, LA	19.0%	8.6%	5.2%	1.7%	0.0%	65.5%
Charlotte, NC	23.5%	3.7%	1.2%	1.2%	1.2%	69.1%
Cincinnati, OH	25.8%	7.9%	3.6%	1.0%	0.5%	61.2%
Los Angeles, CA	20.6%	15.4%	2.6%	0.4%	0.4%	60.7%
Memphis, TN	28.4%	6.2%	4.9%	0.0%	0.0%	60.5%
Weighted Average	**23.8%**	**9.7%**	**3.3%**	**0.8%**	**0.5%**	**62.0%**

On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?

Meeting Site	Consumers	Medical Professionals	Federal Government	State/Local Government	Employers	Insurance Companies
Billings, MT	6.3	6.0	5.1	4.7	4.0	2.4
Denver, CO	6.8	6.4	4.2	4.0	3.8	2.5
Des Moines, IA	6.7	5.4	5.0	4.7	2.6	2.2
Detroit, MI	7.6	6.8	3.5	3.7	2.4	1.4
Indianapolis, IN	7.6	6.1	4.9	3.9	3.3	2.2
Jackson, MS	7.8	5.7	3.6	3.0	3.6	1.8
Miami, FL	6.9	5.5	5.0	4.5	3.0	2.3
New York, NY	7.7	6.7	5.2	4.1	2.1	1.4
Philadelphia, PA	6.7	6.0	4.4	4.4	3.1	1.5
Phoenix, AZ	7.7	5.2	3.9	3.7	3.4	2.0
Providence, RI	8.0	6.8	4.1	3.8	2.8	2.3
Sacramento, CA	7.4	6.4	3.8	3.8	2.9	2.5
Salt Lake City, UT	6.8	4.9	4.6	4.7	3.1	2.6
Seattle, WA	7.3	5.9	4.3	4.0	2.3	1.6
Tucson, AZ	6.6	6.2	3.9	3.4	3.2	2.6
Meeting Average	**7.2**	**6.0**	**4.4**	**4.0**	**3.0**	**2.1**

Note: Not included are community meeting data from Kansas City, Albuquerque, Hartford, Las Vegas, Eugene, San Antonio, Fargo, Lexington, Little Rock, and Sioux Falls because participants did not answer a comparable question. In the Orlando community meeting, participants grouped responses into categories that were not comparable with the other meetings.

Should some people be responsible for paying more than others?		What criteria should be used for making some people pay more?						Should public policy continue to use tax rules to encourage employer-based health insurance?		
Meeting Sites Sorted from Lowest to Highest	**Yes**	**All pay same**	**Family size**	**Health Behaviors**	**Income**	**Other**	**Other or some combination**	**Meeting Sites**	**Yes**	**Abstain**
Sacramento, CA	43.0%	NA	NA	NA	NA	NA	NA	Albuquerque, NM	39.3%	NA
Indianapolis, IN	58.4%	15.5%	3.6%	29.0%	47.2%	4.7%	NA	Baton Rouge, LA	86.8%	NA
Baton Rouge, LA	59.6%	6.3%	14.6%	27.1%	43.8%	8.3%	NA	Billings, MT	45.8%	NA
Jackson, MS	60.3%	25.5%	4.3%	19.1%	38.3%	12.8%	NA	Charlotte, NC	61.8%	NA
Tucson, AZ	61.0%	18.4%	0.0%	18.4%	50.0%	13.2%	NA	Cincinnati, OH	50.4%	NA
Miami, FL	63.0%	NA	NA	NA	NA	NA	NA	Denver, CO	38.5%	NA
Orlando, FL	63.9%	20.9%	6.2%	14.7%	41.1%	17.1%	NA	Des Moines, IA	23.9%	NA
Phoenix, AZ	64.6%	26.0%	2.0%	12.0%	52.0%	8.0%	NA	Detroit, MI	23.1%	NA
Denver, CO	66.0%	15.6%	4.4%	15.6%	56.6%	7.8%	NA	Eugene, OR	31.6%	NA
Memphis, TN	66.2%	15.1%	2.7%	11.0%	57.5%	13.7%	NA	Fargo, ND	44.2%	26.9%
Kansas City, MO	72.2%	NA	NA	NA	NA	NA	NA	Hartford, CT	14.9%	41.4%
Charlotte, NC	72.4%	11.9%	1.2%	27.4%	32.1%	27.4%	NA	Indianapolis, IN	30.8%	NA
Des Moines, IA	73.4%	16.9%	4.2%	15.5%	60.6%	2.8%	NA	Jackson, MS	72.1%	NA
Billings, MT	76.3%	11.9%	7.1%	28.6%	44.0%	8.3%	NA	Kansas City, MO	36.3%	NA
Seattle, WA	77.0%	NA	NA	NA	NA	NA	NA	Las Vegas, NV	24.7%	NA
Providence, RI	79.2%	20.4%	2.0%	26.5%	44.9%	6.1%	NA	Lexington, KY	63.2%	17.9%
Salt Lake City, UT	80.0%	8.5%	4.2%	22.5%	59.2%	5.6%	NA	Little Rock, AR	41.6%	23.0%
Detroit, MI	81.1%	11.7%	6.5%	6.5%	68.8%	6.5%	NA	Los Angeles, CA	37.4%	NA
Philadelphia, PA	82.5%	7.9%	5.3%	7.0%	70.2%	9.6%	NA	Memphis, TN	29.3%	NA
Fargo, ND	NA	5.7%	0.9%	11.3%	20.8%	NA	61.3%	Miami, FL	67.4%	NA
Little Rock, AR	NA	11.1%	5.1%	6.0%	15.4%	NA	62.4%	New York, NY	NA	NA
Sioux Falls, SD	NA	12.9%	3.2%	22.6%	9.7%	NA	51.6%	Orlando, FL	60.2%	NA
Los Angeles, CA	NA	19.8%	4.1%	10.6%	50.5%	15.0%	NA	Philadelphia, PA	32.1%	NA
Albuquerque, NM	NA	NA	NA	NA	NA	NA	NA	Phoenix, AZ	53.1%	NA
Hartford, CT	NA	NA	NA	NA	NA	NA	NA	Providence, RI	26.5%	NA
Las Vegas, NV	NA	NA	NA	NA	NA	NA	NA	Sacramento, CA	NA	NA
Eugene, OR	NA	NA	NA	NA	NA	NA	NA	Salt Lake City, UT	52.8%	NA
San Antonio, TX	NA	NA	NA	NA	NA	NA	NA	San Antonio, TX	13.7%	48.4%
New York, NY	NA	NA	NA	NA	NA	NA	NA	Seattle, WA	32.2%	NA
Lexington, KY	NA	NA	NA	NA	NA	NA	NA	Sioux Falls, SD	NA	NA
Cincinnati, OH	NA	NA	NA	NA	NA	NA	NA	Tucson, AZ	50.0%	NA
Weighted average	67.7%	15.3%	4.2%	16.2%	47.0%	9.3%	8.0%	**Weighted average**	**41.4%**	**5.6%**

How much more would you personally be willing to pay in a year (in premiums, taxes, or through other means) to support efforts that would result in every American having access to affordable, high quality health care coverage and services?

Meeting Site	$0	$1-99	$100-299	$300-999	$1000+	Don't Know
Albuquerque, NM	21.7%	7.5%	18.3%	18.3%	24.2%	10.0%
Baton Rouge, LA	8.7%	19.6%	19.6%	26.1%	19.6%	6.5%
Billings, MT	15.0%	16.3%	18.8%	18.8%	21.3%	10.0%
Charlotte, NC	44.6%	8.1%	10.8%	9.5%	16.2%	10.8%
Cincinnati, OH	24.2%	19.2%	15.2%	10.1%	11.8%	19.4%
Denver, CO	11.9%	15.7%	16.7%	24.3%	25.2%	6.2%
Des Moines, IA	13.6%	11.9%	15.3%	30.5%	20.3%	8.5%
Detroit, MI	9.7%	12.5%	15.3%	20.8%	33.3%	8.3%
Eugene, OR	13.4%	11.9%	11.9%	17.9%	32.8%	11.9%
Fargo, ND	11.0%	16.0%	30.0%	16.0%	13.0%	14.0%
Hartford, CT	20.0%	10.0%	13.3%	26.7%	21.7%	8.3%
Indianapolis, IN	11.6%	14.9%	14.9%	16.0%	22.1%	20.4%
Jackson, MS	33.9%	16.1%	14.5%	12.9%	4.8%	17.7%
Kansas City, MO	6.7%	12.4%	19.1%	23.6%	24.7%	13.5%
Las Vegas, NV	14.5%	18.4%	21.1%	19.7%	15.8%	10.5%
Lexington, KY	11.2%	15.3%	18.4%	28.6%	20.4%	6.1%
Little Rock, AR	14.0%	26.3%	22.8%	17.5%	7.0%	12.3%
Los Angeles, CA	37.7%	14.4%	8.5%	9.7%	10.6%	19.1%
Memphis, TN	30.9%	1.5%	4.4%	13.2%	30.9%	19.1%
New York, NY	25.4%	3.0%	6.0%	13.4%	35.8%	16.4%
Orlando, FL	17.5%	10.7%	20.4%	14.6%	16.5%	20.4%
Philadelphia, PA	9.0%	12.3%	12.3%	13.1%	27.9%	25.4%
Phoenix, AZ	18.8%	15.3%	20.0%	18.8%	20.0%	7.1%
Providence, RI	23.7%	7.9%	21.1%	15.8%	23.7%	7.9%
Salt Lake City, UT	22.8%	13.9%	20.3%	25.3%	11.4%	6.3%
San Antonio, TX	8.4%	15.0%	23.4%	19.6%	18.7%	15.0%
Sioux Falls, SD	6.3%	15.6%	15.6%	25.0%	28.1%	9.4%
Tucson, AZ	22.6%	19.4%	0.0%	29.0%	12.9%	16.1%
Weighted average	**18.9%**	**14.4%**	**16.1%**	**17.4%**	**19.1%**	**14.1%**

Note: Participants in the Sacramento, CA, Miami, FL and Seattle, WA community meetings did not respond to a comparable question.

Please rate each of the following public spending priorities to reach the goal of health care that works for all Americans. (RANKINGS FROM EACH MEETING WHERE QUESTION WAS ASKED THIS WAY)

Meeting Site	Guarantee Enough Providers	Invest in Public Health	Guarantee Health Insurance for All	Develop Health Information Technology	Improve Minority Access	Biomedical and Technological Research	Ensure Health Care for All, including Safety Net Programs for Poor	Preserve Medicare and Medicaid
Billings, MT	4th	1st	5th	3rd	8th	6th	2nd	7th
Charlotte, NC	5th	1st	4th	8th	7th	6th	2nd	3rd
Cincinnati, OH	4th	2nd	1st	8th	7th	6th	3rd	5th
Denver, CO	6th	4th	1st	8th	5th	7th	2nd	3rd
Des Moines, IA	3rd	2nd	1st	6th	5th	4th	7th	8th
Detroit, MI	3rd	2nd	1st	7th	4th	6th	8th	5th
Eugene, OR	5th	2nd	1st	7th	4th	8th	3rd	6th
Indianapolis, IN	3rd	2nd	1st	8th	5th	7th	4th	6th
Jackson, MS	3rd	5th	2nd	8th	4th	7th	1st	6th
Miami, FL	7th	4th	1st	8th	6th	5th	2nd	3rd
Phoenix, AZ	4th	2nd	1st	6th	3rd	5th	8th	7th
Providence, RI	5th	3rd	1st	7th	2nd	8th	4th	6th
Salt Lake City, UT	4th	1st	5th	6th-T	8th	6th-T	3rd	2nd
Seattle, WA	2nd	3rd	1st	8th	4th	7th	6th	5th

Considering the rising cost of health care, which of the following should be the MOST important priority for public spending to reach the goal of health care that works for all Americans? (SELECT ONE)

Meeting Site	Guarantee Enough Providers	Invest in Public Health	Guarantee Health Insurance[1] for All	Develop Health Information Technology	Improve Minority Access	Biomedical and Technological Research	Ensure Health Care for All, including Safety Net Programs for Poor	Preserve Medicare and Medicaid
Albuquerque, NM	8.4%	12.2%	58.8%	1.5%	1.5%	0.8%	12.2%	4.6%
Baton Rouge, LA	6.5%	23.9%	37.0%	8.7%	0.0%	2.2%	17.4%	4.3%
Fargo, ND	6.3%	28.1%	42.7%	1.0%	1.0%	4.2%	13.5%	3.1%
Kansas City, MO	3.1%	18.4%	40.8%	1.0%	2.0%	1.0%	33.7%	NA
Las Vegas, NV	9.7%	20.8%	37.5%	2.8%	6.9%	2.8%	12.5%	6.9%
Lexington, KY	5.8%	23.3%	51.5%	2.9%	1.9%	1.0%	10.7%	2.9%
Little Rock, AR	7.4%	22.3%	48.9%	1.1%	1.1%	0.0%	14.9%	4.3%
Los Angeles, CA	9.4%	8.3%	70.7%	0.6%	3.3%	0.0%	5.0%	2.8%
Orlando, FL	3.0%	17.0%	33.0%	3.0%	2.0%	0.0%	31.0%	11.0%
San Antonio, TX	0.9%	23.4%	47.7%	0.9%	0.9%	0.9%	16.8%	8.4%
Sioux Falls, SD	6.3%	21.9%	46.9%	3.1%	0.0%	0.0%	18.8%	3.1%
Weighted average	**6.2%**	**18.5%**	**49.8%**	**1.9%**	**2.1%**	**1.0%**	**15.8%**	**4.6%**

[1]In the Hartford community meeting, which is not included in the above table, participants changed the categories to include "Guarantee high quality care for everyone." This option was selected by 80% of participants. Note: Participants in the Memphis, Philadelphia, Sacramento, New York, and Tucson community meetings did not answer a comparable question.

If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans, which is most important to you? (SELECT ONE)

Meeting Site	Individual Tax Incentives	Expand State Medicaid, SCHIP, etc.	Rely on Free Market	Expand Medicare/ FEHBP	Expand Employer Tax Incentives	Employer Insurance Mandate	Expand Neighborhood Health clinics	Create a National Health Program	Individual Insurance Mandate	Increase State Program Flexibility
Albuquerque, NM	11.1%	2.5%	2.5%	3.7%	2.5%	8.6%	4.9%	56.8%	6.2%	1.2%
Cincinnati, OH	7.8%	11.6%	6.0%	6.6%	3.9%	4.5%	2.4%	39.7%	17.0%	0.6%
Fargo, ND	9.9%	7.7%	7.7%	5.5%	12.1%	4.4%	3.3%	34.1%	9.9%	5.5%
Hartford, CT	0.0%	3.7%	0.0%	3.7%	3.7%	3.7%	5.6%	74.1%	5.6%	0.0%
Las Vegas, NV	5.8%	7.2%	0.0%	8.7%	1.4%	2.9%	2.9%	44.9%	20.3%	5.8%
Lexington, KY	6.3%	5.3%	3.2%	2.1%	2.1%	8.4%	1.1%	54.7%	16.8%	0.0%
Little Rock, AR	11.9%	9.9%	1.0%	11.9%	5.0%	1.0%	5.0%	25.7%	27.7%	1.0%
Los Angeles, CA	6.2%	6.2%	2.6%	7.2%	2.1%	4.1%	6.7%	59.5%	3.6%	1.5%
San Antonio, TX	1.9%	4.9%	4.9%	5.8%	3.9%	1.9%	1.0%	54.4%	19.4%	1.9%
Sioux Falls, SD	7.7%	11.5%	0.0%	15.4%	3.8%	3.8%	0.0%	30.8%	23.1%	3.8%

If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans, which of these proposals would you suggest for doing this? (RANKINGS FROM EACH MEETING WHERE QUESTION WAS ASKED THIS WAY)

Billings, MT	8th	6th	10th	3rd	7th	9th	2nd	1st	4th	5th
Charlotte, NC	6th	10th	9th	3rd	4th	8th	2nd	5th	1st	7th
Denver, CO	9th	6th	10th	3rd	8th	7th	2nd	1st	4th	5th
Des Moines, IA	7th	6th	10th	2nd	8th	9th	3rd	1st	4th	5th
Detroit, MI	9th	6th	10th	3rd	8th	4th	2nd	1st	5th	7th
Eugene, OR	9th	6th	10th	5th	8th	7th	2nd	1st	4th	3rd
Indianapolis, IN	5th	6th	10th	4th	9th	8th	3rd	1st	2nd	7th
Jackson, MS	9th	7th	10th	3rd	4th	6th	2nd	1st	5th	8th
Kansas City, MO	7th	4th	NA	3rd	5th	9th	2nd	1st	6th	8th
Memphis, TN	7th	5th	10th	3rd	9th	6th	2nd	1st	4th	8th
Miami, FL	9th	4th	10th	3rd	6th	7th	2nd	1st	5th	8th
New York, NY	9th	4th	10th	2nd	8th	6th	3rd	1st	5th	7th
Philadelphia, PA	9th	7th	10th	3rd	8th	5th	2nd	1st	4th	6th
Phoenix, AZ	7th	9th	10th	5th	6th	4th	2nd	1st	3rd	8th
Providence, RI	9th	8th	10th	4th	7th	6th	2nd	1st	3rd	5th
Sacramento, CA	8th	7th	10th	3rd	9th	6th	2nd	1st	4th	5th
Salt Lake City, UT	6th	7th	9th	5th	8th	10th	2nd	3rd	1st	4th
Seattle, WA	9th	7th	10th	4th	8th	6th	2nd	1st	3rd	5th
Tucson, AZ	7th	5th	10th	4th	8th	9th	3rd	2nd	1st	6th

Note: Participants in the Orlando and Baton Rouge community meetings did not answer a comparable question.

Appendix C:
Working Group Health Care Poll

Total poll responses (internet, Catholic Health Association, and paper) as of August 31, 2006 (14,165) Including:

- **Paper polls added to the CHCWG poll (n = 641).**
- **Catholic Health Association (CHA) posting of the CHCWG poll. These responses were forwarded to the CHCWG from CHA (n = 1,079).**
- **Responses submitted by members of the Communication Workers of America (CWA) to the CHCWG Internet Poll (n = 505).**

1. How much do you agree or disagree with the following statement about health insurance coverage and public policy in the United States? By public policy, we mean a public goal set out in federal or state law.

It should be public policy (that is, a public goal set out in federal or state law) that all Americans have affordable health care insurance or other coverage.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**78.5%**	77.8%	60.5%	89.7%
Agree	**13.1%**	17.5%	30.1%	6.5%
Neutral	**2.0%**	2.3%	4.3%	0.8%
Disagree	**2.1%**	0.6%	2.6%	0.4%
Strongly disagree	**3.5%**	0.6%	1.7%	1.4%
Not applicable/No response	**0.9%**	0.6%	0.8%	1.2%

2. Which one of the following do you think is the MOST important reason to have health insurance?

	Total Poll responses	Paper Polls	CHA	CWA
To pay for everyday medical expenses	**34.5%**	35.6%	35.3%	25.5%
To protect against high medical costs	**61.0%**	60.4%	61.7%	48.5%
No opinion	**3.7%**	2.2%	2.6%	25.4%
No response	**0.9%**	1.9%	0.4%	0.6%

3. Health insurance coverage can be organized in different ways. Which statement best describes your views on how health care coverage should be organized?

	Total Poll responses	Paper Polls	CHA	CWA
Provide coverage for particular groups of people (for example, employees, people who are elderly or cannot work because of disability, or people with very low incomes) as is the case now.	**11.5%**	12.0%	19.4%	5.15%
Provide coverage for everyone, for	**84.5%**	83.0%	75.1%	92.5%

***Note: Percentages may not add up to 100% due to rounding.**

a defined level of benefits, (either by expanding the current system or by creating a new system).				
No opinion	**2.9%**	3.4%	4.5%	1.4%
No response	**1.2%**	1.6%	1.0%	1.0%

4. Some health insurance models are designed to provide "basic" or "essential" services. When you think about the different kinds of health care that people use, which of the following services do you believe need to be included in BASIC insurance coverage for you and your family? Check all that apply.

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Annual Physicals & Preventive Care	**93.5%**	93.2%	95.9%	96.6%
Chiropractic Care	**36.5%**	32.6%	36.8%	52.7%
Community-based Care Services (for people with disabilities)	**70.4%**	67.9%	61.5%	75.3%
Complementary and Alternative Medicine (such as acupuncture)	**36.1%**	31.5%	24.6%	44.2%
Dental Care	**81.7%**	85.5%	82.7%	91.7%
Doctor's Office Visits	**87.5%**	85.2%	90.4%	94.3%
Elective Surgery (such as plastic surgery)	**6.0%**	11.7%	6.8%	12.7%
Emergency Room Visits	**89.6%**	84.7%	85.7%	95.5%
Family Planning	**65.9%**	64.1%	53.5%	66.3%
Hearing Aids	**63.2%**	58.5%	53.8%	75.6%
Home Health Care	**70.6%**	68.6%	66.4%	79.6%
Hospice and Other Palliative Care (pain management)	**77.7%**	72.0%	73.8%	83.0%
Hospital Stays (including surgery)	**92.1%**	88.9%	90.0%	94.7%
Imaging Tests (MRI, CAT, X-ray)	**89.5%**	83.9%	84.1%	93.9%
Lab Tests	**92.5%**	89.6%	91.8%	94.3%
Medical Equipment (such as wheelchairs, prosthetics)	**73.5%**	66.3%	66.2%	81.6%
Mental Health Care	**81.2%**	76.9%	79.2%	84.8%
Nursing Home Care	**65.6%**	61.0%	61.9%	78.6%
Outpatient Surgery	**86.0%**	81.9%	83.8%	91.5%
Physical, Occupational & Speech Therapy	**76.6%**	68.6%	78.3%	84.8%
Prescription Drugs	**90.7%**	90.2%	91.1%	96.0%
Substance Abuse Treatment	**61.7%**	53.7%	58.9%	70.3%
Vision/Eye Care	**79.2%**	83.2%	77.4%	91.3%

***Note: Percentages may not add up to 100% due to rounding.**

5. Who should decide what services are covered in "basic" health insurance?

	Total Poll responses	Paper Polls	CHA	CWA
Consumers	**26.9%**	15.5%	15.1%	51.5%
Employers	**0.6%**	0.5%	1.5%	0.4%
Government	**3.5%**	3.0%	1.9%	1.4%
Insurance Companies	**0.5%**	0.0%	0.6%	0.0%
Medical Providers	**4.7%**	2.5%	5.5%	3.0%
Some combination of the above	**61.6%**	75.5%	72.0%	42.2%
Not sure	**1.6%**	2.3%	3.1%	1.4%
No response	**0.7%**	0.8%	0.3%	0.2%

6a. People may have different views about what is most important to them and their families when it comes to getting health care. Which of the following would be MOST important to you and your family if you have an opportunity to choose health care coverage?

	Total Poll responses	Paper Polls	CHA	CWA
Protecting the privacy and confidentiality of my medical history and treatment information	**4.0%**	4.7%	3.6%	2.6%
Not having to deal with paperwork and bills	**2.7%**	2.5%	1.4%	3.0%
Keeping down the cost of my insurance premiums	**23.2%**	18.9%	21.2%	38.4%
Keeping down out-of-pocket costs for visits, drugs, or other supplies	**23.2%**	18.9%	33.1%	27.5%
Convenience and waiting times for appointments and services	**1.6%**	6.9%	5.6%	0.8%
Being able to get information about the quality of health care services I need in order to make informed decisions about care for my family and me	**11.4%**	1.6%	0.6%	8.1%
Being able to get information about the costs of health care services I need in order to make informed decisions about care for my family and me	**6.1%**	14.4%	12.7%	3.4%
Having health care providers who are respectful and communicate well	**4.7%**	4.2%	4.4%	1.6%
Being able to choose which hospital to go to	**1.1%**	2.5%	1.7%	0.8%
Being able to choose my own personal physician	**17.0%**	21.5%	13.1%	11.5%
Being able to choose my own medical specialist	**4.1%**	3.3%	2.4%	2.2%
No response	**0.9%**	0.8%	0.2%	0.2%

***Note: Percentages may not add up to 100% due to rounding.**

6b. Which would be the NEXT MOST important?

	Total Poll responses	Paper Polls	CHA	CWA
Protecting the privacy and confidentiality of my medical history and treatment information	**4.7%**	4.8%	3.7%	2.6%
Not having to deal with paperwork and bills	**4.7%**	5.5%	1.4%	3.0%
Keeping down the cost of my insurance premiums	**18.7%**	16.5%	21.2%	38.4%
Keeping down out-of-pocket costs for visits, drugs, or other supplies	**21.4%**	15.3%	33.1%	27.5%
Convenience and waiting times for appointments and services	**2.8%**	6.6%	5.6%	0.8%
Being able to get information about the quality of health care services I need in order to make informed decisions about care for my family and me	**9.0%**	4.5%	0.6%	8.1%
Being able to get information about the costs of health care services I need in order to make informed decisions about care for my family and me	**7.3%**	10.4%	12.7%	3.4%
Having health care providers who are respectful and communicate well	**5.9%**	5.3%	4.4%	1.6%
Being able to choose which hospital to go to	**4.1%**	4.2%	1.7%	0.8%
Being able to choose my own personal physician	**14.7%**	15.6%	13.1%	11.5%
Being able to choose my own medical specialist	**5.3%**	8.1%	2.4%	2.2%
No response	**1.5%**	3.1%	0.2%	0.2%

7. One way or another, we all pay for the increasing costs of health care through increased insurance premiums, taxes, or consumer prices. How much do you agree or disagree with the following statements about paying for health care?

a. We should all be responsible for setting aside enough money to pay for most of our health care expenses.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**7.2%**	6.2%	5.5%	4.8%
Agree	**14.7%**	18.1%	24.0%	5.4%
Neutral	**14.6%**	14.8%	21.1%	11.5%
Disagree	**29.7%**	30.1%	34.1%	20.0%
Strongly disagree	**30.9%**	25.7%	13.8%	56.8%
Not applicable/No response	**2.8%**	5.0%	1.5%	1.5%

b. We should all pay for part of our health care costs so we will be more careful about how we use health care

***Note: Percentages may not add up to 100% due to rounding.**

services.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.2%**	21.7%	20.3%	4.2%
Agree	**37.2%**	39.5%	50.2%	20.2%
Neutral	**12.2%**	10.8%	9.8%	10.5%
Disagree	**16.4%**	13.1%	14.3%	43.6%
Strongly disagree	**12.9%**	11.7%	4.4%	20.2%
Not applicable/No response	**2.1%**	3.2%	0.9%	1.3%

c. People with health problems, who use more health services, should have to pay higher insurance premiums.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**5.3%**	2.5%	6.1%	2.0%
Agree	**11.0%**	10.6%	14.7%	5.0%
Neutral	**12.5%**	15.0%	18.5%	5.7%
Disagree	**34.9%**	35.3%	41.5%	30.5%
Strongly disagree	**34.0%**	30.7%	17.9%	55.8%
Not applicable/No response	**2.4%**	5.8%	1.2%	1.0%

d. People with higher incomes should pay higher premiums for employer-sponsored health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**15.0%**	14.0%	8.1%	33.3%
Agree	**21.7%**	23.6%	18.2%	16.0%
Neutral	**17.1%**	17.3%	18.0%	15.5%
Disagree	**27.1%**	23.9%	40.4%	22.0%
Strongly disagree	**16.1%**	14.5%	13.9%	12.1%
Not applicable/No response	**3.0%**	7.9%	1.5%	1.2%

e. People with higher incomes should pay more for health insurance they buy for themselves from insurance companies.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.4%**	12.6%	6.8%	34.1%
Agree	**19.3%**	21.8%	15.9%	15.7%
Neutral	**17.9%**	18.1%	20.1%	14.5%
Disagree	**28.0%**	24.6%	41.6%	22.0%
Strongly disagree	**17.1%**	14.5%	13.9%	12.1%
Not applicable/No response	**3.3%**	8.2%	1.7%	1.8%

***Note: Percentages may not add up to 100% due to rounding.**

f. Everyone should pay the same amount for health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.8%**	17.2%	14.5%	16.2%
Agree	**18.6%**	17.8%	26.7%	14.3%
Neutral	**14.1%**	14.3%	18.5%	11.7%
Disagree	**27.1%**	25.4%	29.2%	18.6%
Strongly disagree	**17.1%**	15.9%	9.7%	36.4%
Not applicable	**3.2%**	9.4%	1.5%	2.8%

8. How much do you agree or disagree with the following statements about controlling the rising costs of health care in America?

a. Health plans/insurers should use financial incentives (such as higher payments) to hospitals and doctors that provide efficient, high-quality care.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.2%**	10.0%	11.0%	13.3%
Agree	**40.3%**	30.1%	43.0%	51.9%
Neutral	**17.8%**	18.9%	19.2%	16.0%
Disagree	**16.2%**	23.1%	19.3%	8.7%
Strongly disagree	**8.4%**	10.6%	5.5%	6.5%
Not applicable	**3.2%**	6.5%	2.9%	3.6%

b. Health plans/insurers should not pay for high-cost technologies or treatments that have not been proven to be safe and medically effective.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.3%**	14.0%	12.9%	6.5%
Agree	**36.3%**	43.1%	44.5%	23.8%
Neutral	**23.7%**	17.8%	20.1%	43.4%
Disagree	**17.1%**	15.3%	16.3%	15.3%
Strongly disagree	**6.1%**	6.6%	3.9%	4.4%
Not applicable	**2.5%**	3.3%	1.5%	6.6%

c. Health plans/insurers should not pay for high-cost technologies or treatments even if they have been proven to be safe and medically effective, if less expensive yet equally safe and medically effective technologies or treatments are available.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**13.3%**	9.7%	11.0%	5.7%
Agree	**36.9%**	35.9%	41.6%	23.2%
Neutral	**14.3%**	11.5%	14.7%	28.7%
Disagree	**20.7%**	16.2%	22.8%	27.5%
Strongly disagree	**11.7%**	10.0%	8.4%	12.3%
Not applicable	**3.0%**	16.7%	1.4%	2.6%

***Note: Percentages may not add up to 100% due to rounding.**

d. Health plans/insurers should use financial incentives (such as adjusting premiums and copayments) to encourage consumers to use more efficient and high-quality providers.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**13.5%**	10.0%	12.2%	5.9%
Agree	**41.6%**	40.9%	52.9%	29.1%
Neutral	**18.3%**	17.6%	17.6%	32.5%
Disagree	**15.7%**	17.9%	12.6%	21.2%
Strongly disagree	**7.9%**	7.3%	3.2%	7.5%
Not applicable	**3.0%**	6.2%	1.5%	3.8%

e. Governments should set limits on prices for health care products, such as prescription drugs or medical devices.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**39.0%**	33.9%	29.8%	37.4%
Agree	**32.4%**	34.5%	38.4%	45.0%
Neutral	**9.2%**	11.4%	11.9%	5.9%
Disagree	**9.5%**	11.9%	12.6%	5.5%
Strongly disagree	**7.7%**	5.2%	6.1%	3.6%
Not applicable	**2.1%**	3.2%	1.3%	2.6%

f. Governments should make it harder to qualify for enrollment in their programs that provide health coverage or health care services.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**3.4%**	2.0%	5.3%	4.2%
Agree	**5.0%**	3.6%	9.6%	3.2%
Neutral	**9.6%**	8.9%	17.7%	6.9%
Disagree	**31.0%**	37.0%	38.6%	24.0%
Strongly disagree	**46.6%**	43.7%	25.5%	56.0%
Not applicable	**4.4%**	4.8%	3.2%	5.8%

g. Governments should improve the administration and efficiency of their health care programs.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**56.0%**	50.4%	47.2%	41.0%
Agree	**30.0%**	36.0%	39.6%	29.5%
Neutral	**7.4%**	7.2%	7.7%	23.2%
Disagree	**2.0%**	1.7%	1.9%	2.2%
Strongly disagree	**1.9%**	0.8%	1.5%	0.6%
Not applicable	**2.8%**	4.9%	1.1%	3.6%

***Note: Percentages may not add up to 100% due to rounding.**

h. The private sector should increase efforts to improve the efficiency of health care providers that are paid through private insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**34.6%**	28.9%	20.8%	49.5%
Agree	**37.7%**	40.1%	44.5%	32.3%
Neutral	**15.8%**	16.5%	25.4%	11.5%
Disagree	**4.9%**	5.0%	5.9%	3.0%
Strongly disagree	**2.9%**	3.1%	2.0%	1.4%
Not applicable	**4.1%**	6.4%	1.5%	2.4%

i. Doctors, hospitals, and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**32.7%**	24.2%	20.8%	49.5%
Agree	**38.0%**	44.0%	44.5%	32.3%
Neutral	**20.3%**	18.6%	25.4%	11.5%
Disagree	**4.3%**	7.2%	5.9%	3.0%
Strongly disagree	**1.8%**	2.5%	2.0%	1.4%
Not applicable	**2.8%**	3.6%	1.5%	2.4%

9. How much MORE would you be willing to pay (taxes, premiums, copayments, or deductibles) in a year to support efforts that would result in every American having access to affordable, high quality health care coverage and services?

	Total Poll responses	Paper Polls	CHA	CWA
$0	**12.8%**	10.6%	17.0%	12.9%
$1-$99	**17.1%**	15.6%	26.2%	13.5%
$100-$299	**21.3%**	19.3%	20.7%	14.1%
$300-$999	**16.9%**	14.5%	11.1%	9.7%
$1,000 or more	**11.7%**	12.8%	3.3%	4.2%
Don't know	**18.9%**	22.9%	21.0%	44.2%
No response	**1.3%**	4.2%	0.6%	1.6%

10. Considering the rising cost of health care, which of the following should be the MOST important priorities for public spending on health and health care in America? Choose up to 3.

	Total Poll responses	Paper Polls	CHA	CWA
Guaranteeing that there are enough health care providers, especially in inner cities and rural areas	**24.1%**	30.9%	21.3%	20.8%
Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics or disasters	**49.7%**	48.2%	54.6%	34.5%

***Note: Percentages may not add up to 100% due to rounding.**

Guaranteeing that all Americans have health insurance	**64.6%**	63.5%	58.2%	82.4%
Funding the development of computerized health information to improve quality and efficiency of health care	**11.4%**	9.1%	10.8%	7.9%
Funding medical education to ensure that we have enough high quality medical professionals and health care workers	**16.6%**	19.8%	19.3%	14.1%
Funding programs that help eliminate problems in access to or quality of care for minorities	**10.6%**	10.3%	6.7%	5.5%
Funding biomedical and technological research	**10.5%**	8.6%	7.7%	9.7%
Guaranteeing that all Americans get health care when they need it, through some form of private or public program, including "safety net" programs for those who cannot afford care otherwise	**69.8%**	67.4%	76.3%	80.8%

11. Many people believe that fixing our health care system will require trade-offs by everyone (such as consumers, employers, government agencies, insurers, and providers). By trade-offs, we mean reducing or eliminating something to get more of something else. How much do you agree or disagree with the following possible trade-offs?

a. Accepting a significant waiting time for non-critical care to get a 10 percent reduction in health care costs.

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Strongly agree	**9.4%**	21.5%	7.0%	3.0%
Agree	**35.8%**	39.3%	32.9%	21.6%
Neutral	**16.1%**	12.5%	20.5%	14.3%
Disagree	**24.2%**	12.5%	25.7%	20.8%
Strongly disagree	**9.8%**	8.6%	11.6%	8.9%
Not applicable	**4.8%**	5.0%	2.4%	31.5%

b. Paying a higher deductible in your insurance for more choice of doctors and hospitals

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Strongly agree	**6.4%**	21.5%	3.9%	1.2%
Agree	**29.2%**	39.3%	32.9%	11.3%
Neutral	**15.7%**	12.5%	16.7%	13.7%
Disagree	**30.2%**	12.5%	33.4%	27.7%
Strongly disagree	**13.6%**	8.6%	11.0%	15.3%
Not applicable	**4.8%**	5.0%	2.0%	30.9%

***Note: Percentages may not add up to 100% due to rounding.**

c. Paying more in taxes to have basic health insurance coverage for all

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**26.2%**	21.5%	7.0%	9.7%
Agree	**36.9%**	39.3%	32.9%	27.9%
Neutral	**10.5%**	12.5%	20.5%	9.1%
Disagree	**11.5%**	12.5%	25.7%	11.9%
Strongly disagree	**11.3%**	8.6%	11.6%	11.9%
Not applicable	**3.7%**	5.0%	2.4%	29.5%

d. Expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**3.3%**	3.6%	2.2%	1.4%
Agree	**13.7%**	13.9%	19.9%	6.5%
Neutral	**16.9%**	16.2%	24.4%	10.3%
Disagree	**38.9%**	34.5%	38.0%	32.3%
Strongly disagree	**22.4%**	21.4%	13.4%	19.2%
Not applicable	**4.9%**	10.4%	2.0%	30.3%

e. Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.6%**	20.8%	16.0%	9.5%
Agree	**35.8%**	34.6%	37.8%	25.7%
Neutral	**16.6%**	15.6%	21.0%	15.1%
Disagree	**11.1%**	10.8%	15.6%	8.3%
Strongly disagree	**8.3%**	10.0%	7.4%	10.1%
Not applicable	**4.5%**	8.2%	2.3%	31.3%

12. There are different ways to assure coverage for all Americans. Remembering that we all pay for the cost of health care through insurance premiums, taxes, or consumer prices, how much do you agree or disagree with the following options?

a. Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**12.3%**	8.3%	7.9%	6.0%
Agree	**29.7%**	32.0%	41.5%	20.2%
Neutral	**13.6%**	12.2%	17.2%	11.7%
Disagree	**23.9%**	23.7%	23.2%	45.0%
Strongly disagree	**16.9%**	15.1%	8.1%	14.7%
Not applicable	**3.6%**	8.7%	2.3%	2.6%

***Note: Percentages may not add up to 100% due to rounding.**

b. Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.8%**	21.5%	10.5%	16.0%
Agree	**43.9%**	46.0%	46.6%	55.0%
Neutral	**12.0%**	10.8%	17.6%	17.4%
Disagree	**10.8%**	10.0%	18.5%	5.5%
Strongly disagree	**6.4%**	3.3%	4.5%	2.6%
Not applicable	**3.2%**	8.4%	2.2%	3.6%

c. Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**10.1%**	5.0%	6.5%	4.4%
Agree	**13.0%**	15.3%	23.5%	10.5%
Neutral	**14.1%**	14.0%	25.5%	11.5%
Disagree	**25.8%**	29.3%	28.3%	28.1%
Strongly disagree	**33.7%**	28.0%	13.8%	42.0%
Not applicable	**3.2%**	8.3%	2.3%	3.6%

d. Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**24.2%**	20.9%	7.5%	18.8%
Agree	**40.1%**	40.6%	39.1%	58.4%
Neutral	**19.2%**	19.3%	32.6%	12.9%
Disagree	**7.8%**	8.1%	13.5%	5.0%
Strongly disagree	**5.8%**	2.5%	4.7%	1.4%
Not applicable	**3.0%**	8.6%	2.6%	3.6%

e. Require businesses to offer health insurance to their employees.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.3%**	20.0%	17.2%	29.3%
Agree	**32.3%**	37.0%	46.3%	52.9%
Neutral	**17.5%**	17.3%	17.7%	8.9%
Disagree	**13.6%**	12.5%	11.7%	2.6%
Strongly disagree	**9.9%**	4.8%	4.9%	1.6%
Not applicable	**3.3%**	8.4%	2.3%	4.8%

***Note: Percentages may not add up to 100% due to rounding.**

f. Expand neighborhood health clinics.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**27.2%**	25.1%	12.3%	19.8%
Agree	**45.9%**	48.7%	50.4%	51.7%
Neutral	**18.1%**	14.2%	26.3%	23.0%
Disagree	**3.6%**	2.3%	8.0%	1.6%
Strongly disagree	**2.0%**	1.6%	0.8%	0.4%
Not applicable	**3.2%**	8.1%	2.2%	3.6%

g. Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**47.5%**	41.3%	16.3%	55.1%
Agree	**22.8%**	26.8%	30.3%	25.0%
Neutral	**10.1%**	12.5%	23.2%	7.5%
Disagree	**7.0%**	6.7%	16.4%	4.8%
Strongly disagree	**10.2%**	6.2%	10.4%	4.8%
Not applicable	**2.3%**	6.4%	3.3%	3.0%

h. Require that all Americans enroll in basic health care coverage, either private or public.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.2%**	20.8%	12.0%	11.1%
Agree	**28.0%**	28.7%	40.9%	21.4%
Neutral	**21.4%**	22.2%	22.8%	16.4%
Disagree	**16.0%**	13.3%	15.3%	35.4%
Strongly disagree	**11.7%**	6.2%	5.8%	11.3%
Not applicable	**3.9%**	8.9%	3.2%	4.2%

i. Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**15.6%**	15.9%	9.7%	7.7%
Agree	**39.3%**	40.1%	44.6%	24.0%
Neutral	**23.4%**	17.8%	28.4%	19.8%
Disagree	**11.5%**	10.8%	10.5%	34.1%
Strongly disagree	**6.8%**	7.5%	3.4%	10.3%
Not applicable	**3.5%**	8.0%	2.9%	4.2%

***Note: Percentages may not add up to 100% due to rounding.**

j. Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**26.7%**	23.4%	23.2%	20.0%
Agree	**42.5%**	43.4%	57.7%	25.7%
Neutral	**13.0%**	11.2%	12.1%	11.7%
Disagree	**8.3%**	8.1%	3.2%	30.9%
Strongly disagree	**6.1%**	6.6%	0.9%	7.9%
Not applicable	**3.5%**	7.3%	2.9%	3.8%

We have a few final questions just to help us better understand who our respondents are.

13. Are you male or female?

	Total Poll responses	Paper Polls	CHA	CWA
Male	**36.0%**	27.0%	17.8%	52.9%
Female	**61.7%**	69.6%	80.5%	44.4%
Decline to answer/No response	**2.3%**	3.4%	1.7%	2.8%

14. How old are you?

	Total Poll responses	Paper Polls	CHA	CWA
Under 25	**3.2%**	3.9%	2.7%	0.0%
25 to 44	**27.7%**	15.8%	36.2%	18.0%
45 to 64	**54.5%**	45.25%	55.8%	71.3%
65 and over	**12.3%**	31.5%	3.2%	7.9%
Decline to answer	**2.3%**	4.0%	2.0%	2.8%

15. Are you Hispanic or Latino?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**2.7%**	4.5%	1.2%	3.6%
No	**90.0%**	88.1%	93.6%	84.8%
Decline to answer/No response	**7.3%**	7.2%	5.2%	10.5%

16. Which of these groups best represents your race?

	Total Poll responses	Paper Polls	CHA	CWA
White	**84.1%**	82.0%	92.4%	74.7%
Black or African American	**2.2%**	6.1%	0.5%	4.4%
Asian	**1.0%**	0.6%	0.8%	0.8%
Native Hawaiian or Pacific Islander	**0.1%**	0.0%	0.2%	0.2%
American Indian or Alaska Native	**0.5%**	0.9%	0.2%	1.0%
Other	**1.8%**	1.7%	0.5%	2.8%
2 or more of the above	**1.7%**	2.0%	0.4%	3.0%
Decline to answer/no response	**8.6%**	6.7%	5.0%	13.3%

***Note: Percentages may not add up to 100% due to rounding.**

17. What is the highest grade or year of school you completed?

	Total Poll responses	Paper Polls	CHA	CWA
Elementary (grades 1 to 8) or less	**0.1%**	1.4%	0.0%	0.%
Some high school	**0.4%**	1.4%	0.2%	0.2%
High school graduate or GED	**6.1%**	8.7%	11.5%	13.9%
Some college	**17.7%**	14.5%	21.0%	37.6%
Associate Degree	**8.5%**	8.9%	18.1%	14.5%
Bachelor's Degree	**29.3%**	24.2%	28.4%	21.8%
Graduate degree	**35.7%**	37.9%	18.7%	9.5%
Decline to answer/no response	**2.3%**	3.0%	2.3%	2.6%

18. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**91.1%**	90.3%	96.3%	95.3%
No	**7.7%**	6.6%	3.0%	3.4%
Not sure/no response	**1.3%**	3.1%	0.7%	1.4%

19. Have you attended any community meetings on the American health care system?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**22.9%**	45.9%	14.3%	17.6%
No	**75.7%**	50.9%	85.4%	80.6%
Not sure/no response	**1.4%**	3.3%	0.4%	1.6%

20. Have you participated in any web casts on the American health care system?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**9.9%**	7.6%	5.8%	12.9%
No	**87.9%**	75.7%	93.0%	85.4%
Not sure/no response	**2.2%**	16.7%	1.3%	1.8%

21. Have you read The Health Report to the American People and other material available on our web site?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**21.1%**	13.9%	9.1%	19.8%
No	**76.8%**	69.3%	90.0%	78.2%
Not sure/no response	**2.1%**	16.9%	0.9%	2.0%

***Note: Percentages may not add up to 100% due to rounding.**

Appendix D: University Town Hall Survey

March 22, 2006 (All Universities Combined)

NOTE: TOTAL NUMBER OF RESPONDENTS = 772.

D1. Are you male or female?

Male	40.7%
Female	59.1
No response	0.3

D2. Are you Hispanic or Latino?

Yes	4.2%
No	95.0
No response	0.9

D3. How old are you?

Under 25	17.0%
25-44	35.2
45-64	36.1
65 and over	11.5
No response	0.1

D4. Which of these groups best represents your race? (Check all that apply.)
(NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE RACE: N=759 OUT OF 772.)

Race	**Yes**	**No response**
White	80.9%	19.1%
Black or African American	6.3	93.7
Asian	9.1	90.9
Native Hawaiian or Pacific Islander	0.5	99.5
American Indian or Alaska Native	0.5	99.5
Other	4.2	95.8

D5. What is the highest grade or year of school you completed?

Elementary (grades 1-8) or less	0.4%
Some high school	0.3
High school graduate or GED	0.9
Some college	10.8
Associate Degree	1.6
Bachelor's Degree	31.6
Master's Degree	31.1
Doctoral Degree	22.8
No response	0.7

D6. What is your primary source of health insurance?

Employer-based insurance	65.8%
Self-purchased insurance	10.6
Medicare	9.1
Medicaid	0.5
Veteran's	1.3
Other	7.4
None	4.0
Not sure	0.8
No response	0.5

D7. What is your employment status?

Self-employed	5.2%
Employed, working full-time	46.0
Employed, working part-time	17.5
Not employed currently/looking for work	5.2
Homemaker	1.3
Retired	9.3
Other	14.9
No response	0.7

---

1. Which one of these statements do you think **BEST** describes the U.S. health care system today?

It is in a state of crisis	47.9%
It has major problems	48.6
It has minor problems	3.0
It does not have any problems	--
No response	0.5

2. Which one of the following do you think is the **MOST** important reason to have health insurance?

To pay for everyday medical expenses	30.7%
To protect against high medical costs	63.1
No opinion	1.6
No response	1.2
Other	3.5

3. How much do you agree or disagree with the following statement about health insurance coverage and public policy in the United States? By public policy, we mean a public goal set out in federal or

state law. "It should be public policy (that is, a public goal set out in federal or state law) that all Americans have affordable health care insurance or other coverage."

Strongly Agree	77.2%
Agree	17.8
Neutral	1.6
Disagree	0.7
Strongly Disagree	2.1
No response	0.8

4. Health insurance coverage can be organized in different ways. Which statement best describes your views on how health care coverage should be organized?

Provide coverage for particular groups of people (for example, employees, people who are elderly or cannot work because of disability, or people with very low incomes) as the case is now	7.5%
Provide coverage for everyone, for a defined level of benefits (either by expanding the current system or by creating a new system)	90.0
No response	1.9
Other	0.5

5. Should everyone be required to enroll in basic health care coverage, either private or public?

Yes	82.4%
No	15.0
No response	2.5
Other	0.1

6. Should some people be responsible for paying more than others?

Yes	81.2%
No	15.2
No response	3.4
Other	0.3

7. What criteria should be used for making some people pay more?

(NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE REASON: N=754 OUT OF 772.)

Q	**Reason**	**Yes**	**No response**	**Not/Applicable**
7_a	None-everyone should pay the same	12.3%	87.7%	--%
7_b	Family size	--	--	100.0
7_c	Health behaviors	42.7	57.3	--
7_d	Income	70.7	29.3	--
7_e	Other	--	--	100.0
7_f	Age	6.8	93.2	--
7_g	Prior or current health conditions	7.6	92.4	--

8. How much do you agree or disagree with the following statements about controlling the rising costs of health care in America? (NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE STATEMENT: N=686 OUT OF 772.)

Q	Statement (**S**trongly **A**gree**, A**gree**, N**eutra**l, D**isagree**, S**trongly **D**isagree	SA (5)	A (4)	N (3)	D (2)	SD (1)	Other
8_a	Health plans/insurers should use financial incentives (such as higher payments) to hospitals and doctors that provide efficient, high-quality care.	23.8%	46.9%	15.3%	10.4%	3.6%	--
8_b	Health plans/insurers should not pay for high-cost technologies or treatments that have not been proven to be safe and medically effective.	22.3	35.7	20.6	18.5	2.9	--
8_c	Health plans/insurers should not pay for high-cost technologies or treatments even if they have been proven to be safe and medically effective if less expensive yet equally safe and medically effective technologies or treatments are available.	22.7	39.4	15.3	15.7	6.9	--
8_d	Health plans/insurers should use financial incentives (such as adjusting premiums and copayments) to encourage consumers to use more efficient and high-quality providers.	16.6	43.6	20.0	13.4	6.4	--
8_e	Health plans/insurers should use financial incentives to encourage consumers to pursue healthy lifestyles and prevention.	43.6	38.6	10.5	4.5	2.8	--
8_f	Governments should set limits on prices for health care products, such as prescription drugs or medical devices.	33.7	34.1	14.4	11.7	6.0	0.2
8_g	Governments should make it harder to qualify for enrollment in their programs that provide health coverage or health care services.	1.6	3.4	13.7	34.8	46.5	--
8_h	Governments should improve the administration and efficiency of their health care programs.	53.6	35.1	7.6	2.0	1.6	--
8_i	The private sector should increase efforts to improve the efficiency of health care providers that are paid through private insurance.	32.7	41.6	18.5	5.4	1.9	--
8_j	Doctors, hospitals, and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies.	41.6	42.1	12.0	2.8	1.6	--

8_k. Do you have a preferred solution?
If there is a comment, write the specific response here.
{OPEN-ENDED RESPONSES}

9. There are different ways to assure coverage for all Americans. Remembering that we all pay for the cost of health care through insurance premiums, taxes, or consumer prices, how much do you agree or disagree with the following options?

Q	Statement	SA (5)	A (4)	N (3)	D (2)	SD (1)	Other
9_a	Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own	10.4%	24.7%	17.7%	31.1%	15.9%	0.2%
9_b	Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance	26.5	45.0	12.9	11.1	4.5	--
9_c	Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices	4.8	11.0	14.9	34.9	34.4	--
9_d	Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program	22.1	41.2	23.0	10.2	3.5	--
9_e	Require businesses to offer health insurance to their employees	18.3	28.5	21.1	23.8	8.3	--
9_f	Expand neighborhood health clinics	34.4	44.3	15.8	3.4	2.2	--
9_g	Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance	51.5	26.6	9.1	7.0	5.9	--
9_h	Require that all Americans enroll in basic health care coverage, either private or public	37.7	35.8	12.7	9.7	4.1	--
9_i	Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage	15.5	42.7	22.2	13.5	6.1	--
9_j	Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families	19.7	40.8	18.0	14.8	6.7	--

10. OPTIONAL: Considering the rising cost of health care, which of the following should be the MOST important priorities for public spending on health and health care in America? Choose up to 3. NOTE: 626 RESPONDENTS ANSWERED AT LEAST ONE OF THE QUESTIONS BELOW. THE PERCENTAGES ARE ONLY OF THOSE 626 RESPONDENTS.

		Yes	No Response
10_a	Guaranteeing that there are enough health care providers, especially in inner cities and rural areas	23.5%	76.5%
10_b	Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics or disasters	71.8	28.2
10_c	Guaranteeing that all Americans have health insurance	60.3	39.7
10_d	Funding the development of computerized health information to improve the quality and efficiency of health care	20.3	79.8
10_e	Funding medical education to ensure that we have enough high-quality medical professionals and health care workers	13.9	86.1
10_f	Funding programs that help eliminate problems in access to or quality of care for minorities	20.3	79.8
10_g	Funding biomedical and technological research	11.2	88.8
10_h	Guaranteeing that all Americans get health care when they need it, through some form of private or public program, including "safety net" programs for those who cannot afford care otherwise	65.3	34.7

11. OPTIONAL: How much do you agree or disagree with the following possible trade-off? NOTE: 621 RESPONDENTS ANSWERED AT LEAST ONE OF THE QUESTIONS BELOW. THE PERCENTAGES ARE ONLY OF THOSE 621 RESPONDENTS.

Q	Statement	SA (5)	A (4)	N (3)	D (2)	SD (1)	No response	Other
11_a	Accepting a significant waiting time for non-critical care to get a 10% reduction in health care costs	9.9%	36.7%	21.6%	22.7%	6.6%	2.4%	0.2%
11_b	Paying a higher deductible in your insurance for more choice of doctors and hospitals	8.9	35.3	22.4	24.0	7.7	1.7	--
11_c	Paying more in taxes to have basic health insurance coverage for all	35.0	39.8	9.4	10.7	4.1	1.1	--
11_d	Expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs	5.2	19.1	23.7	38.9	10.8	2.4	--
11_e	Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying	27.7	35.3	20.2	11.3	3.3	2.2	--

Number of Surveys, by University

University Name	Number of Responses	Percent
Boston University	33	4.3%
Drexel University	34	4.4
Emory University	14	1.8
George Washington University	18	2.3
Indiana University	43	5.6
Louisiana State University/Tulane University	27	3.5
Michigan State	39	5.1
Northwestern University	23	3.0
Ohio State University	42	5.4
Penn State University	44	5.7
Purdue University	63	8.2
University of Illinois	26	3.4
University of Iowa	27	3.5
University of Michigan	87	11.3
University of Minnesota	99	12.8
University of Wisconsin	46	6.0
University at Albany	18	2.3
University of Arkansas	10	1.3
University of Louisville	18	2.3
University of South Carolina	10	1.3
Johns Hopkins University	34	4.4
Grey Panthers—Huron Valley	17	2.2

Appendix E: Health Care Presentations

Invited experts, stakeholders, and citizens have given presentations to the Citizens' Health Care Working Group on a wide array of health care subjects. What follows is a list of those presentations, organized chronologically in order of presentation to the Working Group.

Underlined text denotes a link to an electronic document on our website that contains the presentation, biographical information, or meeting summary.

Wednesday, May 11, 2005; Crystal City, VA

Overview of the American Health Care System

- "America's Thinning Social Contract," John Iglehart, Project Hope. (See summary for 5/11/2005.) Provides description of American health care system and health expenditures. Asserts that the United States provides a lower rate of health care coverage than other industrialized countries. Many of the uninsured are employed full time. Health care expenditure growth has been outstripping the rates of increase in wages and non health expenditures. Among 30 countries belonging to the Organization for Economic Development and Cooperation, tax receipts are lowest in the United States, but our expenditures for health care are highest.

Public Insurance Programs: Medicare, Medicaid and SCHIP

- "Overview of Medicare, Medicaid and State Children's Health Insurance Program," Bill Scanlon, Health Policy R&D. (See summary for 5/11/2005.) Describes the three major publicly-funded federal and state health care financing programs.

The Uninsured

- "The Uninsured in America," Peter Cunningham, Center for Studying Health System Change. (See summary for 5/11/2005.) Provides fundamental background information about the uninsured in America and the difficulties in addressing their needs.

Thursday, May 12, 2005; Crystal City, VA

Private Health Insurance: Employer-Based Insurance and the Individual Market

- "Employment-Based Health Benefits Among Mid-Sized and Large Employers," Paul Fronstin, Employee Benefit Research Institute. (See summary for 5/12/2005.) Describes the status of employer-sponsored health insurance and changes taking place that are weakening this form of coverage.

- "Small-Group and Individual Coverage," Deborah Chollet, Mathematica Policy Research. (See summary for 5/12/2005.) Describes features of the small group and individual insurance markets

Public Sector Initiatives to Expand Coverage

- "State Strategies To Expand or Maintain Health Care Coverage," Linda Bilheimer, Robert Wood Johnson Foundation. (See summary for 5/12/2005.) Identifies numerous state initiatives in process or under consideration tailored to expand or maintain coverage and to constrain costs in State Medicaid programs.

- *National Governors' Association (NGA) Reform Proposal*, Matt Salo, NGA (See summary for 5/12/2005.) Describes challenges facing state Medicaid programs from the perspective of the

States and offers some suggestions for change, such as updating federal cost sharing rules, which have not been changed since 1982.

- "Communities in Charge: Financing and Delivering Health Care to the Uninsured: Lessons from Community-Based Initiatives to Expand Coverage and Improve Care Delivery," Terry Stoller, Medimetrix. (See summary for 5/12/2005.) Describes a four-year Robert Wood Johnson Foundation-funded effort to develop comprehensive community-based health care services for the uninsured and the underinsured.

Private Sector Initiatives to Expand Coverage

- "National Health Access," Ken Sperling, CIGNA. (See summary for 5/12/2005.) Describes an initiative promoted by the Human Resources Policy Association to address the health care coverage needs of the working uninsured; an effort scheduled to be implemented in 2005 at many U.S. corporations.

- "Private Initiatives to Expand Coverage," Anthony Tersigni, Ascension Health. (See summary for 5/12/2005.) Describes Ascension Health's efforts to improve health care for underserved members of their communities, including underlying principles and a model for change at the community level. Includes description of some efforts in communities where Ascension Health facilities are located.

Friday, May 13, 2005; Crystal City, VA

Health Care Costs

- "Building the Foundation: Health Care Costs," Jennifer Jenson, Congressional Research Service. (See summary for 5/13/2005.) Provides a broad overview of the large issues and fiscal facts regarding health care in the United States and the relative roles of government and the private sector.

- "National Health Expenditure Accounts," Rick Foster and Stephen Heffler, Centers for Medicare and Medicaid Services. (See summary for 5/13/2005.) Reviews the continuing growth in national health care expenditures in absolute value terms and as a proportion of all national expenditures.

Public Sector Initiatives to Control Costs

- "Controlling Costs in Medicare," Jack Hoadley, Georgetown University. (See summary for 5/13/2005.) Describes ways in which Medicare currently constrains costs and additional options for the future, which include adjustments to the payment system, innovative approaches to purchasing services in the fee-for-service market, and increased enrollment in managed care.

- "Public Sector Initiatives To Control Costs: Medicaid," Jim Verdier, Mathematica Policy Research. (See summary for 5/13/2005.) Describes major direct cost control mechanisms including: limiting eligibility or benefits covered, increasing copayments and deductibles, implementing disease management programs, instituting mechanisms for controlling pharmacy costs, and limiting possibility of fraud.

- "Public Sector Initiatives to Control Costs: The State Children's Health Insurance Program," Genevieve Kenney, Urban Institute. (See summary for 5/13/2005.) Describes some methods that states have used to constrain costs under the program, including enrollment caps and eligibility cutbacks, premium increases, and reduced outreach efforts.

Private Sector Initiatives to Control Costs

- "Private Sector Initiatives to Control Costs Presentation to Citizens' Health Care Working Group," Alice Rosenblatt, WellPoint. (See summary for 5/13/2005.) Describes WellPoint's initiatives to

control costs and provide better information to its health care consumers. Also describes WellPoint's Pay for Performance, pharmacy management, and behavioral health initiatives.

- "Private Sector Initiatives: Controlling Costs and Empowering Consumers," Helen Darling, Washington Business Group on Health. (See summary for 5/13/2005.) Describes employers' efforts to address the growing unsustainability of health care costs, including the introduction and implementation of decision support systems, chronic care management, quality and patient safety efforts, and Health Savings Accounts.

Wednesday, June 8, 2005; Jackson, MS

Access, Safety Net, Health Disparities

- *Rural Health Disparities,* Dr. Dan Jones, Dean and Vice Chancellor, University of Mississippi Medical Center. (See summary for 6/8/2005.) Describes the problem of health disparities in the United States, especially for the poor, and how limited access to care is a major cause of this problem. Describes impact of uninsured on his facility and the financial challenges institutions like his face.

- *Mississippi Health Shortages,* Roy Mitchell, Executive Director, Mississippi Health Advocacy Program (See summary for 6/8/2005.) Describes widespread uninsured and under-served rural public health conditions, the significant adverse impact any reductions in Medicaid or SCHIP would have on the poor, and the importance of improving the health care safety net in Mississippi.

- *Prevention and Insurance Needed,* Dr. Herman Taylor, Director of the Jackson Heart Study, University of Mississippi Medical Center (6/8/2005.) (See summary for 6/8/2005.) Illustrates racial/ethnic health care disparities for cardiovascular disease and other health conditions. He argues for access to preventive care for the nation's 46 million uninsured to lessen "downstream" adverse impacts.

The Reality of Being Uninsured

- *Employer Exclusions and Health Care Needs*, Georgia Rucker. (See summary for 6/8/2005.) Narrates personal story of struggling with health care problems and an employer who enforced a restrictive employment clause to deny health care insurance coverage. Ms. Rucker is currently dependent on her family and church for support.

- *Experiencing Uninsured Status*, Richard Dye. (See summary for 6/8/2005.) Describes his personal experience of being uninsured and how the help of family and friends sustained him.

Local Access Initiatives

- *Coverage Plans for Small Employers*, Bill Croswell, Chamber Plus, Metro Jackson Chamber of Commerce. (See summary for 6/8/2005.) Describes activities of Chamber Plus, a subsidiary of the Chamber of Commerce formed in 1996 in response to the need for a health insurance product for employees of small businesses. Chamber Plus now provides group health insurance coverage for 20,000 employees of small firms in the greater Jackson area. Many other chambers of commerce in Mississippi have also adopted this product.

- "Initiatives at the Community Health Center Level," (PDF version) Dr. Janice Bacon, G.A. Carmichael Community Health Center. (See summary for 6/8/2005.) Briefly summarizes her work at a local community health center and the center's efforts to address chronic conditions such as asthma and diabetes.

- "The Jackson Medical Mall Foundation," Primus Wheeler, Executive Director, Jackson Medical Mall Foundation. (See summary for 6/8/2005.) Focuses on the key elements that allowed the establishment of a central health care facility to work in Jackson, MS. A key factor was the collaboration and cooperation of many individuals who were held together by the shared vision

and active leadership of Dr. Aaron Shirley, an early advocate for and promoter of community health centers.

Friday, July 22, 2005; Salt Lake City, UT

Health Care Challenges: The Federal Perspective

- "21st Century Health Care Challenges: Unsustainable Trends Necessitate Reforms to Control Spending and Improve Value," (as PDF document) David M. Walker, Comptroller General of the United States. (See summary for 7/22/2005.) Explains the unsustainability of current cost trends in Medicare and Medicaid, which now represent the fastest growing components of the federal budget, the implications of these rising costs for the future of the federal budget, and potential areas of inquiry to address interrelated problems of cost, access, and quality.

Health Care Quality

- *Comments on "Crossing the Quality Chasm,"* Donald M. Berwick, MD, MPP (by telephone), President and CEO, Institute for Healthcare Improvement. (See summary for 7/22/2005.) Describes the "quality chasm," the gap between the health care quality we have and what we could have, and its six dimensions: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. To get to better quality, three areas must be addressed: emphasizing knowledge-based care, establishing patient-centered care, and enhancing cooperation.

- "Unwarranted Variations in Health Care," Part 1, Part 2", John E. Wennberg, M.D., M.P.H., Dartmouth Medical School. (See summary for 7/22/2005.) Describes the existence of geographic and institutional variations in the use of health care services that are unrelated to severity of illness or any demographic variations and that do not result in improved outcomes. Addressing these variations would have important consequences for health care costs and quality.

Health Information Technology Panel

- "IT Session: Citizens' Health Care Working Group," Stanley M. Huff, M.D. Senior Medical Informaticist, Intermountain Healthcare. (See summary for 7/22/2005.) Describes the clinical information system in use at Intermountain, an integrated health care system in Utah, lessons learned from use of this system and potential directions for future work in health information technology.

- *"Information Technology in Service of Health Care Providers,"* Eric Pan, M.D., Internist, Center for Information Technology Leadership (See summary for 7/22/2005.) Presents findings from a study "The Value of Health Care Information Exchange and Interoperability," including estimates of annual potential cost savings of $77 billion to the nation's health care system from the standardization of health care information exchange.

- "Health Information Technology," Scott Williams, M.D., Vice President for Health Affairs, HealthInsight, the Quality Improvement Organization (QIO) for Utah and Nevada. (See summary for 7/22/2005.) Describes the key components of health information technology (electronic medical records, health information exchange, and clinical support for decision-making); lays out many of the issues related to the provider level business case for implementing different forms of health information technology and explores potential federal roles in health information technology.

Employer/Employee Initiatives

- "Purchasers' Path to Promoting Higher Value in Health Care," Peter Lee, Pacific Business Group on Health. (See summary for 7/22/2005.) Explains how cost increases and issues of quality can be addressed by purchasers through better information, evaluation, and financial incentives for

both consumers and providers. Examples include consumer support for hospital choice and provider pay for performance mechanisms.

- "Transforming the Health Insurance Delivery Business Model – A Labor-Management Initiative to Manage Care and Targeting Quality," David Blitzstein, United Food and Commercial Workers International Union. (See summary for 7/22/2005.) Describes how improved information collection systems, analysis of costs and outcomes, and making information and results of value analyses available to individuals and organizations can support improved health care service selection.

- "Controlling Healthcare Costs A New Approach," Elizabeth Gilbertson, Hotel Employees and Restaurant Employees International Union Welfare Fund. (See summary for 7/22/2005.) Explains how her organization, working in the context of an extended health care network (with 1,800 physicians), monitors physician cost and care patterns and how such monitoring can lead to reduced costs, better quality of care, maintaining benefit levels, and higher wages.

Tuesday, July 26, 2005; Houston, TX

Hispanic Health Issues

- "Health Disparities," Adela S. Valdez, MD, Valley Baptist Health System. (PowerPoint slides) (See summary for 7/26/2005.) Describes high levels of uninsurance among Hispanics in Texas and the need for more investment in tobacco cessation, nutrition, and encouraging physical activity. The last two health behaviors are especially relevant to reducing the negative consequences of diabetes and obesity. Hispanics have disproportionately high rates of diabetes. In 2004 five of the nation's "fattest" cities were in Texas. She advocated for increased investments in education as the single most important thing to do to reduce health disparities.

- "Hispanic Health and Health Care Issues in Texas and the United States," Karl Eschbach, University of Texas Medical Branch at Galveston. (See summary for 7/26/2005.) Describes Hispanic population trends in the United States and Texas and presents the "Hispanic paradox," a finding of low age-specific mortality rates for the Hispanic population of the United States compared to the non-Hispanic white population, despite the socioeconomic disadvantages of Hispanics. Hispanics have lower heart disease and cancer mortality; and birth outcomes are similar to whites. The Hispanic "advantage" is larger for immigrants than it is for natives and may be attributed to better health habits and selective migration.

Rural Health

- "Rural and Community Health in Texas," Patti Patterson, Vice President for Rural and Community Health, Texas Tech University Health Sciences Center, Lubbock. (See summary for 7/26/2005.) Describes the realities of large distances in rural Texas and the added difficulties that this introduces when trying to assure that individuals have the health care services they need, or that their health doesn't suffer directly from their isolation. She also describes strategies for recruiting and retaining health care providers in rural areas.

- "Fast Facts About Rural Texas," (PDF document) Ernest R. Parisi, Administrator and Chief Executive Officer, East Texas Medical Center, Quitman. (See summary for 7/26/2005.) Describes the challenges of operating a small hospital and local community health network in rural Texas, their dependence upon major public health financing programs such as Medicare and Medicaid, and the impact of the uninsured on these facilities.

- *"Federally Qualified Health Centers,"* Rachel Gonzales-Hanson, Chief Executive Officer, Community Health Development, Inc., Uvalde (See summary for 7/26/2005.) Describes the critical role that community health centers play in the health safety net, the need for continued funding, and the increasing challenges they must address, especially in rural areas.

Long-Term Care, Home and Community Options

- "Long-Term Care: Care for Elders," Nancy Wilson, Huffington Center on Aging, Baylor College of Medicine. (See summary for 7/26/2005.) Describes key issues in long-term care, including lifetime risk, costs, the benefits of community versus institutional care, and other issues of concern. She also gave examples of community-based approaches to long-term care and noted that addressing long-term care needs will involve collaboration, strategic planning, and involvement of consumers, providers, and health agencies.

- "Long-Term Care: A Community Based Approach," Lanette Gonzales, Sheltering Arms, Houston. (See summary for 7/26/2005.) Describes a community-based initiative in Houston, efforts they have made to recruit and retain staff, and the impact of demographic and other trends and their implications for the future.

Retiree Health Care

- "Addressing the Growing Gap in Retiree Health Coverage," Paul Dennett, American Benefits Council. (See summary for 7/26/2005.) Describes the growing number of retirees without employer-sponsored health insurance and the growing percent of health care costs that retirees have to pay themselves. Recommends several actions, including improving care quality and lowering health care costs.

- "Health Coverage in Retirement," Gerry Smolka, AARP. (See summary for 7/26/2005.) Describes trends in retirement and retirement health insurance coverage as well as the special problems faced by early retirees (i.e., those younger than 65) in finding and affording health insurance coverage.

- "US Family Health Plan: Providing High Quality, Cost Effective Healthcare to Military Beneficiaries," Marshall Bolyard, U.S. Family Health Plan. (See summary for 7/26/2005.) Describes a plan available to, and well received by, military beneficiaries, including military retirees.

Wednesday, August 17, 2005; Boston, MA

Mental Health

- "Department of Mental Health: Commonwealth of Massachusetts," Elizabeth Childs, M.D., Commissioner, Massachusetts Department of Mental Health. (See summary for 8/17/2005.) Describes the work of the Massachusetts Department of Mental Health, giving key statistics about the department and its beneficiaries. She also describes three current initiatives and the department's efforts to address stigma as the chief barrier to individuals receiving mental health treatment.

- "Beacon Health Strategies, LLC," Deborah Nelson, Ph.D., Beacon Health Strategies. (See summary for 8/17/2005.) Describes this managed behavioral health plan and the challenges it faces in providing mental health services.

- "The State of Mental Health Services in Massachusetts: The Impact of Inadequate Funding," Toby Fisher, Executive Director, National Alliance for the Mentally Ill. (See summary for 8/17/2005.) Describes some of the difficulties that result from inadequate funding, which include long waits for services, especially troubling when children must wait, and inadequate pharmaceutical benefits. He also described the successful integration of federal, state, and local policies and initiatives from the perspective of a grass roots, advocacy organization.

State, County, and Local Initiatives

- "Cost, Quality And Access: A System Approach," Trish Riley, Director, Governor's Office of Health Policy and Finance, Maine. (See summary for 8/17/2005.) Describes efforts in Maine to

address cost, quality, and access with a special focus on Dirigo Health Care, an effort to expand health insurance coverage to low-income people in Maine.

- "Access Health: Closing the Gap Between Public and Private Insurance Coverage," Vondie Woodbury, Director, Muskegon Community Health, MI. (See summary for 8/17/2005.) Describes a local county program designed to provide health care coverage to those who would otherwise not have it. The program is targeted at small businesses in particular. The premium costs are shared by the employee (30 percent), employer (30 percent) and the community (40 percent).

End of Life

- "Dying in America: A Generation's Crisis and Opportunity," Ira Byock, M.D., Director of Palliative Medicine, Dartmouth Hitchcock Center, NH. (See summary for 8/17/2005.) Describes trends in aging in America, the shrinking pool of caregivers, and the need to shift services for those approaching death away from institutions and toward care in the home. Most people want to live and die at home, not in institutions. For this to happen, there needs to be an emphasis on palliative, rather than on life-extending, but not enhancing, aggressive medical intervention. Hospices can help in reaching this objective and more caretakers will be needed.

- *"Research Findings About End of Life,"* Nicholas Christakis, M.D., Harvard Medical School. (See summary for 8/17/2005.) Describes the components of a "good" death: individuals want to know what to expect, as well as freedom from pain, not being a burden to their families, having a doctor who listens, and the ability to choose to die at home.

- "Defining and Reforming 'End of Life' Care," Joanne Lynn, M.D., Rand, Washington DC. (See summary for 8/17/2005.) Proposes a model of care for the ill that gradually decreases "curative" care while increasing "palliative" care proportionately. The timing of these changes should be based on the predicted life duration, even though it is difficult to forecast exactly when a person will die. More support for family caregivers is essential.

Employer Initiatives: Leapfrog and Bridges to Excellence

- "Bridges to Excellence" (Part 1) and "The Leapfrog Group" (Part 2), Jeffrey R. Hanson, Regional Healthcare Manager, Verizon Communications. (See summary for 8/17/2005.) Describes two employer-based initiatives for improving health care quality. Bridges to Excellence is a system of rewarding high quality performance of providers and encouraging consumers to purchase high quality care. The initial efforts have focused on diabetes and cardiovascular disease. Leapfrog is an initiative of over 150 purchasers that has focused on identifying specific actions that can result in improved care delivery and on setting up a system of rewards for top performers.

Friday, September 23, 2005; Portland, OR

The Oregon Health Plan

- "White Paper distributed at Citizens' Health Care Working Group hearing" (PDF version), John Kitzhaber, M.D., Center for Evidence Based Policy, Oregon Health & Science University, former Governor of Oregon. (See summary for 9/23/05.) Sets forth his belief in the need to change the health care system from one that rations people to one that rations care. He asserts that major change is needed, incremental change will not suffice.

- "Oregon Health Decisions: Community Meetings Process," Michael J. Garland, D. Sc. Rel., Oregon Health & Science University. (See summary for 9/23/05.) Describes the efforts by a variety of individuals in Oregon to conduct public discussions, formulate a new system for organizing care, and pursue it through to partial enactment and implementation within the state. .

- *[No title or slides]*, Ralph Crawshaw, Co-founder Oregon Health Decisions (Co-presented with M. Garland - See summary for 9/23/05.) Describes the process they went through to hold community level meetings in developing the Oregon Health Plan and the impact of these meetings on developing the plan and on the meeting participants.

The Health Services Commission: Prioritizing Benefits

- "The Work of the Health Services Commission – Prioritizing Benefits," Alison S. Little, M.D., Oregon Health Services Commission. (See summary for 9/23/05.) Describes the process the Commission used to develop a prioritized list of benefits that formed the core of the Oregon health plan.
- "White paper distributed at Citizens' Health Care Working Group hearing" (PDF version), Ellen C. Lowe, Oregon Health Services Commission. (See summary for 9/23/05.) Offers a personal perspective on Oregon's outreach efforts to develop the Oregon Health Plan, based on her experiences as the citizen member of the Oregon Health Services Commission.
- *[No title or slides]*, Diane Lovell, Oregon Public Employees Benefit Board and Oregon Health and Sciences University Employee Benefits Council. (See summary for 9/23/05.) Describes the open, public, and transparent process employed in Oregon in developing the Oregon Health Plan and emphasizes the importance of these characteristics.
- "Methods for Comparative Evidence Reviews," Dr. Marian McDonagh, Oregon Evidence-based Practice Center for the Drug Effectiveness Review Project. (See summary for 9/23/05.) Describes the technical process of review and decision-making regarding selection of pharmaceuticals that are covered by Medicaid. The methodology is intended to be transparent, systematic, and unchallengeable. Participants in the process make sure that the information is very readable. Oregon wants to make sure that its researchers have high standards and are impartial in their evaluation of what constituted equivalent drugs for treatments.
- *"Lessons Learned from the Oregon Experience,"* Bruce Goldberg, M.D., Oregon Office for Health Policy and Research. (See summary for 9/23/05.) Summarizes the lessons learned from the effort in Oregon to develop an alternative approach to providing insurance coverage.

Lessons Learned

- "White paper distributed at Citizens' Health Care Working Group hearing " (PDF version), John Santa, M.D., M.P.H., Center for Evidence-based Policy, Oregon Health & Sciences University. Attachment to paper - M. Gold article (PDF only); see also related article online. (See summary for 9/23/05.) Describes the values and central priorities that continue to motivate those seeking to further the purposes of the Oregon Health Plan, including equity, transparency, value, explicit decision-making, and local control.
- *[No title or slides]*, Mark Ganz, President and CEO, the Regence Group (See summary for 9/23/05.) Describes some of the activities his firm is undertaking, including efforts to develop an electronic health record for the group's members.

Public Sector/Private Sector Perspectives

- "Lessons Learned from Health Care Reform," Jean I. Thorne, Oregon Public Employees' Benefit Board. (See summary for 9/23/05.) Former Oregon Medicaid Director reviews the process that Oregon followed and candidly describes the successes and failures of the state's efforts.

Appendix F: National Health Care Polls and Survey Reports Related to the Working Group Analyses

Polling Organization	Date	Survey
ABC News/Washington Post Poll	**October 2003**	A national survey of a sample of 1,000 adults was conducted from October 9-13, 2003; the survey field work was managed by TNS Intersearch. http://webapp.icpsr.umich.edu/cocoon/ICPSR-STUDY/03942.xml
America's Health Insurance Plans: Post Election Health Care Priorities Survey	**November 2004**	This survey was conducted by Ayres, McHenry & Associates, from November 3 – 4, 2004. It was based on telephone interviews with adults who voted in the 2004 presidential election national sample of 1,000. http://www.ahip.org/content/default.aspx?bc=39%7C4176
Americans for Health Care and Center for American Progress	**November 2005**	This national survey was conducted November 15-22, 2005, there were 1,104 adult respondents. http://www.americanprogress.org/atf/cf/%7BE9245FE4-9A2B-43C7-A521-5D6FF2E06E03%7D/HEALTHCARE_TOPLINES.PDF
By the People: National Deliberative Poll	**November 2005**	This poll was conducted by Stanford University's Center for Deliberative Democracy. 981 adult Americans completed pre and post experiment questionnaires. For a summary of the survey results use the following link: http://cdd.stanford.edu/polls/btp/2005/btp-poll-results.pdf ; for more information regarding the Deliberative Poll questions use the following link http://www.pbs.org/newshour/btp/pdfs/onlinepollsignificantchanges.pdf
California Healthcare Foundation: National Consumer Health Privacy Survey	**November 2005**	This survey was a collaboration between Forrester Research and the California Healthcare Foundation. Forrester surveyed 2,100 U.S. adults; the final survey included 1,000 national respondents and an additional 1,000 oversampled California residents. http://www.chcf.org/topics/view.cfm?itemID=115694
CBS News/New York Times	**January 26, 2006**	Poll: "Bush's Approval Remains Low: Heading into the State of the Union, Just 42 Percent Approve of President." This survey was conducted January 20 – 25, 2006. There were 1229 respondents nationwide. http://www.cbsnews.com/stories/2006/01/26/opinion/polls/main1243679.shtml
CBS News/New York Times Poll	**June 17, 2005**	Survey of 1,111 adults, conducted June 10 – 15, 2005. http://www.nytimes.com/packages/html/politics/20050617_poll/20050617_poll_results.pdf
CBS News/New York Times	**May 13, 2003**	See CBS News online (May 13, 2003), "Poll: Economy Remains Top Priority." This poll was conducted by CBS News and the New York Times from May 9 – 12, 2003. It was based on telephone interviews with a national sample of 910 adults. http://www.cbsnews.com/stories/2003/05/13/opinion/polls/main553730.shtml
CBS News/New York Times Poll	**March 1993**	This was a survey conducted by CBS News and the New York Times from March 28 – 31, 1993. It was based on telephone interviews with a national adult sample of 1,368.
Center for Studying Health System Change, Issue Brief No 95	**May 2005**	"An Update on Americans' Access to Prescription Drugs." Findings from the 2001 and 2003 HSC CTS Household Survey. The 2001 survey had a response rate of 59 percent and contains information from more than 46,400 persons 18 years or older. The 2003 survey, with a 57 percent response rate, includes data from more than 36,500 adults. http://www.hschange.com/CONTENT/738/
Center for Studying Health System Change, Issue Brief No 94	**March 2005**	"More Americans Willing to Limit Physician-Hospital Choice for Lower Medical Costs." Findings are based on the CTS Household Survey, a nationally representative telephone survey conducted in 1996-97, 1998-99, 2000-01 and 2003. http://www.hschange.com/CONTENT/735/
Center for Studying Health System Change (HSC), Issue Brief No 85	**June 2004**	"Tough Trade-offs: Medical Bills, Family Finances and Access to Care." Findings from the 2003 HSC Community Tracking Study (CTS). The survey contains information on about 25,400 families and 46,600 persons, and the response rate was 57 percent. http://www.hschange.com/CONTENT/689/

Commonwealth Fund/Harris Interactive Poll, Public Views on Shaping the Future of the U.S. Health Care System	**August 2006**	Survey of 1,023 adults conducted by Harris Interactive. "Public Views on Shaping the Future of the U.S. Health Care System." http://www.cmwf.org/usr_doc/Schoen_publicviewsfuturehltsystem_948.pdf
Commonwealth Fund 2005 International Survey on Sicker Adults	**November 3, 2005**	"Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems In Six Countries." Article in Health Affairs – Web Exclusive: Patients' Experiences by Schoen, Osborn, Huynh, Doty, Zapert, Peugh, and Davis. Includes 700-750 adults in Australia, Canada and New Zealand; and 1,500 or more in the United Kingdom, United States, and Germany. Interviews were conducted by telephone between May 9 and May 17, 2005 in the five English speaking countries and between May 9 and June 12, 2005 in Germany. The margin of sample error was approximately plus or minus 4 percent. http://www.cmwf.org/Publications/publications_show.htm?doc_id=313012
Commonwealth Fund 2001 Health Insurance Survey	**April – July 2001**	This survey was conducted by Princeton Survey Research Associates from April 27 through July 29, 2001. It consisted of 25 minute telephone interviews of a national sample of 3,508 adults; the margin of sampling error was plus or minus 2.0 percentage points. http://www.cmwf.org/surveys/surveys_show.htm?doc_id=230522
Democratic Leadership Council Poll	**July 2002**	This survey was conducted by Penn, Schoen & Berland Associates between July 13 – July 15, 2002 and was based on interviews with a sample of 800 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Employee Benefit Research Institute: 2000 – 1998 Health Confidence Surveys	**November 2000, September 1999, April 1998**	The 2000 Survey was conducted between April 26 and May 28, 2000 with 1,001 individuals; the 1999 survey was conducted May 13 and June 14, 1999 with 1,001 individuals; the 1998 survey was conducted February 1998 with 1,002 individuals. Each survey incorporated twenty-minute telephone interviews with adults ages 21 and older. http://www.ebri.org/surveys/hcs/
Employee Benefit Research Institute: 2001 Health Confidence Survey	**October 9, 2001**	"Americans' Satisfaction With Health Care Rises, But Pessimism About Future Remains." This survey was conducted between April 17 and May 27, through 20-minute telephone interviews with 1,001 individuals 21 and older. http://www.ebri.org/surveys/hcs/2001/
Employee Benefit Research Institute: 2002 Health Confidence Survey	**September 25, 2002**	"Confidence & Satisfaction in Health Care System Show Little Change Over Time, But Americans Still Worry Abgout Its Future." This survey was conducted between April 18 and May 19, 2002, through 20-minute telephone interviews with 1,000 individuals ages 21 and older. Random digit dialing was used to obtain a representative cross section of the U.S. population. http://www.ebri.org/surveys/hcs/2002/
Employee Benefit Research Institute: 2003 Health Confidence Survey	**September 29, 2003**	"Workers Worry About Losing Job Health Coverage; Express Growing Enthusiasm for Government Plan." This survey was conducted between April 24 and May 24, 2003, through 20 minute telephone interviews with 1,002 individuals age 21 and older. http://www.ebri.org/surveys/hcs/2003/
Employee Benefit Research Institute: 2004 Health Confidence Survey	**October 28, 2004**	"Americans Cut Savings To Pay Rising Health Bills, Fears Future Cost, Access Problems," The survey was conducted between June 21 and July 23, 2004, through 20-minute telephone interviews with 1,203 individuals ages 21 and older. http://www.ebri.org/surveys/hcs/2004/
Employee Benefit Research Institute: Issue Briefs #275	**November 2004**	"Public Attitudes on the U.S. Health Care System: Findings From the Health Confidence Survey." The findings from the 2004 Health Confidence Survey (HCS), which focuses on Americans' satisfaction with the health care system today and their confidence in the system's future. The survey examines Americans' attitudes about employment-based health benefits, health savings accounts, and benefits in the work place. The Issue Brief also looks at long-term trends in satisfaction and confidence with the health care system since the first HCS was conducted in 1998. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3507

Employee Benefit Research Institute: 2005 Health Confidence Survey	**October 18, 2005**	"Most Americans Satisfied With Quality of Health Care But the Public Does Not Link Cost to Quality." This poll was conducted from June 21 to Aug, 6, 2005 through 20-minute telephone interviews with 1,003 individuals age 21 and older. http://www.ebri.org/surveys/hcs/2005/
Employee Benefit Research Institute: Issue Briefs #288	**December 2005**	"Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey" this survey was conducted between September 28 and October 19, 2005 through an 18-minute internet survey. The base sample was randomly drawn from Harris Poll Online; slightly more than 1,200 adults were in the sample. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3606
Gallup Poll, Tuesday Briefing	**June 28, 2005**	Rick Blizzard, "Safety, Security Flatline with Patients: Medical Error Initiatives Fail to Make Patients Feel Safer" http://www.galluppoll.com/content/?ci=17125&pg=1.
Gallup Poll	**November 7-10, 2005**	This poll is the most recent of the annual polls conducted by Gallup that asks Americans, without prompting to name the most urgent health problem facing the country at the present time. The 2005 survey included 1,011 adults nationwide. http://www.galluppoll.com/content/default.aspx?ci=20032
Gallup Poll: Healthcare Panel: More Information…	**November 22, 2005**	Gallup Poll of national random sample of 1,010 U.S. adults age 18 and older conducted in September 2005. http://www.galluppoll.com/content/?ci=19555&pg=1
Gallup Poll: Healthcare Panel: Costs More Troubling Than Quality	**November 1, 2005**	Same poll as above.
Gallup Poll: Healthcare Panel: How Do People Choose Hospitals	**October 25, 2005**	Same poll as above.
Gallup/CNN/USA Today Poll	**January 2000**	This survey was conducted for the Cable News Network in conjunction with USA Today. The survey was conducted by the Gallup organization January 13 – 16, 2000. It was based on telephone interviews with a national adult sample of 1,027. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Gallup/Newsweek Poll	**March 1993**	This was a survey by Newsweek, conducted by the Gallup Organization, March 25 – 26, 1993 and based on telephone interviews with a national adult sample of 755. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Harris Interactive Poll, Health Care News	**February 23, 2005**	A telephone survey of 1,012 Americans ages 18 and older conducted between February 8-13, 2005. See Alan F. Westin testimony at the hearing on privacy and health information technology www.patientprivacyrights.org, under News Room. Survey Summary at http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=894
Harris Interactive Poll: Health Care News	**August 10, 2004**	"Two in Five Adults Keep Personal or Family Health Records and Almost Everybody Thinks This Is a Good Idea." This survey was conducted online within the United States between July 12 and 18, 2004 among a nationwide cross section of 2,242 adults ages 18 and over. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=832
Harvard School of Public Health and Robert Wood Johnson Foundation: Health & Healthcare Priorities Survey	**April 2001**	This survey was done by Harvard School of Public Health and the Robert Wood Johnson Foundation. It was conducted by the ICR/International Communications Research from April 25 – May 20, 2001. It was based on telephone interviews with a national adult sample of 1,210. Use http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Health Affairs Data Watch Managed Care Web Exclusive	**November 10, 2004**	"Public Perceptions of Cost Containment Strategies: Mixed Signals for Managed Care," by Schur, Berk, and Yegian. The survey was organized by International Communications Research (ICR). Telephone interviews were conducted from 4–10 August 2004. A random-digit-dialing approach was used by surveyors to interview 2,024 respondents. http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.516/DC1

Health Affairs Data Watch Children and Elderly Web Exclusive	**September 14, 2004**	"Americans' Views About the Adequacy of Health Care for Children and the Elderly," by Berk, Schur, Chang, Knight, and Kleinman. The survey was managed by International Communications Research (ICR). Telephone interviews were conducted 4–18 June 2004. A random-digit-dialing approach was used to contact the 2,013 respondents. http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.446/DC1
Health Affairs Data Watch Chronic Care Policies	**July/August 2002**	A telephone survey of 51 questions was given to a national sample of 1,663 adults between March and November 2000. The complete article is in *Health Affairs*, Vol 21, Issue 4, 264-270, can be found using the following links: http://www.healthaffairs.org/RWJ/Thamer.pdf or http://content.healthaffairs.org/cgi/reprint/21/4/264.pdf
Health Affairs Health Tracking Market Watch	**March/April 2001**	"Patients' Attitudes Toward Cost Control Bonuses For Managed Care Physicians," by Gallagher, St. Peter, Chesney, and Lo, *Health Affairs*, Volume 20, Number 2, pages 186-192. The survey was conducted the summer of 1998 with a random sample of 3,784 phone numbers, 1,050 people were interviewed. http://content.healthaffairs.org/cgi/reprint/20/2/186.pdf or http://content.healthaffairs.org/cgi/content/abstract/20/2/186
Insurance Newscast, Wednesday, 10/12/2005, Ceasefire on Health Care Event	**October 12, 2005**	Former Senator John Breaux Reveals 'What Americans Want in Health Care Reform," Working with Bill McInturff and Geoffrey Garin, http://www.insurancebroadcasting.com/101205-6.htm
International Journal for Quality in Health Care and Oxford University Press	**2002**	"Satisfaction with Quality and Access to Health Care Among People with Disabling Conditions," article by Lezzoni, Dave, Soukup, and O'Day: Volume 14 Number 5 pages 369 – 381. http://intqhc.oxfordjournals.org/cgi/content/abstract/14/5/369; for PDF version use: http://intqhc.oxfordjournals.org/cgi/reprint/14/5/369.pdf
Kaiser Public Opinion Spotlight: Health Care Costs	**August 2005**	Public Opinion on Health Care Costs: http://www.kff.org/spotlight/healthcosts/index.cfm
Kaiser Family Foundation: May/June 2005 Health Poll Report Survey	**June 2005**	This was a survey by the Kaiser Family Foundation conducted by the Princeton Survey Research Associates International between June 2 and June 5, 2005 through telephone interviews of 1,202 adults, ages 18 years and older. http://www.kff.org/kaiserpolls/upload/May-June-2005-Kaiser-Health-Poll-Report-Toplines.pdf
Kaiser Family Foundation: National Survey of the Public's Views About Medicaid	**June 2005**	This was a Kaiser Family Foundation survey conducted by the Princeton Survey Research Associates International. The results were based on the telephone interviews of 1,201 adults between April 1 and May 1, 2005. http://www.kff.org/medicaid/upload/National-Survey-of-the-Public-s-Views-About-Medicaid-Chartpack.pdf
Kaiser Family Foundation/Harvard School of Public Health: Health Care Agenda for the New Congress Survey	**November 2004**	This survey was conducted by ICR-International Communications Research, November 4 – November 28, 2004 and based on telephone interviews with a national adult sample of 1,396. http://www.kaisernetwork.org/health_poll/hpoll_index.cfmor for a PDF file http://www.kff.org/kaiserpolls/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50263#search=%22Kaiser%20Family%20Foundation%2C%20Harvard%20School%20of%20Public%20Health%2C%20November%202004%22
Kaiser Family Foundation: HealthPoll Report	**September/ October 2004**	Kaiser Family Foundation: HealthPoll Report: Public's Expectations of Health Insurance and Attitudes Towards Potential New Insurance Options. Source data from the Kaiser Family Foundation Health Insurance Survey, 2003, conducted April 30 – July 20, 2003 among 2,507 adults ages 18-64. http://www.kff.org/healthpollreport/Oct_2004/index.cfm
Kaiser Family Foundation Survey: January/February 2004 Health Poll Report Survey	**February 2004**	This survey fieldwork was conducted by Princeton Survey Research Associates International, February 5 – February 8, 2004, with 1,201 respondents 18 and older. The margin of error was plus or minus 3 percentage points. http://www.kff.org/kaiserpolls/upload/Kaiser-Health-Poll-Report-Survey-Toplines.pdf#search=%22health%20poll%20report%20february%202004%20%22

Kaiser Family Foundation Survey: Health Insurance Survey	**April 2003**	The survey was conducted by Princeton Survey Research Associates International, April 30 – July 20, 2003 and based on telephone interviews with a national adult age 18-64 sample of 2,507. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Kaiser Family Foundation: Clinton Health Care Reform Plan Survey	**March 1993**	This survey was sponsored by the Kaiser Foundation and was conducted by Louis Harris & Associates between March 3 and March 10, 1993. It was based on telephone interviews with a national adult sample of 1,255. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Lake Snell Perry & Associates	**March 1, 2003**	A national poll of 1,002 adults conducted August 30 – September 1, 2002 for Robert Wood Johnson Foundation "Last Acts" initiative. See Journal of Pain & Palliative Care Pharmacotherapy, Vol. 17(2). 2003. http://www.haworthpress.com/store/E-Text/View_EText.asp?a=3&fn=J354v17n02_11&i=2&s=J354&v=17
Los Angeles Times/Bloomberg Poll	**April 16, 2006**	The Los Angeles Times/Bloomberg Poll contacted 1,357 adults nationwide by telephone April 8 through April 11, 2006; this sample included 1,234 registered voters. The margin of sampling error is plus or minus 3 percentage points.
Los Angeles Times/Bloomberg Press	**March 2005**	Survey of 2,563 adults contacted by telephone February 25 – March 5, 2006. Los Angeles Times/Bloomberg News http://www.sscnet.ucla.edu/issr/da/index/techinfo/M11001.HTM
Los Angeles Time Poll	**July 1994**	Survey was conducted by Los Angeles Times, July 23 – July 26, 1994 and based on telephone interviews with a national adult sample of 1,515. Use http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
NBC News/Wall Street Journal Survey	**July 2006**	This survey was conducted by Hart/McInturff between July 21 – 24, 2006. 1,010 adults were interviewed. http://www.pos.org/latestnumbers/wsjjune2006.pdf
NBC News/Wall Street Journal Survey	**April 2006**	This survey was conducted by Hart/McIntruff between April 21 – 24, 2006, interviews were held for 1,109 adults including a national sample of 1,005 plus and an oversample of 104 Hispanics. http://www.pos.org/latestnumbers/wsjapr2006.pdf
NBC News/Wall Street Journal Survey	**March 2006**	This survey was conducted by Hart/McIntruff between March 10 and March 13, 2006. 1,005 adults were interviewed. http://www.pos.org/latestnumbers/wsjmar2006.pdf
NBC News/Wall Street Journal Survey	**January 2006**	This survey was conducted by Hart/McIntruff from January 26 – 29, 2006, 1, 011 adults were interviewed. http://www.pos.org/latestnumbers/wsjjan2006.pdf
NBC News/Wall Street Journal Survey	**February 2005**	The survey was conducted by Hart/McIntruff, February 10 – 14, 2005, 1,008 adults were interviewed. http://www.pos.org/latestnumbers/wsjfeb2005.pdf
NBC News/Wall Street Journal Survey	**October 2004**	This survey was conducted by Hart/McIntruff, October 16 – 18, 2004. 1,004 adults were interviewed. http://www.pos.org/latestnumbers/wsjoct2004.pdf
NBC News/Wall Street Journal Poll	**June 1991**	This was a survey by NBC News in conjunction with the Wall Street Journal conducted by Hart and Teeter Research Companies from June 22 – 25, 1991. It was based on telephone interviews with a sample of 1,006. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
National Public Radio (NPR)/Kaiser/ Kennedy School Health Care Study	**March – May 2002**	This survey was a partnership between NPR, Kaiser Family Foundation, and Kennedy School. It was conducted by International Communication Research. It was based on telephone interviews with a random representative sample of 1,205. http://www.npr.org/news/specials/healthcarepoll/results.pdf
Pew HispanicCenter/Kaiser Family Foundation	**April 2004**	Pew/Kaiser 2004 Latinos Politics and Civic Engagement Survey, conducted by ICR – International Communications Research, April 21 – June 9, 2004. It was based on telephone interviews with a national adult Hispanics sample of 2,288. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.

Pew Research Center for the People and the Press, March 2006 News Interest Index	**March 15, 2006**	Princeton Survey Research Associates International conducted telephone interviews with a national sample of 1,405 adults, March 8 – 12, 2006. http://people-press.org/reports/display.php3?ReportID=271
The Pew Research Center for the People and the Press	**May 10, 2005**	"Beyond Red vs. Blue." The 2005 Political Typology Survey is a national telephone interview sample of 2,000 adults age 18 and over. The Typology Callback Survey conducted in March 2005 obtained 1,090 respondents from the initial December 2004 survey. The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates between July 14 and August 3, 2003.
Pew Research Center for the People and the Press	**August 7, 2003**	The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates International between July 14 and August 3, 2003. http://people-press.org/reports/pdf/190.pdf
Princeton Survey Research Associate: Newsweek Poll	**August 1994**	Princeton Survey Research Associate conducted this survey between August 4 and August 5, 1994. The survey is based on telephone interviews with a national adult sample of 750. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Princeton Survey Research Associate: Newsweek Poll	**June 1994**	Princeton Survey Research Associates conducted this survey on June 17, 1994. The survey was based on telephone interviews with a national adult sample of 499. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Public Agenda: Bills and Proposals	**November 2004**	"Half of Americans Say the Healthcare System Has Major Problems, and Most Say It Needs Fundamental Changes To Be Completely Rebuilt." Survey sources included: Gallup Organization 11/04: telephone survey of 1,016 adults, November 7-10, 2004. CBS News/New York Times 2/05: telephone survey of 1,111 adults, February 24 – 28, 2005. http://www.publicagenda.org/issues/major_proposals_detail2.cfm?issue_type=healthcare&proposal_graphic=majprophealthfundamental.jpg
Public Agenda: Bills and Proposals	**November 2004**	"Nearly Two-Thirds of Americans Say the Federal Government Should Guarantee Health Insurance for All Americans, But Half Say They Would Not Be Willing To Pay Higher Premiums or Higher Taxes." Gallup Organization 11/04: 508 adults surveyed between November 7 – 10, 2004. Kaiser/Harvard 11/04: 1,396 adults surveyed between November 4 – November 28, 2004. The margin of error is plus or minus 4 percent. http://www.publicagenda.org/issues/major_proposals_detail.cfm?issue_type=healthcare&list=2
Public Agenda: People's Chief Concerns	**November 2004**	"Americans Are Far More Likely To Rate Their Own Health Care and Coverage as 'Excellent' or 'Good' Than They Are the Quality of Health Care and Coverage in the U.S." Gallup Organization: 1,016 adults surveyed via telephone interviews from November 7 – 10, 2004. http://www.publicagenda.org/issues/pcc_detail.cfm?issue_type=healthcare&list=4
Public Agenda: People's Chief Concerns	**March 2005**	"Six in 10 Americans Say They Worry "a Great Deal" about the Availability of Health Care" Gallup Organization: Telephone interviews conducted March 7 – 10, 2005. There was a sample of 1,004 adults. http://www.publicagenda.org/issues/pcc_detail.cfm?issue_type=healthcare&list=6
Public Opinion Strategies Poll for The Markle Foundation	**October 2005**	"Attitudes of Americans Regarding Personal Health Records and Nationwide Electronic Health Information Exchange." Public Opinion Strategies conducted two national surveys for the Markle Foundation: the first was conducted September 20 – 22, 2005 among 800 adults; the second September 28 – October 2, 2005 among 800 registered voters; the margin of sample error was plus or minus 3.46 percentage points. http://www.phrconference.org/assets/research_release_101105.pdf

Research!America An Alliance for Discoveries in Health: Charlton Research Company National Survey 2005	**2005**	The source is a national survey conducted in 2005, by the Charlton Research Company for Research!America. http://www.researchamerica.org/polldata/2005/healthservices05.pdf
Research!America Polling in JAMA: Public Attitudes and Perceptions About Health-Related Research	**September 21, 2005**	This article is by Woolley, Mary and Propst, Stacie, *JAMA.* 2005;294:1380-1384. The article can be found at the following link: http://jama.ama-assn.org/cgi/content/abstract/294/11/1380
Research!America: An Alliance for Discoveries in Health	**November 2004**	Research!America/APHA National Poll on Americans' Attitude Toward Public Health, Results presented at the 132nd Annual American Public Health Association Annual Meeting. http://www.researchamerica.org/polldata/2004/apha2004.pdf
Stony Brook University – Health Pulse of America	**February 18 – March 8, 2004**	Stony Brook University Center for Survey and Research conducted this poll between February 18 and March 8, 2004. It was based on a nationally representative sample of telephone numbers drawn from blocks with at least one-listed residential number. There were 863 adults interviewed from across the nation. http://sunysb.edu/surveys/HPAMarch04.htm
The New York Times/CBS News Poll	**January 27, 2006**	This was a survey of 1,229 adults, conducted January 20 – 25, 2006. Use the following link for more information: http://www.nytimes.com/packages/pdf/politics/20060127_poll_results.pdf
Time/CNN/Yankelovic Partners Poll	**March 1994**	This survey was by done for Time in coordination with the Cable News Network. Yankelovich Partners conducted this survey from March 2 - 3, 1994. It was based on telephone interviews with a national adult sample of 600. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Time/CNN/Yankelovic Partners Poll	**June 1993**	This survey was conducted by Yankelovich Partners, June 17 – June 21, 1993 and based on telephone interviews with a national adult sample of 901. An oversample of 364 adults who voted for Ross Perot for President was also taken. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Towers Perrin HR Services: Thought Leadership	**September 28, 2005**	"Employee Health Care Decisions are Fueled by Fear and Insecurity." This is a Towers Perrin survey of 1,400 employees. http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2005/200509/PO_decisions.pdf
U.S. News and World Report Survey	**January 1994**	The Tarrance Group and Mellman, Lazarus & Lake conducted this survey on January 17 and January 18, 1994. It is based on telephone interviews with a national sample of 1,000 registered voters. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm .
USA Today/Kaiser Family Foundation/Harvard School of Public Health: Health Care Costs Survey	**August 2005**	ICR/Harvard University conducted this telephone survey between April 25 and June 9, 2005, with 1,531 adults ages 18 and over responding. http://www.kff.org/newsmedia/upload/7372.pdf#search=%22USA%20Today%2FKaiser%20Family%20Foundation%2FHarvard%20School%20of%20Public%20Health%3A%20Health%20Care%20Costs%20Survey%2C%20%20August%202005%22
Wall Street Journal/Harris Interactive Health-Care Poll	**July 31, 2006**	"Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults." Harris Interactive conducted this survey of 2,325 U.S. adults between July 11 and 13, 2006. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss12.pdf

Wall Street Journal Online/Harris Interactive Health-Care Poll	**April 4, 2006**	"Many U.S. Adults Believe Health Care Quality Care be Fairly Assessed, but Few Willing to Pay Significantly Higher Premiums for Superior Care." Harris Interactive conducted this survey online of 2123 American adults between March 20 and 22, 2006. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss06.pdf
Wall Street Journal Online/Harris Interactive Health-Care Poll	**January 2006**	"Kicking a Bad Habit Could Pay Off." This survey of 2,007 U.S. adults was conducted online by Harris Interactive between December 12 and December 14, 2005. See The Wall Street Journal online (January 6, 2006). http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss01.pdf
Wall Street Journal Online/Harris Interactive Poll	**October 20, 2005**	"Poll Shows Strong Public Support For Range of Health Practices." Harris Interactive conducted this survey of 2,242 U.S. adults online from September 6 to 12, 2005. http://online.wsj.com/public/article/SB112973460667273222-7Jjp4Ckx_LsV4gI5rjzrENNIcAQ_20061020.html?mod=blogs
Wall Street Journal Online/Harris Interactive Health Care Poll, The Wall Street Journal Online	**October 7, 2005**	"Poll Indicates Strong Support for New Medical Technologies." This is a Harris Interactive online survey of 2,048 adults conducted between September 30 and October 4, 2005. The overall results have a sampling error of plus or minus 3 percentage points. http://online.wsj.com/public/article_print/SB112862766275261910-6zvnFPlXTEOE7jFI3fGQPoAnHm8_20061008.html
Wall Street Journal Online/Harris Interactive Health-Care Poll, News Room	**September 16, 2005**	"Considerable Concern Exists Among U.S. Adults About the Frequency of Unnecessary or Overly Aggressive Medical Treatment." Harris Interactive conducted this survey of 2,286 U.S. adults between August 31 and September 2, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=970
Wall Street Journal Online/Harris Interactive Health Care Poll, News Room	**July 21, 2005**	"Majority of U.S. Adults Think it is a Good Idea to Forbid Direct-to-Consumer Advertising for New Prescription Drugs When They First Come to Market." Harris Interactive conducted this online survey of 2,207 U.S. adults between July 6 and 8, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=947
Wall Street Journal Online/Harris Interactive Health-Care Poll	**May 24, 2005**	"Public Interest in the Use of Quality Metrics in Healthcare is Mixed – Unless It Allows Them to Reduce Their Health Insurance Costs." This survey was conducted online between May 11 and 13, 2005 with a national sample of 2,129 adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=931
Wall Street Journal Online/Harris Interactive Health-Care Poll	**March 2, 2005**	"Many Nationwide Believe in the Potential Benefit of Electronic Medical Records and are Interested in Online Communications with Physicians." Harris Interactive conducted this online survey of 2,638 U.S. adults between February 17 and 21, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=895
Wall Street Journal Online/Harris Interactive Health Care Poll	**February 24, 2005**	**"**Health Information Privacy (HIPAA) Notices Have Improved Public's Confidence That Their Medical Information Is Being Handled Properly." This was a nationwide Harris Poll of 1,012 U.S. adults surveyed by telephone between February 8 and 13, 2005 by Harris Interactive. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=894
Wall Street Journal Online/Harris Interactive Health-Care Poll	**October 1, 2004**	"Doctors' Interpersonal Skills Valued More than Their Training or Being Up-to-Date." Harris Interactive conducted this survey of 2,267 U.S. adults online between September 21 and 23, 2004. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2004vol3_iss19.pdf
Wall Street Journal/Harris Interactive Health Care Poll	**July 20, 2004**	"Americans Are Concerned About Hospital-Based Medical and Surgical Errors." Harris Interactive conducted this survey between July 8 and July 12, 2004 with a sample size of 2,847 U.S. adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=825

Wall Street Journal Online/Harris Interactive Health-Care Poll	**December 4, 2003**	"Most People Uncomfortable with Profit Motive in Health Care." Harris Interactive conducted this survey of 2,587 U.S. adults conducted online between November 13 and 17, 2003. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2003vol2_iss12.pdf
Wall Street Journal Online/Harris Interactive Health Care Poll	**November 13, 2003**	"No Consensus on Personal Responsibility for Health Care." This survey of 2,231 US adults nationwide was conducted between October 30 and November 3, 2003. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=708
Wall Street Journal Online/Harris Interactive Health Care Poll	**August 14, 2003**	"National Survey Reveals Top Indicators of Quality of Medical Care." This online survey was conducted between July 24 and 28, 2003, with a national sample of 2,687. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2003vol2_iss4.pdf
Wall Street Journal Online/Harris Interactive Health Care Poll	**August 7, 2003**	"Many Want Quality Health Care, But Few Think They Should Pay for It." This survey was conducted online between July 8 and 10, 2003, with a national sample of 2,357 adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=661
Washington Post/Kaiser Family Foundation/Harvard University, A Generational Look at the Public: Politics and Policy	**October 2002**	This survey was a partnership between the Washington Post, Kaiser Family Foundation, and Harvard University. The survey was conducted by telephone August 2 – September 1, 2002 with a nationally representative sample of 2,886 randomly selected respondents ages 18 and older. http://www.kff.org/kaiserpolls/3273-index.cfm
Winston Group: New Models National Brand Poll	**November 23, 2004**	This survey was conducted by Winston Group, November 23 – 24, 2004 and based on telephone interviews with a national sample of 1,000 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm, *The Uninsured and Health Insurance Coverage/Access* then *The Uninsured* to find the survey questions and results.
Yankelovich Partners:/Time, Cable News Network	**July 1998**	This survey was conduct by Yankelovich Partners July 1998 with a sample size of 1,024 adults.
Yankelovich Partners: Time/Cable News Network	**August 1991**	This survey was conducted by Yankelovich Clancy Shulman, August 27 – August 28, 1991, based on telephone interviews with a national adult sample of 1,000. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Zogby International: In the Media	**October 27, 2005**	"Zogby Survey Reveals Wide Gap Between Consumer Perception and Reality on Health Coverage." A sample of 1,049 privately insured adults were surveyed between September 27 and October 4, 2005; the margin of error is plus or minus 3.1 percent. http://www.zogby.com/news/ReadNews.dbm?ID=1032
Zogby International: In the Media	**April 19, 2005**	"Americans Worry About Losing Their Prescription Drug Coverage More Than The Loss of a Job or Home." Zogby International conducted this survey with interviews of 1,001 adults chosen at random nationwide, the margin of error is plus or minus 3.2 percent. http://www.zogby.com/news/ReadNews.dbm?ID=985
Zogby International Poll for The Galen Institute	**June 2003**	"Medicare vs. Private Health Care Plans." Zogby International conducted this survey on June 18 – June 21, 2003, based on telephone interviews with a sample of 1.007 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm

Appendix G: Response to Comments on the Interim Recommendations

Overview of changes

As a result of comments from the public and its own deliberations, the Citizens' Health Care Working Group has made several modifications to its Interim Recommendation report. These changes were made to clarify the Working Group's intent, provide additional details, and better convey the urgent need for reform that the Working Group has heard from the American public.

First and foremost, the Working Group has restructured its report to make emphatic its major message: to achieve "Health Care that Works for All Americans," it should be public policy, enacted in law, that all Americans have affordable health care. The revised report stresses the goal of affordable health care for all, explains how the individual recommendations work together as a package leading to that goal, sets a target date of 2012 for full implementation, and acknowledges the need for new revenues. The graphic at the start of our report illustrates the relationships among the recommendations and the timeline for their implementation. To further convey the need for immediate action, the report explains what will result if nothing is done.

- Establish Public Policy that All Americans Have Affordable Health Care

In this section of the report, The Working Group makes clear its vision for the health care system, a system which is easy to navigate and in which everyone participates. Its services and benefits are determined through a transparent and accountable process that draws on best practices and these benefits and services are available regardless of changing personal circumstances. These concepts were included in the earlier draft but are emphasized here as is the date for full implementation—2012. There are differing views as to the role government would play in this system: over the comment period we heard from many individuals and groups who advocated for a government-managed health care system financed by taxes. At the same time, we heard from others reluctant to assign additional responsibilities to government. The Working Group does not propose a specific model for achieving what it heard the American people want. While there is great agreement on the ultimate destination, how to get there needs to be determined through ongoing dialogue and action by the Congress and the Administration.

- Guarantee Financial Protection Against Very High Health Care Costs

This recommendation was listed first in the revised materials posted on the Working Group's web site on July 18. This was a concern to many readers who believed beginning the report with the ultimate goal was important. As noted above, the order of recommendations was revised, and additional language was added to make it clear that protection from very high costs was an initial step toward core benefits and services for all. To address the many questions the Working Group received about how this program would work, this report offers two illustrative examples for consideration. The first is a market-based approach; the second is federally-run program based on a social insurance model. The principles, that everyone participates and government

funded subsidies are available based on need, remain unchanged. We have also added language to better explain the relationship we see between this recommendation and the integrated community health network recommendation which follows. The Working Group sees these two proposals—protection against very high health care costs and reforming the health care delivery at the local level—as building blocks for an improved health care system and key steps that can be taken immediately.

- Foster Innovative Integrated Community Health Networks

In the revision of the discussion of this recommendation, the Working Group makes it clear that the networks it envisions are meant for anyone in the community. While the Working Group sees these networks as a sound way to improve care in localities where need is great, it does not see these networks as a form of second-tier care for low-income people, as some writers suggested. To make our intentions more clear, this revision includes more detail on the Working Group's vision for these networks. The discussion provided here places a stronger emphasis on prevention than the earlier draft.

We received many comments from individual community health centers and their associations asking us to remove the proposal to "expand and modify the Federally Qualified Health Center concept" to allow additional providers to qualify for some of the benefits now limited to community health centers and certain other providers. Most of these letters focused on the important role of these centers' citizen governing boards. By statute, at least 50 percent of the members of these boards must be users of the centers' services. We have, however, retained the proposal. The Working Group acknowledges the valuable contributions the community health center program has made in providing care to low-income people over its 40-year history and the central role of community governance in the program. In no way does this recommendation seek to undercut either the program or its structure. The Working Group notes, however, that the organization of health services at the local level varies from community to community. Other successful models of care delivery can be found in many localities. To the extent that these providers are doing similar work for groups of people much like those served by community health centers, they should be encouraged through federal incentives.

- Define Core Benefits and Services for All Americans

The Working Group has expanded the discussion in this section to clarify that core benefits and services would be determined through an open, participatory consensus process. Decisions on inclusion would be based on demonstrated medical effectiveness as well as impact on individual and community health. Additional discussion is provided on the interrelationship of core benefits, evidence-based practice, and incentives that can increase the efficiency of health care delivery. This section also now addresses some important implications of a core set of benefits and services for current coverage in public and private insurance programs.

- Promote Efforts to Improve Quality of Care and Efficiency

This recommendation is fundamentally unchanged. Its accompanying narrative has been expanded to add supporting data and examples of efforts now underway in the public and private sectors.

- Fundamentally Restructure the Way End-of-Life Services Are Financed and Provided

The Working Group added a discussion of professional and family caregivers to the narrative accompanying this recommendation. The narrative now also puts more emphasis on best practices and the need for better demographic, clinical, and epidemiological data to inform policy-making.

- Paying for Health Care for All Americans

The Working Group has expanded its discussion of financing and now places it in a separate section. The final report offers a set of principles it believes must guide sources of financing for these recommendations. First, financing methods must be fair: they should not place undue burdens on the sick; responsibility for financing should be related to a household's ability to pay; and all segments of society should contribute to paying for health care. Second, financing methods should increase incentives for economic efficiency in the health sector and the larger economy. Finally, the methods should be able to generate funds sufficient to pay for the recommendations. The report discusses potential ways its recommendations could be financed, beginning with savings recovered from better management of existing resources. A second source would be the curtailment of subsidies in the current tax code that do not meet the fairness test. If after these two approaches have been taken and additional funds are still needed, this section offers brief examples of policy options for generating new revenues that were mentioned at Working Group meetings or in its online comments.

Summary of Comments

- **Individuals submitting written comments: Internet and paper**

We received about 7,500 comments from individuals on the interim recommendations, including about 3,400 comments from June 2 through July 18, 2006, and over 2,600 through the end of the public comment period on August 31 submitted via the Internet. In addition, about 350 people sent comments via email, and over 100 on paper, including complete versions of the online evaluation form, as well as letters, notes, and postcards. We have also received and reviewed comments on the Interim Recommendations from about 1,000 people who responded directly to the Catholic Health Association web site. An additional 80 individual letters were sent to the Working Group by members of The American Federation of State, County and Municipal Employees. Several other organizations also submitted sets of comments on recommendations

or petitions from individuals affiliated with local chapters, including the Universal Health Care Action Network (North Carolina) and Grass Roots Organizing (Missouri).

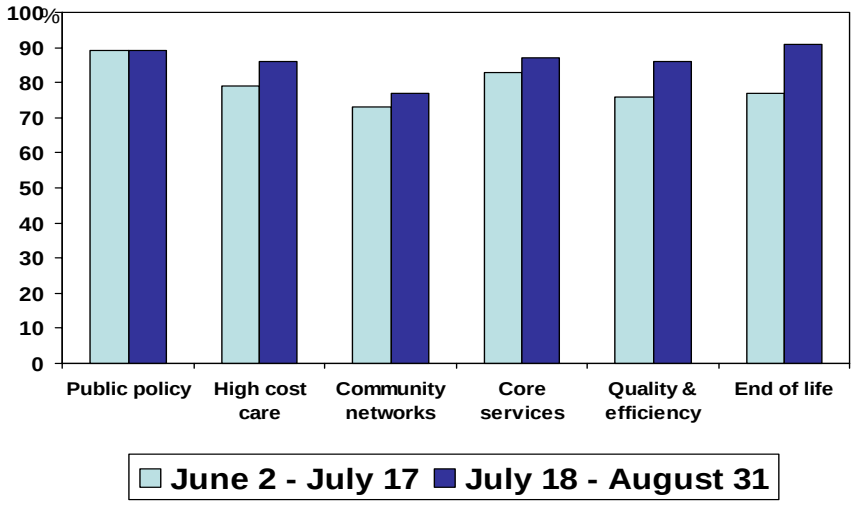
The comments were grouped into two sets, because the additional text was posted on July 18 and the order of the recommendations listed on the Internet was changed. Because the additional material may have altered the way the public viewed the recommendations, we compared responses from each time period separately. Our analysis included a review of a sample of all the comments, but a particular focus on the comments of those who expressed disagreement with the recommendations. We also analyzed a representative sample of all the comments on discussion issues of financing included in the Interim Recommendations.

Overall, the comments reflected the same perspectives and concerns that the Working Group has heard in the community meetings and in the comments and poll results over the past nine months. More than three in four people who provided written comments on each of the six recommendations expressed agreement with the recommendations.

The proportion of people agreeing with the recommendations did not change markedly after July 18, but a slightly higher proportion of individuals providing comments via the Internet indicated agreement with several of the recommendations (Figure G-1). The additional discussion posted on the Working Group web site may have been a factor in this change. A minor format change may have also affected how people provided input. After July 18, the comment page included a one-click box where individuals could indicate whether they agreed or disagreed with each interim recommendation, in addition to the free text area for comments. In the pre-July 18 period, only the free text fields were provided, and agreement was determined by Working Group staff who read the responses in full. After July 18, about two-thirds of those who indicated whether they agreed or disagreed with the Interim Recommendations also provided explanations of their views in the free text fields.

Individuals who provided input via the Catholic Health Association indicated strong levels of support for the recommendations. The letter from the members of the American Federation of State, County and Municipal Employees stated support for most of the recommendations, but also raised some concerns, similar to many others we heard, about "not going far enough."

Percent of Internet Comments Stating Agreement
with Citizens' Health Care Working Group Interim Recommendations



The major points raised by those commenting on the individual Interim Recommendations reflected some common themes, reflecting views about the role of government and social and personal responsibility:

Establish Public Policy that All Americans Have Affordable Health Care

– Of those that agreed, over one-fourth of those commenting want to see the recommendation be explicit – including questions about the structure of the reform, and calls for moving to a single payer system, with a clear commitment to the right to comprehensive coverage for all.

– Among those disagreeing, the principal reasons cited were that people should be responsible for their own health care (about one in four who disagreed); the recommendation involved too much government; market solutions were preferable; or that it would cost too much. About one in 10 disagreeing said the recommendation should specifically call for a government-run system.

Guarantee Financial Protection Against Very High Health Care Costs

– Among those agreeing with the recommendation, just under half provided additional comments or expressed concerns. These included that the recommendation does not go far enough, either because the commenter believes there should be more comprehensive reforms, or concerns that the coverage will be too limited, or more specific concerns about the role of insurers or how the coverage would be financed, or questions about how the policy would actually work. There were also some comments about the need to focus on prevention.

– Close to a third of those who disagreed with the recommendation said they wanted more comprehensive universal health. Others said it was the wrong policy, some citing concerns about too much government, crowding out market-based coverage, or costs. About one in seven disagreeing with the recommendation indicated that people should be responsible for their own health care costs.

- Foster Innovative Integrated Community Health Networks

– More than half of those agreeing with the recommendation cited some concerns, including questions about how the reform would be implemented, a preference for more comprehensive reform, concern about building a "2-tiered" system, and questions about accountability, including the roles of local communities and states in oversight, the need to emphasize prevention services, and how for-profit entities would be involved**.**

– Of those disagreeing after July 18, most cited concerns about too much government/bureaucracy; over one-third of those commenting before July 18 also expressed concerns about bureaucracy. About a fifth of those disagreeing with the recommendation after July said that a more comprehensive universal system should be the goal rather than targeted reforms. Before July 18, a greater percentage of those disagreeing said they want comprehensive rather than incremental reforms.

- Define a Core Benefit Package for All Americans

– About a third of those agreeing with the recommendation also had concerns about particular benefits that should be covered, such as mental health or preventive services. After July 18, about one in five said that the role of insurers in any process of defining covered services or benefits should be limited, or that they should not be included at all.

– The most frequent reasons for disagreeing with the recommendation were distrust of government involvement; a preference for tying benefits to personal behavior or responsibility; and a rejection of the concept altogether among people stating the need for a comprehensive universal health care system.

- Promote Efforts to Improve Quality of Care and Efficiency

– About one in five of those agreeing expressed concerns about focusing on efficiency, accountability, and the role of for-profit health care.

– After July 18, most of those disagreeing are opposed to additional government involvement in health care or government bureaucracy. About one in ten disagreeing wrote that the goal should be comprehensive national health care, rather than any incremental reforms.

- Fundamentally Restructure the Way End-of-Life Services Are Financed and Provided

– Before July 18, most who agreed with the recommendations did not raise additional concerns.

– After July 18, about half of those disagreeing cited objections to too much government or bureaucracy. About one in five in the same time period focused on issues of personal responsibility and choice.

– Comments on financing and broader concerns

Comments addressed a range of issues, including health care costs, the role of government, the type of system that should be put in place, and how reforms should be financed.

Among those commenting on the type of system that should be put in place, most of those commenting favored a single health care system, Medicare for all, or another form of government-organized system that included public and employer-based health care coverage.

- The most commonly-mentioned sources for financing health care for all are income taxes or other forms of public funding, and changing public spending priorities. Others cited a need for greater efficiency or concerns about for-profit health care.

- An analysis of all written comments submitted in one 3-week period found that close to 150 people of about 800 who actually composed and submitted written comments on the Internet had used the term "universal" in one or more recommendations, nine in 10 of those using the term indicated support for some form of universal care system.

- The term "responsibility" was mentioned by a fairly large number of people commenting on the recommendations.
  - About one-third of the comments focused on placing primary importance on personal responsibility:
  - One third advocated public/government responsibility to ensure access to health care for all: and
  - The remainder raised issues of shared responsibility among individuals, employers, and government for ensuring health care for all.

Community Meetings

Fourteen community meetings were held during the comment period on the Working Group's interim recommendations, which began June 2, 2006. They varied in size, sponsorship, and direct Working Group involvement. Three of the meetings were formally organized by the Working Group: two public meetings in Oklahoma City and Milwaukee, and a meeting held at the PayPal campus in San Jose, California for employees of eBay and PayPal. The Mississippi Extension Service, out of Mississippi State University, which earlier in the year had organized meetings across that state, and held meetings on the interim recommendations in Jackson, Hattiesburg, and Greenville which were facilitated by a Working Group staff member. The Dade County Health Department and the Health Foundation of South Florida organized a meeting in Miami that a Working Group member facilitated. Finally, in Muncie, Indiana; Corvallis, Oregon; Cleveland, Ohio; Columbus, Indiana; and Birmingham, Alabama, local groups

organized meetings. Two meetings were held in both Columbus and Birmingham. In all, over 700 people attended these meetings.

While a few of these meetings used the structure of the earlier community meetings and were organized around the four congressional questions, the vast majority focused exclusively on the Working Group's Interim Recommendations. The participants in the meetings varied: attendance at some meetings was dominated by people who work in health care. In general, as at the Working Group's earlier community meetings, many attendees were well-educated, middle-aged women. The Oklahoma City meeting was notable for its over 300 participants and diversity of views.

Public reaction to the interim recommendations from these meetings was consistent with the messages it received on the internet and in the mail. The sentiment among participants was that the American health care system is in trouble and needs change. Some participants saw health care as a global issue, where we have much to learn from other countries. In general, there was strong support for the recommendations, individually and as a package, but a common reaction among participants was that while they agreed with the recommendations, they did not go far enough. A significant percentage of participants, averaging around 20 percent at some meetings, did not support the recommendations, while others were not sure.

At most of these meetings, there was vocal endorsement of "universal health care," which was often coupled with support for a single payer system. At many meetings, there was also an articulate minority concerned about current costs and the damage that failure to address these costs could inflict on American competitiveness.

At many meetings participants had trouble with the recommendation proposing protection against high health care costs and wondered why the Working Group had this limited focus. The Working Group saw this measure as an immediate first step toward the availability of a core set of services for all in 2012, and has clarified both the recommendation on protection against high health care costs and its relationship to the ultimate goal in its final report.

At the well-attended Oklahoma City meeting, the Working Group member and staff were gratified by participants' unexpectedly enthusiastic reaction to two recommendations, Integrated Community Networks and Restructuring End-of-Life Care. Each of these recommendations calls for a rethinking of the status quo with a focus, in major part, on better integration of services at the local level. The response in Oklahoma City suggests the reservoir of energy, imagination and expertise that exists in communities across the country that can be brought to bear on these two recommendations in particular.

Comments from Organizations

The Working Group received over 100 comments on its Interim Recommendations during the public comment period from organizations. Collectively these organizations spoke on behalf of consumers, health care and other professionals, health care organizations, business, labor, insurers, and religious groups. The city of Philadelphia and the Cherokee Nation provided

comments. David Walker, Comptroller General of the United States, also provided comments. Several organizations who advocate for low-income people commented, as did groups that have been formed to pursue health system change. Some organizations provided detailed critiques of each recommendation; others focused on one or two. Some of these organizations represent thousands, even millions of individuals. In some cases local chapters of organizations reiterated or expanded upon the views of their national organization. Some organizations compared the Working Group's recommendations to their own established positions, sometimes enclosing documents spelling out their views.

A summary of individual comments received from organizations follows. The individual letters can be viewed on the Working Group's website www.citizenshealthcare.gov.

The general response to the Working Group's recommendations was positive, and when organizations were critical, more often than not, it was because the writers believed that the recommendations could have gone further. Several organizations questioned the reordering of the recommendations that took place on the Working Group's website about halfway through the comment period. In that revision of the recommendations, to make clear the sequence of implementation steps, the Working Group made the "Guarantee Protection against Very High Health Care Costs" its first recommendation because it could take place relatively quickly. Commenters believed that this move led to a loss of focus on the Working Group's call for affordable health care for all by 2012.

About one in four of the comments from organizations were submitted by federally-funded Community Health Centers or state or national membership organizations representing these centers. These comments were generally supportive of the Working Group's Interim Recommendations with one significant exception. These organizations opposed the proposal to "Expand and modify the Federally Qualified Health Center concept to accommodate other community-based health centers and practices." They noted that community-based, user-dominated governance has been a hallmark of the Community Health Center program since its inception forty years ago and a source of patient empowerment unique in the health care system which should not be modified.

Of comments received from organizations, about one-quarter focused on advocating for universal comprehensive health care. Some praised the Working Group's recommendations as a "strong call for health care coverage for all" but more frequently commenters believed that the recommendations did not go far enough. In all over one-fifth of the organizations commenting called for some form of a national comprehensive tax-payer financed health care system. Many of these commenters cited the Working Group's polls and community meetings to support their views and voiced the belief that the Working Group's recommendations did not accurately reflect public input.

In contrast to these comments, the Working Group received four comments that were very critical of its Interim Recommendation because of the increased emphasis they perceived in them on government's role in health care and lack of emphasis on market-based approaches. One of these organizations challenged the Working Group's findings because its public outreach efforts

did not reach “a representative cross section of the public” and failed to capture the views of the middle class.

A number of comments were received from professional associations representing various types of health care provider or service. In addition to making more general comments, they often argued for adequate attention to their particular interests, such as the health care needs of children, reproductive health, dental health, mental health services, palliative care and HIV care.

Summary of Organization Feedback on Interim Recommendations
Common Themes

- Community health center advocates expressed concern about expanding and modifying the Federally Qualified Health Center concept.
- Many advocacy organizations were disappointed that the recommendations emphasized protection from high cost care rather than access to high quality care for all.
- These same advocacy organizations criticized the recommendations for not going far enough in recommending universal comprehensive health care coverage for all.
- Other groups emphasized the need for free market health care reforms and did not support increased government involvement in health care.
- Groups representing specific populations highlighted the needs of the people they represent and urged inclusion of provisions that would specifically address their concerns.
- Various professional associations who work within the health care system advised including specific health services or references to specific providers in the recommendations.

ORGANIZATION	COMMENTS
Common theme: focus on integrated community health networks	
Access to Care Westchester, Illinois	• Strongly agrees with community networks recommendation to broaden the FQHC concept to include community-based health centers and programs serving under-served populations • Advocates consideration of their model of care which uses private physicians in their own clinics rather than designated public health clinics
Numerous Community Health Centers and related organizations (see list of commenting organizations at right following summary of comments)	• Expresses concern with proposal on expanding and modifying FQHC concept • Argues that patient-dominated health clinic boards are a unique and important feature of the successful Community Health Center program • Urges retention of current FQHC legislation and seeks independent provisions for expanding providers in community networks • Argues that the community networks recommendation does not reflect the majority sentiment expressed in Working Group community meetings Commenting Community Health Centers and related organizations**:** **Allen Hospital, Iowa Health System**, Waterloo, Iowa **Association for Utah Community Health**, Salt Lake City, Utah **Avis Goodwin Community Health Center**, Rochester, New Hampshire **Bi-State Primary Care Association**, Concord, New Hampshire **Colorado Community Health Network**, Denver, Colorado **Community Health Center of Burlington, Inc.,** Burlington, Vermont **Community Health Care Association of New York State**, Albany, New York **Community Health Center of Rutland Region**, Bomoseen, Vermont **Community Healthcare Network**, New York, New York **Coos County Family Health Services**, Berlin, New Hampshire **Decatur County Community Services**, Leon, Iowa **The Georgia Association for Primary Health C**are, Decatur, Georgia **Community Health Centers of Southern Iowa**, Leon, Iowa **Hometown Health Centers, Schenectady Family Health Services**, Schenectady, New York **Hudson River Healthcare**, Peekskill, New York **The Institute for Urban Family Health**, New York, New York **Lamprey Health Care**, Newmarket, New Hampshire **Lutheran Family Health Centers**, Brooklyn, New York **National Association of Community Health Centers, Inc.**, Washington, D.C. **New Jersey Primary Care Association**, Princeton, New Jersey **Oak Orchard Community Health Center**, Brockport, New York **One World Community Health Center, Inc.**, Omaha, Nebraska **Oregon Primary Care Association**, Portland, Oregon

	People's Community Health Clinic, Waterloo, Iowa **River Hills Community Health Center**, Ottumwa, Iowa **William Ryan Community Health Center**, New York, New York **United Community Health Center**, Storm Lake, Iowa **Whitney Young Jr. Health Services**, Albany, New York
National Assembly on School-Based Health Care Washington, D.C.	• Advocates for integrating school-based health care into national health care and education systems • Advises securing a consistent funding stream for school health centers by authorizing school health centers as part of the health care safety net and ensuring that the public health insurance program reimburse SBHC services
Common theme: advocating for universal comprehensive health care	
American Federation of State, County, and Municipal Employees Washington, D.C.	• Argues consideration of different language in the catastrophic coverage recommendation to prevent employers from shifting costs of mandating insurance onto employees • Urges Working Group fulfill its mandate and provide a stronger endorsement of a comprehensive national health care system to reflect the majority public opinion from community meetings and polls • Requests exploration of public catastrophic coverage • Argues that quality and efficiency recommendation uses too broad a definition of fraud and waste, urges specifying "*fraud, waste, and abuse in the system as a whole as it relates especially to for-profit providers of prescription drugs and health care*" • Argues that report should include explicit language to support government's use of purchasing and regulatory powers to rationalize prescription drug prices and control profits of insurance companies and other corporate entities
Catholic Health Association of United States Washington, D.C.	• Strongly supports universal health care for all Americans, but must include non-citizens as well • Urges Working Group to define "*affordable,*" in relative terms • Asks clarification of definitions of palliative, chronic, hospice, and end-of-life care • Advocates for explicit language in the report condemning physician-assisted suicide
Center for Medicare Advocacy, Inc. Washington, D.C.	• Advocates for a universal single payer health care system • Asserts that high deductible coverage is only a stop gap measure and leads to the "doughnut hole" effect
Coalition for Democracy of Central New York Bovina Center, New York	• Argues that recommendations were too vague and need to include provisions for simplifying the health care delivery and financing • Advocates for a health care system that mirrors the Canadian one
United States Conference of Catholic Bishops: Department of Social Development and World Peace Washington, D.C.	• Praises inclusion of a strong call for universal health care coverage with access to a core set of services and financial protection against high health care costs • Observes that the most striking outcome from the Working Group's outreach efforts is that 90 percent of the public who responded to the Internet poll and/or participated in community meetings agreed that affordable health care for all should be public policy • Urges that procedures such as abortion and euthanasia, that they describe as morally objectionable, be excluded • Reaffirms their position that *"health care is a fundamental human right and reform of the nation's health care system must be rooted in values that respect human dignity, protect human life, and meet the needs…*[of the poor]."
Family Planning Advocates Albany, New York	• Advocates for universal single-payer health care for all, including non-citizens living in U.S. • Urges Working Group to expressly advocate for comprehensive reproductive health services • Asserts that "affordable" health care needs to be more explicitly defined • Argues for increasing reimbursement rates for neighborhood clinics • Says report should explicitly address high profit margins of health insurance companies and drug companies • Urges inclusion of abortion services

Health Care for All/NJ Hoboken, New Jersey	• Argues interim recommendations do not accurately reflect citizen feedback from the public at community meetings • Asserts that congressionally mandated questions were biased — leading respondents to discuss the need for "core" rather than comprehensive coverage • Believes recommendations should advocate explicitly for a national, universal single-payer health care system to accurately reflect citizen feedback
Health Care for All/Washington Seattle, Washington	• Argues interim recommendations do not accurately reflect citizen input at community meeting and advocates for comprehensive national health care for all
Institute of Social Medicine and Community Health Washington, D.C.	• Argues recommendations be revised to reflect public feedback and advocate for a comprehensive health care package for all as soon as possible • Supports a civil rights approach to health care processes • Urges clarification of process for arriving at universal health care
International Association of Machinists and Aerospace Workers Upper Marlboro, Maryland	• Asserts that affordable health care for all Americans should be the first recommendation • Argues for adding *"to not harm"* to the core values and principles section • Asserts that core benefits package should be broadened to include comprehensive benefits • Urges explicitly clarifying that protection against high costs is an incremental step toward health care for all • Expresses concern that the public-private partnerships discussed in the community networks recommendation will lead to for-profit entities misusing tax dollars
League of Women Voters Health Care Working Group Medfield, Massachusetts	• Urges reordering of recommendations so that public policy recommendation is first — reflecting community feedback and support • Argues for stronger endorsement in the report for national health care plan, financed by taxpayers, that gives all residents equal quality of care
National Coalition of Mental Health Professionals and Consumers Commack, New York	• Advocates ensuring that mental and substance abuse services are not relegated to a low priority in the recommendations • Argues that the interim recommendations do not reflect public sentiment from community meetings and poll results • Asserts the common message was for a universal, comprehensive system • Argues that rising costs in the health care industry come from high prices for care, administrative costs, and too many basic services performed in a clinical setting
Michigan Legal Services Detroit, Michigan	• Asserts that focus of recommendations should shift from covering high-cost care to providing universal comprehensive health care coverage • Advises keeping the basic structure of federally funded health care centers • Argues for focus on reducing administrative costs and highlighting preventative services and primary care and focusing on the delivery system instead of financing
Michigan Universal Health Care Access Network Detroit, Michigan	• Argues interim recommendations do not go far enough and should include rating criteria for judging a new health care system • Advocates for reducing health care administrative costs and inefficiencies • Argues for financing health care through a new progressive income tax rather than the current fragmented payment system • Argues for a need to address how our current system decreases nation's global economic competitiveness • Asserts that health care should be viewed as a public good • **Follow-up letter**: Asserts frustration that recommendations do not advocate for a progressive tax to finance publicly a national health care program; emphasizing protection against high health care costs will be costly and inefficient but applauds Working Group's commitment to comprehensive health care for all
Midwives Alliance of North America Fairfax, California	• Argues that report needs to reflect citizen feedback at community meetings and advocate for universal national, single-payer health care for all — financed partially by taxpayers • Agrees with promotion of evidence-based medicine, expansion of community health

	clinics, and emphasis on home-based end-of-life care • Argues for inclusion of midwifery services in core package of services
National Association of Free Clinics Washington, D.C.	• Urges inclusion of a definition of "high out of pocket costs" • Argues that the report does not tackle non-citizens' need for health care • Advocates for including vision and hearing services in the core benefits package • Expresses a strong need to make a distinction between free clinics and federally funded health care centers and offers suggestions aimed specifically at free clinics • Argues that health care reform needs also to address potential public health crisis crises (e.g. New Orleans after Hurricane Katrina)
National Advocacy Center, Sisters of the Good Shepherd Silver Spring, Maryland	• Praises Working Group recommending affordable health care for all Americans by 2012 • Advocates reordering the recommendations so that this recommendation comes first
NETWORK Washington, D.C.	• Advocates for affordable and accessible health care for all by 2012—calls for a transformation in health care based on social justice
Public Citizen Washington, D.C.	• Argues that Working Group needs to expressly advocate for a single-payer system in the recommendations • Provides arguments on benefits of single-payer national health care model
Philadelphia Area Committee to Defend Health Care Philadelphia, Pennsylvania	• Argues that interim recommendations do not reflect public sentiment at community meetings because they do not advocate for a single payer universal national health care system • Urges Working Group to draft stronger recommendations that reflect majority opinion at the community meetings
Universal Health Care Action Network Cleveland, Ohio	• Divides critiques into three broad categories: how the recommendations are framed, concern about how accurately they reflect public feedback, and a set of comments on the feasibility of individual recommendations • Argues that recommendations are inter-related and need to be debated as a comprehensive reform package rather than separately • Asserts that American health care system is not a system but is a "collection of loosely linked systems" • Argues that interim recommendations do not accurately reflect the majority who provided feedback to the Working Group and asked for a national health plan, financed by tax payers.
Universal Health Care Action Network of Ohio Columbus, Ohio	• Advocates for changing the order of the recommendations so that Affordable Health Care for all recommendation comes first • Argues that protection against high health care costs should be broadened to include nominal costs for low income persons • Asserts that integrated community health networks should be available to all • Urges more aggressive measures to curtail waste • Argues for eliminating tax cuts for the wealthy
Reach Out America Great Neck, New York	• Disagrees with protection against high health care costs, affordable health care, and a core benefits package in lieu of a universal, publicly financed system of health care
RESULTS Washington, D.C.	• Advocates reordering recommendations to place affordable health care for all as number one • Argues that the timeline needs to be added to spur Congress and the Executive Branch to act
The Workmen's Circle New York, New York	• Disagrees with the revised order of the recommendations and advocates for retaining affordable health care for all as the first recommendation • Argues that the integrated community health network recommendation fails to address the current two-tier system of health care • Disagrees with including "core" benefits package and protection against high health care cost recommendations as they deflects from the ultimate goal of providing comprehensive health care for all

Washington State Ad-Hoc Coalition on the Citizens Health Care Working Group	• Urges shortening the Values and Principles section to the first three bullets • Argues first recommendation should be *"It should be public policy that all Americans have affordable health care"* • Advocates second recommendation should read, *"There should be a national health plan, financed by taxpayers, in which all Americans would get their health insurances"* • Argues third recommendation should read, *"A sufficiently comprehensive benefits packages for all Americans should be defined"* • Proposes additional changes to other recommendations • **Follow up letter:** argues for removing "core" and replacing it with "comprehensive" benefit package • Advocates for not allowing insurance companies and employers to be decision makers in creating the core benefits package • Reiterates Working Group should advocate for comprehensive health care in response to public response through surveys and community meetings
Common theme: Promote a free market health care system	
Association of American Physicians and Surgeons Tucson, Arizona	• Disagrees with the interim recommendations in favor of private market approaches and believes that universal coverage leads to restricted access to care
ERISA Industry Committee Washington, D.C.	• Argues that Working Group should differentiate health care from health insurance arguing that Americans already have access to free health care • Asserts that free health care insurance for all would place an undue burden on taxpayers and lead to rationing • Asserts that a tax-payer system will lead to moral hazard • Argues for restricting unnecessary medical liability lawsuits • Urges Working Group to promote incentives for providers who provide high quality and efficient care
Health Care America Washington, D.C.	• Asserts that the Working Group report is not practical because it does not discuss how to implement the recommendations • Argues that report implicitly calls for increase in the government's role in national health care coupled with a tax increase, which they assert most Americans do not support • Suggests community meetings failed to capture a representative sample of America's middle class • Argues that greater health care coverage does not imply greater access to care • Supports market competition between health plans and packages as the best approach for consumers to enjoy choice in health care • Advocates for four solutions to limit increases in health care costs, including: redirecting non-emergency care to more appropriate locations, enacting medical liability reform, encouraging electronic health records, and introducing pay-for-performance incentives to reward providers for high quality services • Argues that recommendation for integrated community health networks is not notably different from the current system
Institute for Health Freedom Washington, D.C.	• Uses Medicare as a case study to argue that universal, single-payer national health care is not effective in improving health indicators, poverty rates, provider choice, and health privacy
Common theme: all have a special focus	
American Academy of Actuaries Washington, D.C.	• Asks the Working Group refer to their publications as resources for information on a variety of health care issues • *Special focus:*: Argues that actuaries provide unique expertise and perspective on issues related to risk and contingent events
American Academy of Pediatrics Elk Grove Village, Illinois	• *Special focus::* Focus on unique health needs of children • Advocates for increasing Medicaid reimbursements for pediatric services • Argues that integrated community networks recommendation should explicitly refer to children and promote the "child medical home" • Urges development of specific pediatric care quality measures

American Chiropractic Association Arlington, Virginia	• Concludes that health care system needs to shift focus from caring for the seriously ill to disease prevention, early disease detection, and positive lifestyle changes • *Special focus:* Argues chiropractic care is a major component of efficient quality health care and should be fully integrated into the medical delivery system
American Dental Association Washington, D.C.	• Strongly supports inclusion of dental services in definition of core health services • *Special focus:* Argues oral health is an important component of health
American Hospital Association Washington, D.C.	• Presents results from its own independent "listening sessions" held to discuss health care reform with key stakeholders resulting in 10 principles that typify what healthcare should be in America. • *Special focus*: Concludes its vision of health care reform is parallel to the Working Group's interim recommendations
American Psychological Association Washington, D.C.	• *Special focus:* Concerned that the core benefits package will not include adequate mental health services • Argues that "evidence-base care" in benefits section needs to reflect different diagnostic approach for mental health services • Recommends replacing the term "medical" with "clinical" to be more inclusive in treatment by both physicians and non-physicians
Association of Clinicians for the Underserved Tysons Corner , Virginia	• *Special focus:* Advocates for health care reforms that increase underserved community access to care • Encourages greater financial incentives for clinicians to provide preventative care and health education services
Ascension Health Saint Louis, Missouri	• *Special focus:* Praises recommendations and provides a strong endorsement for affordable health care, integrated community health networks, and restructuring end-of-life care
Seton Healthcare Network Austin, Texas	• *Special focus:* Reiterates Ascension Health's comments
Associations of Professional Chaplains Schaumburg, Illinois	• *Special focus:* Argues for greater emphasis on mental, emotional, and spiritual health elements of health care
California Pan-Ethnic Health Network Oakland, California	• Encourages Working Group to add a new recommendation addressing racial disparities in health • *Special focus:* Endorses recommendations but argues for greater emphasis on communities of color
Catholics for a Free Choice Washington, D.C.	• Concurs with finding that the health care system is in desperate need of overhaul • *Special focus:* Argues that core benefits package should include services and medicines based on the needs of the patient not the ideological beliefs of the hospital or provider
Cherokee Nation Tahlequah, Oklahoma	• Argues that the unique relationships with tribes must be honored, Indian Health Service, Tribal Programs, and Urban Indian Clinics (I/T/U) system remain intact and federal funds be used to cover health care expenses imposed on eligible American Indians and Alaskan Natives • Advocates that community health networks include health care services for Indian country • Argues that the I/T/U system should be a critical focus in a new initiative to improve quality and efficiency • *Special focus:*: Carefully take into account how proposed health care reforms will impact the current American Indian and Alaska Native health care system and ensure that any changes have a positive effect on Native Americans and Alaskan Natives
Clinical Social Work Association Seattle, Washington	• *Special focus*: Argues to include physical, mental, dental services in the defined core benefits package

Clinical Social Work Guild Arlington, Virginia	• *Special focus:* Advocates for benefits parity for *mental* and physical services and incorporating language that emphasizes importance of psychosocial aspects of mental and physical health
Congreso de Latinos Unidos Philadelphia, Pennsylvania	• *Special focus:* Argues community-based organizations should be considered as potential outpatient and health and wellness providers/educators especially in communities that frequently encounter obstacles to health care due to language and cultural barriers
Consumers Union Washington, D.C.	• Praises interim recommendations • *Special focus:* Emphasizes need for evidence-based medicine
End-of-Life Nursing Education Consortium Washington, D.C.	• *Special focus*: Suggests integrating end-of-life and palliative care issues throughout all recommendations rather than addressing the issue in a separate recommendation
HIV Medicare and Medicaid Working Group On behalf of 32 organizations from across the country	• Argues that the "core" benefits package should meet the needs of people living with HIV and AIDS • Advocates for explicit measures to protect against high cost out-of-pocket expenses • Strongly supports integrating health networks, including HIV centers of excellence, and ensuring patients have more choice over their end-of-life care, treatment, and environment • *Special focus:* Strongly supports the CHCWG interim recommendations and its call for all Americans regardless of income to have affordable and comprehensive health care
Lourdes (Ascension Health) Binghamton, New York	• *Special focus*: Suggests clarifying high cost in relation to income, otherwise generally supports the recommendations
National Athletic Trainers' Association Dallas, Texas	• *Special focus*: Advocates for supporting policies that enhance injury and illness prevention and preventative care • Argues for policies that address the shortage of health care workers
National Association of Dental Plans Dallas, Texas	• *Special focus:* Argues dental benefits companies are the most effective entities to provide dental coverage with input from dental providers
National Association of Health Underwriters Arlington, Virginia	• Advises Working Group to address high health care costs with the private marketplace subsidizing individual policies and increasing federal subsidies for high risk pools • Urges Working Group to encourage Americans to purchase long term care insurance in their report • *Special focus:* Advocates for retaining the national private health care insurance market
National Association of REALTORS Washington, D.C.	• *Special focus:* Urges support for federal legislation that would authorize the creation of small business health plans through trade organizations • Suggests the small business community be represented on any independent, non-partisan, private-public group called for in the final report
National Committee for Quality Assurance Washington, D.C.	• Recommends supporting pay-for-performance programs for prevention and chronic conditions • Supports recommendation that enhances patient education opportunities • Recommends making organizations who provide the core benefits package responsible for measuring and reporting quality measures • *Special focus:* Supports recommendation on improving quality and efficiency in health care
National Consensus Project for Quality Palliative Care Pittsburgh, Pennsylvania	• Argues that palliative care should be explicitly included as a core benefit • Urges health care policymakers to focus more attention on palliative care to ensure higher quality and more efficiently in care • *Special focus:* Advocates for placing greater emphasis on palliative care
Planned Parenthood Federation of America New York, New York	• *Special focus:* Advocates for CHCWG to address the need to increase funding for public programs that provide low-income women with comprehensive reproductive health services, as well as pre- and post-natal care services

Provena Central Illinois Region United Samaritans Med. Ctr., Danville, Illinois; and Covenant Med. Ctr., Urbana, Illinois	• *Special focus:* Supports recommendations to provide protection against high health care costs, making affordable health care public policy, and reforming end-of-life care to support the wishes of the patient
Providence Hospital (Ascension Health) Mobile, Alabama	• *Special focus*: Generally supports recommendations
Religious Coalition for Reproductive Choice Washington, D.C.	• *Special focus:* Concerned that the content of the core benefit package may be determined by ideological factors and not respect diverse beliefs • Argues for addressing the inequities in medical care and coverage within the system • Advocates for including comprehensive reproductive services and pre-post natal care in the core benefits package
St. Vincent Health (Ascension Health) Indianapolis, Indiana	• *Special focus:* Praises recommendations, placing particular emphasis on protection against high health care costs, integrated community health networks, and improving the quality of care
Supportive Care Coalition Portland, Oregon	• Concerned that emphasis on preventative care will force Americans living with chronic illness to be fully responsible for their own care • Advises the CHCWG to include spiritual and bereavement services in core benefits package • *Special focus:* Urges CHCWG to integrate end-of-life services into the other recommendations, where appropriate
United University Church Los Angeles, California	• *Special focus:* Concerned that delivery of controversial core services such as HIV prevention education, abortion, emergency contraception, condom distribution will be hindered at faith-based medical facilities
Vista Care Scottsdale, Arizona	• *Special focus:* Agrees wholeheartedly with recommendations, especially end-of-life
Common theme: Comprehensive comments on recommendations	
American Academy of Physician Assistants (AAPA) Alexandria, Virginia	• Supports health care delivered by qualified providers in physician-lead teams that are accountable to high professional standards • Advocates for incentives to control costs through optimal use of primary care (e.g. health promotion and disease prevention), reducing administrative costs, eliminate cost shifting, and creating greater incentives for providers to give patients appropriate care • Argues that fair and comprehensive medical liability reform is needed • Endorses system reform that enhances the patient-provider relationship— and when appropriate—defer to the patient's family to make decisions regarding patient care
American College of Physicians Washington, D.C.	• Agrees with recommendations on moving toward universal access to care, creating a non-partisan, public-private group to create the core benefits package • Argues for the need to identify target populations that are the most in need of health care coverage, access, and care • Urges inclusion of explicit language on how to make prescription drugs more affordable • Emphasizes need to make reimbursement levels for covered services fair and appropriate • Argues for including explicit provisions on eliminating disparities in health care based on social, ethnic, racial, gender, sexual orientation and demographic differences • Advocates for stronger emphasis on basic consumer protection rights, including rights to information • Argues for ongoing evaluations of health care reforms • Asserts need to respect individual choice of providers

AFL-CIO Washington, D.C.	• Strongly supports end-of-life, integrated community networks, and public policy recommendations • Argues that $4,000 deductible for high health care cost protection is still too high for poor Americans and would discourage necessary care • Advocates for stronger language on greater transparency for insurance "purchasers" not just "consumers" • Argues for quality and efficiency recommendation to *endorse payment systems to reward high quality care and improvements in care"* • Strongly endorses the core benefits package and argues the recommendation is in contrast to the model of care implicit in the high deductible plan
American Medical Association Chicago, Illinois	• Argues that the best method of expanding health care coverage is to cap or revoke the subsidy of employment-based coverage with the addition of a federal tax credit or premium subsidy for the uninsured • Supports legislation to allow individuals to "buy in" to state employee purchasing pools • Argues that emphasis on safety net in community health networks recommendation will undermine proposal to expand coverage to the uninsured • Supports price transparency, health information technology improvements and a greater emphasis on community-based and home health alternatives for end-of-life and long term care • Disagrees with defining a core benefit package and instead argues that benefit mandates should be minimized to allow markets to permit a wide choice of coverage options
American Medical Student Association Reston, Virginia	• Asserts that recommendations would be strengthened if they included financial and long-term outcome projections • Argues that high cost recommendation implies every American needs catastrophic coverage, when what they need is comprehensive care including the preventative and chronic care management health care service noted in the community network recommendation • Argues that if federally funded health care centers are expanded to include new providers, they should be required to meet current federal guidelines • Advocates for including all providers—not just federally subsidized programs—in provisions to improve quality and efficiency and increasing Medicare funding to address demographic changes in aging • Advocates for single payer system to finance comprehensive national health care • Stresses that the core benefits package recommendation must include a continuing evaluation component to review/revise benefits as necessary
American Nurses Association Silver Spring, Maryland	• Praises Working Group support for affordable, quality health care for all • Urges acknowledgement of discrepancies between community meeting input and the recommendations • Argues the recommendations should have more explicit language on health care as a right for all—citizens and residents • Advocates including more explicit language on controlling long term costs through emphasis on primary care and health maintenance • Asks CHCWG to clarify whether protection against high care costs includes long term care • Asserts that the community health networks need to be integrated with social services • Advises against consumer-driven healthcare because of underlying assumption that patients are able to make the appropriate medical choices • Urges integration of end-of-life services throughout the recommendations • Advocates for explicit language on chronic pain management within section on palliative care • Asks recommendation on affordable health care policy to include language on "removing financial barriers to care" • Requests the CHCWG make a clear distinction between health services and health insurance

	• Advocates including specific mention of "single payer" as a preferred path to financing reform • Requests that insurers not play a role in defining the core benefits package as reflected in public feedback
American Osteopathic Association Washington, D.C.	• Advocates for the creation of a national data bank that evaluates adverse medical events to improve quality of healthcare • Advocates for focusing more on long-term impact of medical interventions on the patient's quality of life as opposed to controlling costs • Disagrees with the core benefits package, arguing it is not feasible
American Public Health Association Washington, D.C.	• Advocates for guaranteeing basic health coverage rather than *protection against very high health care costs* • Stresses including guaranteed Medicaid funding to federally funded health care centers in integrated community network recommendation • Recommends changing current Medicare payment policy for hospice care • Argues that data and specific details are needed to support the recommendation on affordable health care • Requests more specifics on expert group who establishes core benefit package
Cincinnati USA Regional Chamber Cincinnati, Ohio	• Urges CHCWG to quantify affordable health care and clarify who is calling for this recommendation • Argues for more explicit language for each of the recommendations
City of Philadelphia Department of Public Health And additional letter endorsed by 17 organizations and 39 individuals	• Argues highlighting the importance of state and local government, business and labor, faith-based groups, payer organizations, and representatives for the public in defining a core benefits package • Suggests using Philadelphia's Health Leadership Partnership (HLP) as a model for building and integrating community health networks • **Second letter:** Reiterates City's support of community networks recommendation and urges use of HLP as a national model
General Accountability Office (GAO) Washington, D.C.	• Urges Working Group to explicitly explain their method of incorporating public feedback and expert opinion when developing recommendations • Critiques public policy recommendation for not addressing implicit fiscal challenge of charge • Argues that recommendations need to make clear whether core benefits package will replace Medicare and Medicaid • Advocates for separating the core benefit package into two levels of benefits—one universal, government basic coverage (preventative, some wellness, and catastrophic coverage) and the other— supplemental, private insurance to cover non-essential services • Argues for using Medicare/Medicaid as explicit "prototypes" when promoting affordable health care • Advocates for establishing national 'medical best practices'
Health Care Leadership Council Washington, D.C.	• Encourages greater emphasis on consumer education and outreach • Advocates for government-financed private sector health Information technology investment to spur innovation • Encourages Working Group to argue for medical liability reforms
Independent Living Resource Center San Francisco San Francisco, California	• Disagrees with any recommendation using income as a determinant policy because that promotes a two-tiered system • Concerned that the public/private partnerships discussed in the community networks recommendation will lead to corrupt and wasteful government contracts • Proposes offering free tuition in exchange for M.D.s working in low resource locations • Argues that greater emphasis in the report needs to be placed on independent living for people with disabilities • Argues that consumers need options in a core benefits package that fit their needs

Mid-Valley Health Care Advocates Corvallis, Oregon	• Urges recommendations to emphasize protection from high health care costs for all citizens, not just low-income families • Disagrees with new order of recommendations • Concerned that the integrated community network will create a two-tiered system of healthcare
National Coalition on Health Care Washington, D.C.	• Advocates for inclusion of language specifying all Americans should have access to health care insurance and timely access to care • Argues that rising healthcare costs need to be reduced to the annual increase in GDP per capita through limits on increases in insurance premiums for core benefit coverage and rates for reimbursing providers • Supports a $1 billion federal investment in improving national health care quality and efficiency • Urges combining high cost care and affordable health care for all recommendations into one
National Health Law Program Los Angeles, California	• Advocates for clarifying values and principles, explaining how the recommendations will be implemented, and resolving potential inconsistencies between the terms "medically" effective and "evidence-based" • Supports inclusion of comprehensive women's health and language services • Urges recommendation to protect low-income individuals during the transition to health care reform • Advocates for broadly defining the standards and evidence that will be acceptable to determine core benefits • Argues for a financing system in which the government is the single payer • Advocates for financing strategies that consider low-income individuals' existing tax contributions and relative burdens • Urges replacement of all references to "citizens" with "Americans" with "Americans" defined to include immigrants • Argues that report should state that health is a human right • Advocates for spending what is necessary to attain the highest standard of health for everyone • Asks for clarification that "right care at the right time" means that low-income individuals can receive medically necessary services at no cost without delay without cost-sharing • Urges a distinction between "define set of benefits" and the "set of core health services" • Argues that recommendations should explicitly state coverage of health service will not be linked to health status or behavior • Suggests adding "quality" to the principle of affordability to guarantee "quality, affordable health care coverage" • Urges clarification of the appointment process for the private-public group to minimize political influences • Argues for coupling the proposal to expand health centers with the commitment to provide sufficient resources for the task • Advocates for maintaining the requirement that patients occupy a majority of seats on an organization's governing board as a condition of Federal funding • Suggests the Working Group define length and scope of end-of-life services expansively with full funding by the federal government • Argues for prioritizing the collection of racial, ethnic, and language data as the new health information systems are implemented
National Small Business Association Washington, D.C.	• Argues for requiring that everyone have healthcare coverage and providing federal subsidies for low income individuals and • Advocates for pay for performance incentives for health care providers based on outcomes rather than procedures • Suggests the individual tax exclusion for health insurance coverage should be limited to the value of a basic benefits package • Argues health services to be added to the core benefits package undergo cost/benefit analysis

Schuylkill Alliance for Health Care Access, Inc. Pottsville, Pennsylvania	• Advocates for patient incentives to induce healthier lifestyles • Argues patient out-of-pocket expenses should be based on a sliding scale • Advises using sin taxes for financing • Argues government health agencies need to improve coordination
Service Employees International Union Washington, D.C.	• Asserts importance of retaining 2012 timeline for implementing recommendations • Argues that more attention in the recommendations needs to be given to protecting Americans from high health care costs • Advocates for including preventative services, long term care, and provider choice in the core benefits package

Health Care That Works For All Americans

Health Report To The American People

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

The Health Report to the American People

Contents of the Health Report

I. A Snapshot of Health Care Issues in America

Every American needs health care services - for routine check-ups and preventive care (such as flu shots), for treating chronic conditions like diabetes, for receiving urgent care for serious injuries or illnesses, and for helping us live comfortably in our last days of life. Our need for health care varies over the course of our lives and can change based on our situation at a given time. We are all at risk for needing critical and expensive care.

How well our health care system responds to our needs for care and the costs associated with delivery of this care are subjects of much debate. There is clear evidence that rising health care costs, unreliable quality, and lack of access to needed services are key problems which must be addressed as we work to develop a health care system that works for all Americans.

Health care is getting more expensive-and costs keep going up.

- **Costs are rising sharply** - Our costs for health care were estimated to be about $6,300 per person in 2004 [12], and are projected to increase to about $12,300 by 2015 [19].
- **We spend more now than we did in the past** - In 1960, we spent about a nickel out of every dollar on health care in the United States. Today, our spending has tripled to about 15 cents out of every dollar, and that proportion is expected to rise sharply over the next ten years [11].
- **We're making fundamental choices in our own lives based on the costs of health care** - The need for employer-sponsored health insurance to cover the high costs of medical care is why some workers postpone retirement, why some mothers re-enter the workplace, and why some people decide against starting their own small businesses.

Quality of care falls short of the mark.

Many of us are benefiting from medical advances, and are living longer, healthier, and more productive lives. However, medical care is complicated and medical science cannot always provide solutions to all our health problems all the time. In addition, our health care system is very complex and has many layers, including doctors, insurance companies, and hospitals. The red tape and communication barriers inherent in the system can create hurdles for both health care providers and for patients. Many of us receive inappropriate or unnecessary care:

- Adults get, on average, only 55% of the recommended care for many common conditions [2].
- Many unnecessary medical errors occur. From 44,000 to 98,000 deaths are estimated to occur annually due to medical errors [5].
- Americans often face difficult decisions, such as end-of-life care:
- Not all of the care people receive at the end of life is effective in improving quality of, or prolonging, life.
- We're spending about a quarter of all health care costs on caring for people in their last year of life [7].
- More than half of Americans say that being able to be at home when dying is important, but only 15 percent of Americans die at home [8].
- 93 percent of those asked believe that being free of pain is important, but only 30 to 50 percent of Americans achieve this objective [8].

Many Americans don't have access to health care services.

Even though our country has pioneered many major medical developments, millions of Americans do not have access to needed medical care. Some areas of the country do not have enough or the right types of health care providers to serve the population's needs. And more than 15 percent of Americans report that they have no regular place to go when they need health care [6].

Compounding the problem is that many people lack insurance coverage to pay for the health care they need. Some individuals have no coverage at all; others have limited coverage that may not include some important services or may require high out-of-pocket payments before coverage kicks in. People may also have inadequate coverage for specific services such as prescription drugs, mental health or long-term care. For example, no more than 10 percent of elderly people have private insurance for long-term care [118].

Generally, there are two main sources for funding for health insurance in America. *Private* funds consist of payments for health insurance premiums and payments that we make directly out of our own pockets when we get care. Most private coverage is purchased by employers on behalf of their employees. *Public* sources of funding use tax dollars to fund federal, state, and local government programs like Medicare and Medicaid. In addition, some people rely on programs that combine public and private dollars.

However:

- Over 46 million Americans have no health insurance,[1] [52] and many more have insurance with limited benefits.
- Most of these uninsured people are in working families, and most are in families with incomes above the poverty line. Many people either can't afford to buy health insurance or choose not to buy it [9].
- Uninsured Americans are nearly eight times more likely than Americans with private health insurance to skip health care because they cannot afford it [10]. These Americans may face serious health consequences from delaying or failing to get timely and effective health care when it's needed.
- A person's race, ethnicity, and socioeconomic status continue to be associated with differences in the quality of care provided, the person's access to care, and the person's overall health.

These problems work together to cause serious consequences for our society.

Our health care system is threatened by rising costs, unreliable quality, and problems accessing care. These problems are complex and interrelated, because the entire health system works like an "ecosystem," where changes made in one aspect of the health care system can affect other parts of the system. New technologies can improve the quality of care, but may lead to even higher costs. Rising costs contribute to increasingly unaffordable care. And when people without health insurance or with inadequate benefits receive care they can't pay for, costs for others can increase.

Together, all of these problems affect many aspects of our society:

- **Individuals** – Americans are having increasing difficulty protecting themselves against catastrophic loss and are having trouble paying for the increasing costs for health care.
- **Government** – Increased costs are placing pressure on our government's ability to pay for other programs. This may create a need for tax increases, cuts in health care benefits, or cuts in other public programs.
- **Businesses** – Higher health insurance premiums make businesses less likely to offer comprehensive health insurance to their employees. Higher premiums also make it harder to afford insurance. If current trends continue, employers and their workers could experience decreasing profits and wages because of the rising costs of health care. Jobs are also being outsourced to other countries as businesses strive to save money.

[1] The estimates vary depending on whether the focus is on how many people are uninsured at a specific point in time or for the whole year, but the bottom line is that many Americans are uninsured.

Exploring options.

States, communities, and large health care systems are attempting to deal with the interrelated health system issues of cost, quality, and access. In hearings around the country, we heard about several interesting public and private sector initiatives that have been put in place. Designing and implementing these programs requires substantial financial and institutional support. Sustaining the efforts presents new challenges. Most of these programs are new, so we don't know yet how well they will work over the long-term. And, because these programs were designed to work in particular places, we don't know whether the programs would fit, or work successfully, in other locations or settings.

Other programs we learned about are more narrowly focused: some are designed specifically to control health care costs; others focus on improving the cost effectiveness and quality of health care; still others concentrate on improving access to primary care services or expanding health insurance coverage to a greater number of people. Still other approaches are aimed at improving efficiency by offering rewards to providers for delivering cost-efficient, high-quality services, such as providing recommended health screenings, or when a high proportion of their patients receive appropriate care for conditions such as diabetes or heart disease.

Over time, more efficient ways of operating health care organizations and using health information, as well as general improvements in our health, could ease some of the pressure on our health care system. While investments now could reap important rewards over time, the benefits from these broader improvements will not eliminate the growing, interrelated problems that face our health care system.

Our review of the evidence reinforces our conclusion that we need to address the entire health care system, not just specific problems in cost, quality, or access, no matter how urgent they may seem from our different perspectives. Ideally, savings gained from improving efficiency and quality in the system can be used to make other needed changes. But no single initiative that we have reviewed can provide all the answers to our health care system's problems. That's why we need to engage you in this discussion.

II. Health Isn't Guaranteed-We Are *All* at Risk

"I was an elementary science teacher. I ate right, exercised regularly, and was rarely ill. I had only fleeting contact with the health care system. But then I got sick. I was always tired no matter how much sleep I got. My vision became blurry, and I had difficulty hearing sometimes. Eventually I was diagnosed with multiple sclerosis, a chronic neurological disease."

– Montye Conlan

As Montye's story shows, you never know when you'll need to take advantage of health care services.

Normally, people's use of health care services consists of routine medical and dental checkups, none of which are overwhelmingly cost prohibitive for most Americans. But we tend to be affected by more health care problems as we age. As individuals in the Baby Boom generation age, the demands on the health care system will increase substantially. If medical science continues to advance, people will also live longer and will require additional health services.

Services we all need.

Some of our health care is provided in hospitals, some is provided in physician offices, and some is provided at home, in a rehabilitation facility or in a nursing home. We pay for many medical and surgical procedures and prescription drugs that are very expensive, but we also use a lot of low-priced services and drugs.

From routine care to treating serious injuries or illnesses, Americans need health care:

- 1 out of 5 Americans have a routine checkup at a doctor's office each year. [6]
- In 2002, over 4 million babies were born; 12 percent of them prematurely. [13]
- By the time they are 3 years old, 3 out of 4 children get an ear infection. [14]
- Every year, motor vehicle crash injuries result in half a million hospitalizations. [15]
- There are 4 million visits to the emergency room for broken bones every year. [16]
- As of 2002, nearly a third of seniors reported that they had at least one cataract surgery. [17]
- An estimated 212,920 women will develop new cases of invasive breast cancer in 2006. [18]

We spent $1.9 trillion in 2004 on health care, much of it falling into the following categories [122]:

1. **Professional health care services**. These services, such as those provided by physicians, nurses, and dentists, accounted for about $587 billion in 2004. This is almost one-third of all the money we spent on health care services and supplies [122]. Although most routine doctor and dental visits are not very expensive, we make many such visits.

Last year:

- 9 out of 10 children under age 18 had at least one health care visit.
- 3 out of 4 adults ages 18 to 44 had at least one health care visit.
- 6 out of 7 adults ages 45-64 had at least one health care visit.
- 9 out of 10 people ages 65 and older had at least one health care visit.
- 2 out of 3 people over age 2 saw a dentist. [6]

2. **Hospital services**. Hospital care remains the second most expensive type of health care. Hospital costs amounted to $571 billion in 2004 [122], even though only 7 percent of Americans spent the night at a hospital [20]. While most of us do not need to go to the hospital in any given year, it is usually very costly when we do, and sometimes extraordinarily so. In fact, the average cost of a hospital stay in 2002 was nearly $12,000 [21].

3. **Prescription drugs.** The amount we spend on prescription drugs ranked third compared to our spending on other health care services in 2004 [122]. We are spending more of our health care dollar on prescription drugs than we ever have in the past. Not only are we buying more drugs than before, but also we are spending on newer drugs that cost more [24]. The

rapid increase in brand name prescription drug prices has also contributed to our high spending.

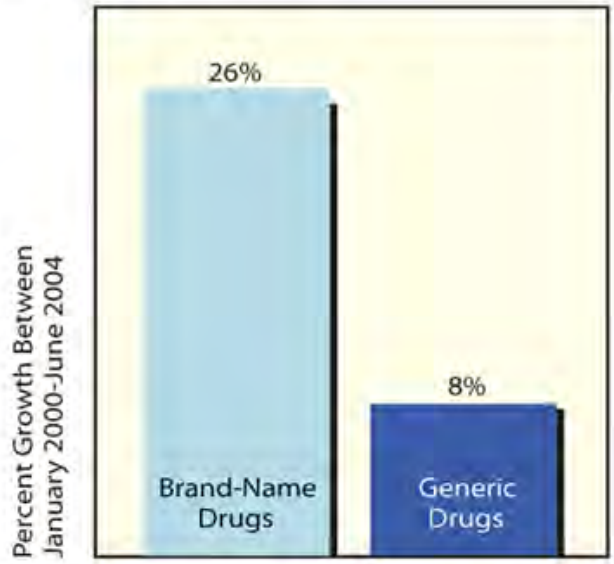
Prescription drug use – and spending – continues to increase rapidly:

- About 1.3 billion prescriptions were ordered or provided during physician office visits in 2003. [22]
- 139 million prescriptions were ordered or provided during hospital visits in 2003. [22]
- In 2004, spending on prescription drugs was more than three times as high as it was in 1993. [122]
- Also in 2004, prescription drugs accounted for $188.5 billion, 10 percent of health care spending —up from less than 6 percent in 1993. [122]

Some popular prescription medications are now available in generic form(chemical copies), which has lowered their cost [25]. As shown in Figure 1, prices for brand-name drugs grew three times as fast as prices for generic drugs.

Figure 1:

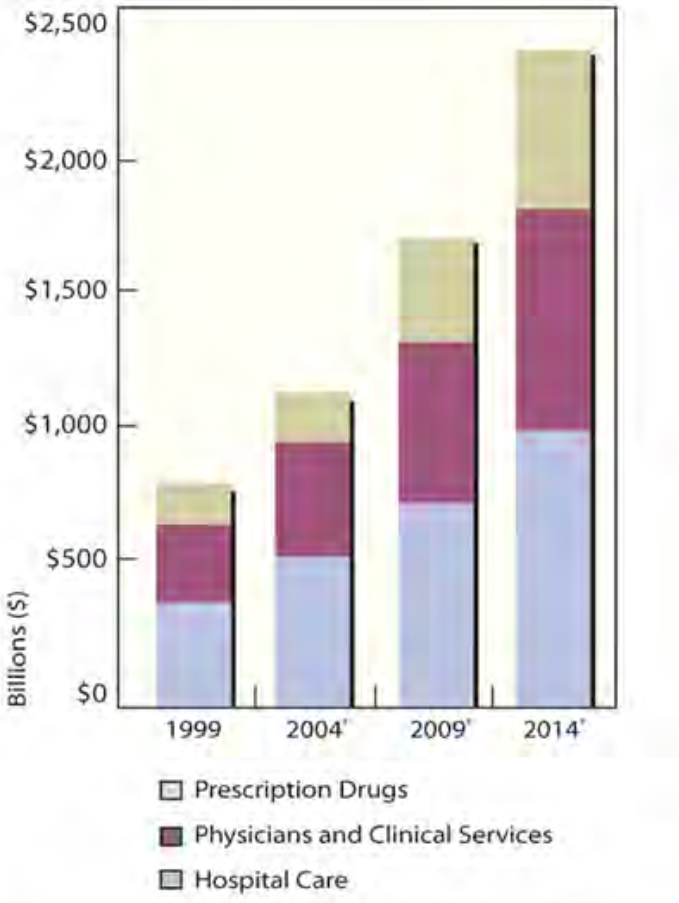
Brand-Name Drug Prices Are Growing Faster Than Generics



Source: GAO. Prescription Drug Price Trends, GAO 05-104R. 2004

As shown in Figure 2, national spending for the top three health care services (hospital care, physicians and clinical services, and prescription drugs) is expected to increase rapidly over the next decade.

Figure 2:
Spending on Key Health Services is Growing Rapidly



Source: Centers for Medicare and Medicaid Services, Office of the Actuary; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.
* Projected

4. **Long-term care**. More people today have disabilities or chronic care needs that require long-term care through a range of medical and social services. They generally have serious problems performing basic activities such as bathing or dressing. The services they need may be provided in their homes, in adult day care facilities, in nursing homes or assisted living facilities [26].

Nursing home and home health care costs are increasing significantly as a share of what we spend on health care. This is a result of the fact that the American population is living longer. Expenditures on nursing home care and medical equipment are rarely covered completely by public or private insurance. Americans paid out-of-pocket for a considerable portion (about 28 percent) of nursing home care in 2004 (almost $32 billion) [12]. Americans also paid out-of-pocket for a wide variety of medical equipment and other medical supplies, totaling just over $40 billion. [122]

Nursing home and home health care costs are increasing:

- Almost half of people age 65 and older are already receiving care in a nursing home or are likely to do so at some point in the future. [28]
- Spending on home health care is projected to double over the next ten years. [19]

Different people, different needs.

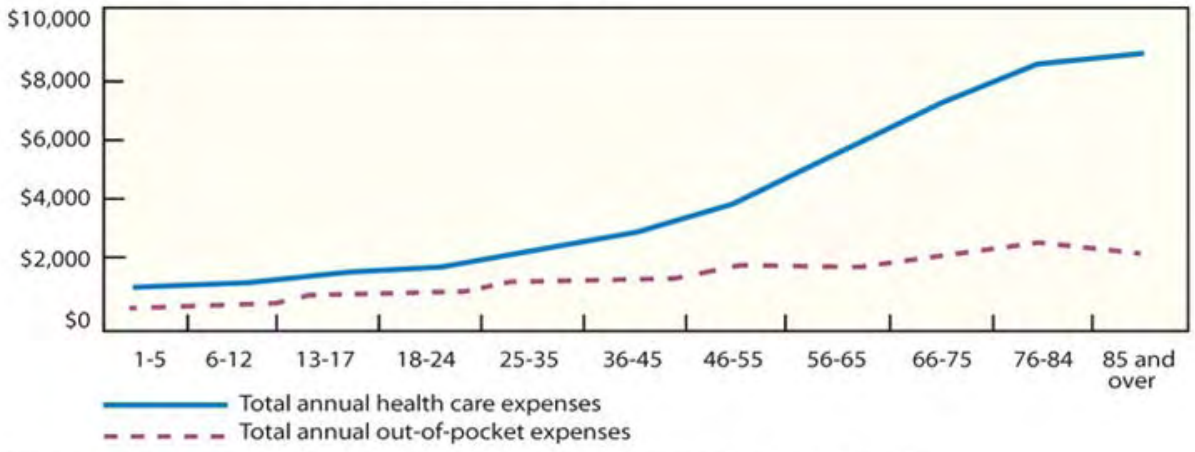
As Montye Conlan's story at the beginning of this section shows, Americans are always at risk of needing various health care services, often when least expected. While our need for services can be unpredictable, a number of factors do influence both what kind of care people need and the costs they incur for these services. A large portion of all health care is used by a small number of people. Private insurers and public programs try to spread these costs to make it possible for everyone to get care when they need it.

Age

Health care expenses are relatively low during childhood. In fact, only one-fifth of all lifetime health care expenses occur during the first half of life [29]. As we age, however, our health care needs increase, especially between ages 65 and 85:

- About half of all health care expenses in a person's lifetime occur after age 65 [29].
- Medicare beneficiaries aged 65 and older are more than twice as likely to use hospital services as are younger adults [25].
- The annual average expense for the care of adults ages 76 to 84 is $8,000 – nearly eight times the average health care costs for children ages 1 to 5 years [21]. (See Figure 3.)

Figure 3:
A Person's Health Care Spending Increases with Age



Source: U.S. Department of Health and Human Services and Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002.

People need different types of health care according to how old they are and which health problems they have.

Ages 0 - 5

- While most babies are born healthy, the few babies who are born premature, underweight, or with breathing problems must stay in the hospital for many days receiving expensive life-saving treatment.
- Four out of five children 19-35 of age receive all of the immunizations that are recommended.
- 94 percent of young children visit a doctor at least once a year.

Ages 6 - 17

- Over the course of a year, 86 percent of children and adolescents go to a doctor's office or clinic and 1 in 5 visit an emergency room.
- About three-quarters of children and adolescents ages 2-17 years go to the dentist each year.

Ages 18 - 64

- Most women who have babies are between the ages of 20 and 34. More than 4 out of 5 mothers get health care during the first trimesters of their pregnancies.
- At this age, men are less likely to go to doctors or hospitals than at any other time in their lives.

Ages 35 - 54

- For every 100 people age 45 and older, there are 44 health care visits in which cholesterol-lowering drugs are discussed, prescribed or provided.
- Seventy percent of women age 40 and over have had a mammogram in the past two years, while roughly half of Americans age 50 and older are estimated to have participated in colorectal cancer screening.

Ages 65+

- About two-thirds of seniors received a flu shot in the past year, and more than half have been vaccinated for pneumonia at some point in their lives.
- Each year, for every 100 seniors, there are more than 650 visits to doctors' offices, roughly 40 visits to hospital outpatient departments, and roughly 50 visits to emergency rooms.
- In addition to receiving health care at doctors' offices and hospitals, one out of 7 people age 65 and older and one out of 2 people age 85 and older need long-term care. [6, 41, 75]

Serious and chronic conditions

Regardless of age, any of us can experience illnesses or injuries that require serious medical attention at any time. These ailments cost significantly more than routine care. In any given year, close to half of all health care spending pays for the care received by only 5 percent of the population – those experiencing serious health care conditions [30]. Some of those conditions last only a short period of time, while others are chronic, or ongoing.

In 2004, almost half of all people in the United States had a chronic condition that ranged from mild to severe. That year, 23 million Americans had heart disease, 22 million had asthma, more than 13 million had diabetes [22], 400,000 had multiple sclerosis [31], and more than 750,000 had cerebral palsy [32].

The ten most costly chronic conditions for adult Americans are:

- Asthma
- Cancer
- Cerebrovascular disease
- Chronic back/neck problems
- Chronic obstructive pulmonary disease
- Diabetes
- High blood pressure
- Ischemic heart disease
- Joint disorders like arthritis or rheumatism
- Mood disorders like depression [33]

More than 39 million adults have two or more chronic conditions. Managing chronic conditions can require people to change their lifestyles or even their jobs. Serious chronic illness may require a lot of health care and expensive medications over long periods of time. Health care for people with chronic diseases accounts for 75 percent of the nation's total health care costs [34]. For example, people with diabetes incurred an average of $13,243 in health care bills in 2002 [35].

Alternatively, certain illnesses or injuries also require extensive medical care, but only over a short time period. These costs can be equally prohibitive:

- In 2001, the insurance costs for a premature baby (defined as being born more than 2 weeks early) averaged over $41,000 for the first year – almost 15 times as much as for a full-term baby ($2,800) [36]. The hospital costs for the one in one-hundred newborns with the most serious health problems average over $400,000 [37].
- The average cost for surgically repairing a torn knee ligament is approximately $11,500 [38].

Other factors

Lifestyle factors such as exercise, diet, and environmental and living conditions can affect Americans' health needs. Research suggests that race and ethnicity, attitudes about going to a health care provider, and the ability to understand health care and how to use it, are also significant factors in determining how people seek as well as receive health care [39, 40].

In addition, as we discuss in other sections of this report, the amount and type of health care services that Americans use reflects how much people believe they can afford, as well as the availability of doctors, clinics, or hospitals.

III: Sharply Rising Costs

"My husband had some complications with his back surgery and wound up on a respirator in the intensive care unit for five days, in a neuro-acute unit for four more days. Even though he and I both had insurance, the 20 percent [coinsurance] of the bill was $80,000."

– Chris Wright

Americans are fortunate to have medical technologies in this country that can save lives. You never know when an unexpected illness or injury might mean that you, too, need to rely on new, cutting-edge services. But at the same time, top-notch care comes at a high cost, as Chris found.

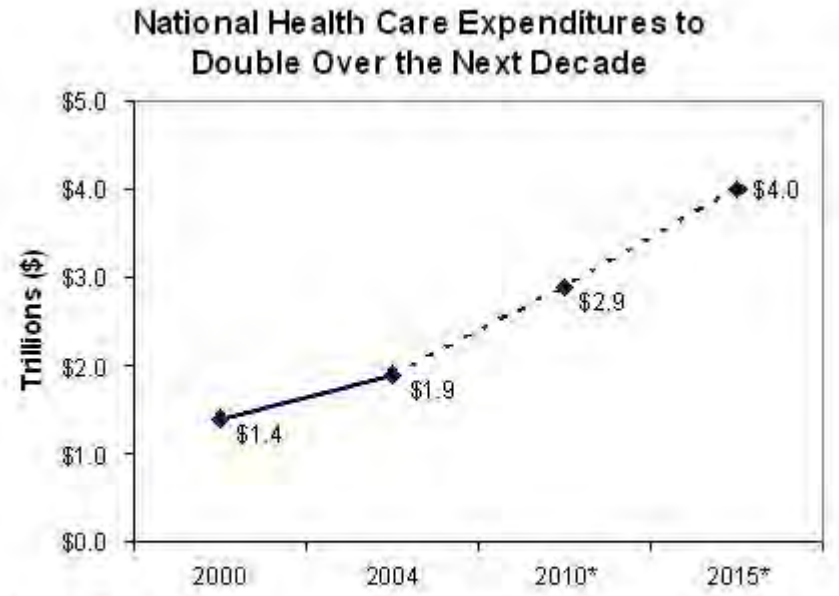
In one way or another, whether through taxes, higher prices, or lower wages, the American people—about 290 million of us [42]—supply all of the money used to pay for health care. To have a constructive discussion about what changes should be made to improve our health care system, we need to understand more fully the flow of dollars in the current system and why health care costs are continuing to rise rapidly.

As you review the information in this section, keep in mind that this story is only partly about dollars. Health care is personal. Over our lifetimes, all of us will interact with the health care system as patients, relatives or friends of patients, and caregivers. We all have a stake in preserving what works in the system, as well as fixing what does not work.

We're spending hundreds of billions of dollars on health care - and the numbers keep going up.

The amount this country spends on health care is extremely large:

- In 2004, we spent about $1.9 trillion dollars on health care services, medical research, and other things related to health care, like running and building hospitals, clinics, and laboratories [122].
- Almost all of that money – 93 percent – was spent on health care services and supplies.
- Our spending for health care was, on average, about $6,300 per person in 2004, and this spending is projected to increase to $12,300 per person by 2015 [19].
- Overall health care spending is predicted to be $4.0 trillion in 2015. (See Figure 4.)



We spend much more on health care than what the official numbers show. Informal care-giving—care provided by family, friends, and volunteers, often at no charge—does not show up in the spending estimates:

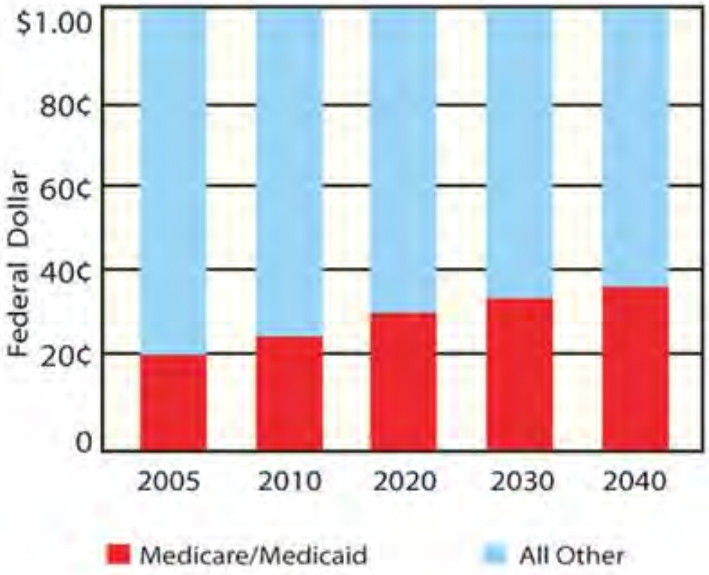
- In 2003, around 22.4 million households had some form of informal care-giving for a household member aged 50 and older, and this number is expected to increase by 17 million by 2007 [43].
- One recent estimate put the economic value of this care at nearly $260 billion [44].
- Many of us are providing informal care for younger people with serious health care problems – care that is not included in these estimates. Informal caregivers often have to cut back on the time they spend in paid jobs, which reduces their own income and workplace productivity. Informal caregivers also are at greater risk for developing health problems of their own because of the stress associated with this added responsibility.

Americans are spending more on health care than ever before:

- In 1960, we spent about a nickel of every dollar of income on health care. In 2001, we spent nearly triple that amount, spending 14 cents of every dollar on health care [11].
- By comparison, our spending on education has not grown nearly as much. In 1960, we spent about a nickel out of every dollar on education at all levels—primary, secondary, college, and university. Forty-one years later, we had only increased our education spending to seven cents out of every dollar [11].
- And every year, an even larger portion of our federal dollar goes to health care:
- The growth in the resources Americans now put toward health care is greater than the growth in resources for many other kinds of goods and services we need and use.
- If trends continue to follow the path of the last 20 years, Medicare and Medicaid will account for nearly 30 percent of all government spending by 2020, and about 36 percent by 2040[45]. (See Figure 5.)

Figure 5:

Medicare and Medicaid Are Consuming More of Our Federal Dollar



Source: H. Aaron and J. Meyer, "Chapter 4: Health" in Restoring Fiscal Sanity: Meeting the Long-Run Challenge, A. Rivlin and I. Sawhill, ed., Brookings Institution Press, 2005.

We all pay for health care.

We are paying our growing health care bill through sales, income, property or payroll taxes, or through increased premium payments, reduced wages, or when we pay higher prices for the products and services we buy. That money is channeled through private and public sources, including what we pay out-of-pocket, to health care providers.

Private funding for health care.

Private spending consists of what people pay for health care, indirectly through their premiums to insurers or directly through out-of-pocket payments to providers, as well as contributions made by charities and other private organizations.

Private health insurance's largest single expense – 39 percent of its total spending – was for professional services provided outside of a hospital, such as doctors' visits [37]. Although private insurance typically offers some coverage, more than a third of what people with private insurance spend out of pocket for health care pays for these services – mostly doctor visits and other clinical care ($38 billion) and dental services ($33 billion). People with private insurance also spent a lot on prescription drugs. In 2003, they spent nearly $53 billion out-of-pocket for prescription drugs.

Most private coverage is purchased in the group market by employers on behalf of their employees. In 2005, virtually all large companies offered health insurance to their employees. Only half of the smallest companies (fewer than 10 employees) offered it. Increasingly, firms are requiring employees to make contributions toward the premiums, for both single and family coverage. In 2005, the typical employee paid over 15 percent of the premium for single coverage and almost 30 percent of the premium for family coverage, averaging $610 a year for single coverage and $2,713 a year for family coverage [46].

Employer health coverage is subsidized through the federal tax system, since workers do not have to pay taxes on compensation received in the form of employer-provided health insurance. Premiums paid by employers that are part of employees' compensation are exempt from payroll taxes and from individual income taxes. As a result, both employers and employees pay less in taxes than they would if employees were paid only in wages, and, for many employees, there is an effective discount on their premiums because group rates (through employers) are generally lower than premiums for individual coverage. The Congressional Budget Office estimates that, in 2004 alone, the exclusion of health benefits from taxation will reduce federal revenues by $145 billion [47].

The private sector also plays a critically important role in supporting health research in the United States. Industry—pharmaceutical, biotechnology, and medical device firms— pays for more than half (57 percent) of all the biomedical research conducted here, adding up to close to about $54 billion in 2003. Other private funds, mostly foundations and charities, pay for another 3 percent. Industry support for the development of pharmaceuticals, biomedical products, and devices has grown rapidly, more than doubling from 1994 to 2003 (after adjusting for inflation). Spending on research on medical devices has been growing particularly fast, increasing by 264 percent from 1994-2003 [114].

Public programs

Federal, state, and local governments support a variety of public health care programs. The two largest government programs are Medicare and Medicaid. These programs make up about a third of our total national health spending (see Figure 6). The way these programs work affects virtually every aspect of our health care system. Throughout this report, we talk about ways that Medicare and Medicaid are trying to address many of the problems facing our health care system, including innovations to improve quality of care and increasing access to health insurance.

Medicare is a national health insurance that covers almost everyone in America age 65 and over as well as millions of people under 65 who have become disabled or have developed end-stage kidney disease. In 2004, Medicare covered about 35 million seniors, over 6 million persons with disabilities, and 100,000 people with end-stage kidney disease [48]. About half of the money collected for Medicare comes from a specific payroll tax that goes only into a special Medicare fund, and almost a third comes from general revenues from income and other federal taxes. Individuals covered by Medicare also pay premiums, which are taken out of their Social Security checks each month. In 2006, individuals with Medicare coverage of physician and other health care services pay $88.50 per month in premiums ($1,062 per year), plus, if they chose to enroll, an additional premium (estimated to average $25 per month) for the new Medicare prescription drug benefit. [123]

The federal government also uses general income taxes to pay for a large portion of the *Medicaid and the State Children's Health Insurance Program* (*SCHIP*) programs. Medicaid is a national program run by the states that provides medical assistance to certain low income individuals and families (eligibility varies by state). In 2004, about 55 million people were enrolled in Medicaid at some point during the year, and almost half of them were children [50]. About 6 million children were enrolled at some point in SCHIP in 2004 [51]. State governments also use tax money to help pay for Medicaid and SCHIP.

Medicare, Medicaid, and SCHIP cover different types of services for different populations. However, all are facing increasing costs.

- Medicare's spending on hospital care is projected to almost double over the next 10 years – from $163 billion in 2004 [122] to about $340 billion in 2015. More than half of Medicare's spending goes to pay for hospital care – which is often very expensive – for its growing population. By comparison, around a third of either Medicaid's or private insurers' spending goes to hospital care [122, 12].
- Medicare's spending on physician and clinical services is also projected to more than double by 2015 [12].

- Medicare's share of prescription drug expenses will increase dramatically in 2006, when Medicare Part D coverage of prescription drugs first takes effect.
- Medicaid pays for more long-term care than any other public payer or private insurer. As a result, a significant portion (about 20 percent) of its expenditures for health services and supplies are spent for nursing home and home health services [12]. The number of people age 65 and older who will use a nursing home during their lives is expected to double over the next 20 years, and one-quarter of those entering a nursing home are expected to be there for at least one year [28].
- From 1993 through 2003, Medicaid payments for long-term care such as personal care services, adult day care, transportation, or skilled nursing services more than doubled, growing by more than $62 billion [27].
- Both Medicaid and SCHIP are covering a growing number of people, primarily poor children whose families cannot afford health coverage [52].

Public funds also pay for other important health care programs, including the health care provided by the Department of Veterans Affairs, the Department of Defense programs for the military (and their dependents and retirees), and the Indian Health Service. In addition, federal money is used for public health activities such as infectious disease control and bioterrorism preparedness through agencies like the National Institutes of Health and the Centers for Disease Control and Prevention. Both state and local governments use tax revenues to pay for other health care services, such as local clinics, public hospitals, and prescription drug assistance.

All levels of government support medical research, education, and training of health care professionals. These kinds of programs do not provide services directly but still play an essential role in health care.

Biomedical research plays a particularly important role in shaping health care in America. This research is essential to development of medical advances and technological breakthroughs that improve the effectiveness and quality of medical care and thereby prolong and enhance the quality of our lives. [114]

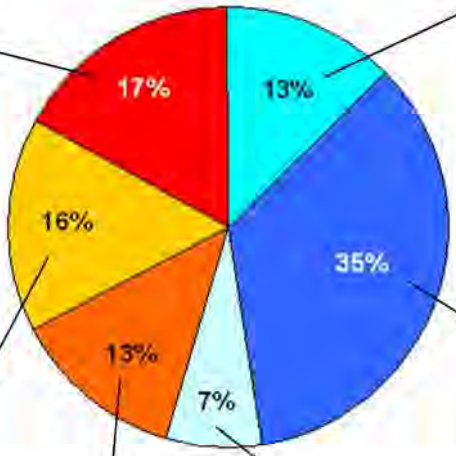
In 2004, the Federal government spent over $33 billion on biomedical research, mostly at the National Institutes of Health. While private industry is the largest direct source of funding for biomedical research, the federal investment is critically important. The NIH budget doubled in the five years from fiscal year 1999 though 2003. The agency provided more than $15 billion in project grants to researchers, and several billion dollars more in grants to research centers around the country [119]. In addition to providing funding to researchers in universities and in industry, the federal government also builds research programs in the private sector by providing "seed money" that can increase the chances that private sector organizations will add their support to new research initiatives [120]. There is also some federal investment in research to calculate the clinical and economic value of new and existing medical treatments and technologies. In fiscal year 2005, the federal government spent about $1.8 billion on all types of health services and health policy research combined [121].

Figure 6:
Public and Private Sources Pay for Health Care, 2004

Medicare is the national health insurance program for people age 65 or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (ESRD), which is permanent kidney failure requiring dialysis or a kidney transplant.

Medicaid is a program that pays for medical assistance to individuals and families who meet certain categorical eligibility criteria based on income, assets (like home ownership), and in most states, very high medical expenses. This program is jointly funded by federal and state governments. Medicaid is the largest source of funding for medical and health-related services for people with limited income.

State Children's Health Insurance Program (SCHIP) is operated by states. This program allows each state to offer health insurance for certain children up to age 19 who are not already insured. Each state sets its own guidelines regarding eligibility and services.



Out-of-Pocket payments are made directly by people receiving health care at the time services are used.

Private Health Insurance is insurance provided through organizations not operated by the local, state, or federal governments. The majority of private health insurance is employer-based, meaning people receive insurance as part of their compensation packages.

Other Private Spending is made up of money spent by private organizations such as charities, which help people pay for health care.

Other Public Spending is made up of other federal programs like those serving veterans, military and their families, and Native Americans. State and local programs are also included in the percentage of other public spending.

Note: Percentages may not add up to 100% due to rounding. Out-of-pocket payments do not include premiums.
Source: Centers for Medicare and Medicaid Services, National Health Accounts, 2004.

Numerous factors contribute to rising costs.

A combination of factors, including how we use technology and how much we pay for health care contribute to rising costs. The prices we pay are affected by the way the health care system is organized in the U.S.

Technology

America leads the world in medical technology research and development. Total spending on biomedical research has been increasing rapidly, growing from $37 billion in 1994 to about $94 billion in 2003. Investments in research have made the United States the global leader in pharmaceutical development: by one estimate, about 70 percent of all new drugs under development around the world in 2003 belonged to organizations headquartered in the United States. This level of achievement has important benefits, both for our economy and for our health care [114].

There is no question that the products of this research, such as vaccines, and other drugs, and devices used in the diagnosis and treatment of disease, save countless lives. Our current health care system lacks effective mechanisms for weighing the relative benefits of new health technology. However, is it appropriate to limit this research because these new potentially life-saving products are, in part, responsible for driving up health care costs?

The way that we use technology — using many, often expensive, tests, using sophisticated equipment and expensive new treatments— has been suggested as a major cause of the country's large increases in health care costs [53]. For example, Medicare increased its spending for imaging services, such as magnetic resonance imaging services (MRIs), in physician offices alone by over $3 billion from 1999 to 2003 [54]. While it is difficult to weigh the costs and the benefits of life-enhancing technologies, the decision to use them is often made without patients, families, or those receiving or paying for the care fully understanding the possible benefits and problems that may result [91].

The way we pay for care

In our fragmented health care system, there are many ways in which we pay providers. Some ways we pay for health care in the U.S. may lead health care providers to provide more, rather than fewer, services. For example, in fee-for-service systems, physicians and hospitals are paid each time they provide a service; the more they do for patients, the more they get paid. At the same time, how much patients have to pay when they use health care services may affect their decisions about getting care.

The actual prices we pay for medical services and supplies are also affected by how much it costs to run health care organizations. For example, physicians and other professional health care workers' salaries are higher than those in other industrialized countries [56]. Other factors, some of which are discussed below, may also drive prices. Whatever the reasons, prices we pay for health care tend to be high. The approaches we have tried to control health care costs have not proved to be very effective. For example, managed care, which pays providers a fixed amount for each patient, gave doctors a strong incentive to use services carefully. While managed care seemed to reduce health care cost increases for a short time in the 1990's, health care costs accelerated again in part due to public backlash against managed care's limits on access to services [112]. We have relied on competition among providers in the private sector to determine what prices are and have generally not wanted to have the government directly control prices as some other nations have.

Administrative costs

We pay for health care in a very complicated way: different government agencies, insurance companies, and individuals all pay for part of various health care bills. This complex system can lead to duplications and inefficiencies, which result in higher administrative costs. Patients also suffer, wasting time and undergoing numerous frustrations as paperwork costs are passed on to them.

Hospitals and doctors' offices in the United States often employ many workers to process bills and payments, since the bills go to several different government programs and various private insurance companies. In contrast, fewer employees are needed for this purpose in systems where there are fewer payers, such as the health care systems in many other industrialized nations, because there are fewer payers for health care [3]. The health services industry is the largest industry group in terms of employment in the United States [55].

In our multiple payer system, some administrative costs are necessary for organizations to run smoothly. Your family doctor, for example, must not only pay for staff to process bills, medical records and other paperwork, but also to coordinate your care with other health care providers. Your employer, likewise, pays for staff to manage the company's health insurance plan and deal with changes in enrollment, billing problems, and so forth. Some activities that fall into the category of "administration" may add value to health services. Employers may sponsor prevention and wellness programs designed to increase the effectiveness or efficiency of health care in various ways. Insurance carriers and health plans spend part of their budgets on developing and marketing new products. These are part of the costs of doing business in a competitive market.

There is no agreement on what exactly administrative costs are or should be, and estimates of how much is spent on them vary considerably [57]. For example, the administrative costs for 232 Medicare managed care plans ranged from 3 percent to 32 percent of total costs in 1999, according to the Office of the Inspector General of the Department of Health and Human Services [58]. Administrative costs for the Veterans' Health Administration (VHA) were 14 percent of the agency's FY 2005 budget [59]. Another insight about administrative costs can be found in the formula that the Medicare program uses to pay physicians. It uses an estimate of physicians' medical practice expenses, which include employee wages, office rent, and supplies and equipment [60], as well as the costs of professional liability insurance, to set payment rates. Together, practice expenses and liability insurance account for about 48 percent of Medicare's annual payments to physicians [61].

About 8 percent of total national health spending in 2004 went toward administrative costs and profits of insurance companies, plus the costs of running government programs, such as Medicare and Medicaid. This does not include the administrative costs of doctors, hospitals, and other health care providers [122]. Private insurers may pay about three times more in administrative costs than Medicare [62]. However, private insurers may use some of this money to provide programs like disease management or consumer education programs that government insurance does not offer. Some experts believe, in fact, that government programs may not spend enough on administration; greater investment in administration might help public programs such as Medicare be more efficient and provide better service, reduce errors, or identify fraud and waste [63].

Waste, fraud and abuse

One approach to reducing spending is to try to eliminate waste. Sometimes we get more care than we need because we, or our doctors, are not sure what is best, and we would rather err on the side of caution (issues related to overuse of care are discussed under Quality Shortcomings). But it is also important to consider whether a less expensive type of medical test can be substituted for a costly one without causing harm, or whether the price of certain services is unnecessarily high.

Preliminary estimates for 2005 show that the Office of Inspector General's efforts to reduce waste in government health programs will recover $15.6 billion of fiscal year 2005. In addition, audits to uncover fraud and abuse are expected to recover an additional $1.4 billion [66].

We all feel the burden.

Increasing health care costs affect every aspect of our economy, from the individual level to all levels of business and government.

Individuals

Across America, people are feeling the effects of rising health care costs in different ways:

- **Problems paying for any care at all** – Some people simply can't afford to pay for health care. Hospitals, clinics, doctors, nurses, dentists, and pharmacists are seeing an increasing number of people who seek care but are unable to pay for it [67]. People may also have to cut corners by doing without the prescription drugs, physical therapy, or medical supplies they need. If employees have to pay more for their health insurance coverage through their employers, many low-income workers may turn down this coverage and instead go without insurance, joining the ranks of the uninsured [70]. As discussed earlier in this report, people without insurance may postpone preventive care. They may gamble on not getting sick or being injured in accidents that might require expensive medical care. When they do need and receive care that they are unable to pay for, everyone from health care providers and taxpayers to people with insurance shoulder the costs.
- **Obstacles to getting the care they need –** As health care providers spend more on medical equipment, supplies, and personnel (including the costs of providing health insurance to health care workers), some reduce costs by providing less charity care to people who can't pay [67]. Even if they do serve these patients, it may become increasingly difficult to obtain referral and specialty services, equipment, and prescription drugs for uninsured patients; some people may not be able to get the care they need [68].
- **Pressures on household finances –** As a whole, Americans spent two months' worth of their earnings on health care in 2003. In another 10 years, health care spending could eat up another week's earnings, leaving less money for housing, food, and transportation.

Health care providers

Even with governmental support and private insurance, many providers are still left with unpaid bills. In 2001, it was estimated that people who were uninsured or were unable to pay the full costs of their care used about $35 billion in services that neither private nor public insurers paid for [69]. Part of the cost is reimbursed by public programs, but much is passed, or "shifted," to consumers through higher costs for services or higher insurance premiums.

Businesses

Employers are finding it increasingly difficult to carry the burden of offering insurance to their workers and their dependents. As a result, they may:

- Experience decreasing profits and offer fewer wage increases.
- Raise the prices of the goods and services they offer, increasing costs for consumers.
- Ask their workers to pay a higher dollar amount of rising health insurance premiums.
- Shift jobs overseas to decrease their labor costs.

Government

If health care spending continues at its current pace, our national debt could continue to increase:

- Currently, 19.6 percent of all federal spending goes toward the two largest federal health care programs, Medicare and Medicaid. State governments are also feeling the pressure of soaring health care costs [45].
- If health care costs continue to grow as they have, all of the growth in the economy will go toward health care by 2051 [45], leaving no resources for expansions in other areas.

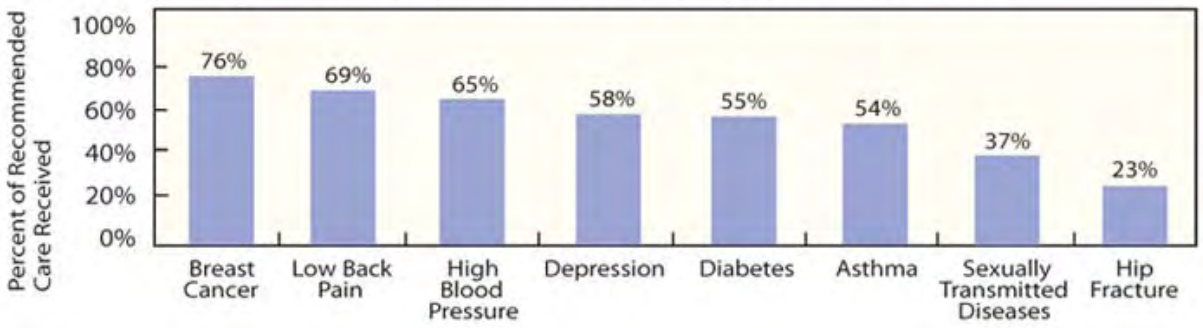
Underlying these trends is the coming impact of the Baby Boom generation. When the Boomers – people born just after World War II – reach age 65 (starting in 2011), the number of people enrolled in Medicare will double [48]. As discussed in Section II of this report, people between ages 65 and 85 need more health care services and incur more health care-related expenses.

IV. Quality Shortcomings

Our care doesn't always meet medical standards.

Most Americans are generally healthy and satisfied with their care. In 2002-2003, 85 percent of Americans reported being in “excellent”, “very good” or “good” health [71], and about half of Americans say they are “very” or “extremely” satisfied with the health care they have received in the past two years, according to a recent national survey [72]. However, some Americans don’t always get the care they need. In fact, adults get, on average, only 55% of the recommended care for many common conditions [2]. Examples of the percent of recommended care that individuals receive for some common health conditions are shown in Figure 7.

Figure 7:
Adults Receive Only Some of the Recommended Care for Many Common Conditions



Source: McGlynn, et al., New England Journal of Medicine, 2003

Underuse and overuse

Striking the right balance between too much and too little care is a great challenge. Vaccines, colonoscopies, complete preventive care for diabetes, treatment for depression, and medicines to prevent additional heart attacks are all underused – that is, not everyone who should receive these health care services actually receives them [73-76].

On the other hand, some health care services are used too much. Too many patients take antibiotics that will not help them when they have colds and other viruses, some surgeries have questionable benefit, and some physician visits are not needed [2, 77, 78].

Some medical services are used much more frequently in some areas of the United States compared to other regions of the country. This disparity may be due to the overuse of some types of care. For example, Medicare pays for more care per beneficiary in Miami than it does in Minneapolis [79]. However, there is no evidence that the patients in regions where they receive more care have better health outcomes or that they are more satisfied than others who receive less care at less cost [80, 81]. This means that we may be able to get the same results using less of some forms of health care and spending less money.

Medical errors

There are also serious concerns about safety and preventable errors that occur in the health care system. The Institute of Medicine has estimated that between 44,000 and 98,000 people die every year as a result of medical errors – that’s more than the number who die every year from car accidents, or breast cancer, or AIDS [5]. Studies in the states of Colorado, Utah, and New York have all estimated that medical errors occur in 2-4 percent of hospitalizations [82-84].

- Some medical errors are serious enough to keep a patient in the hospital for up to 11 extra days, and the added expense may be as large as $57,000 per patient [85].
- Up to 7,000 patients die in a given year as a result of medication errors alone [86].

Spending vs. outcomes

In the United States, we're simply not getting the biggest "bang for our buck." The United States spends at least $1,800 per person more on health care than any other developed country, but our health outcomes are not always better than in the countries that spend less.

It is difficult to compare health care across different countries, because there are factors like environmental, cultural, economic, and population differences that can affect health and longevity. However, a recent study compared health care quality in five countries that share a lot in common in cultural and economic history (Australia, Canada, New Zealand, the United Kingdom, and the United States). It focused on 21 different measures, including:

- Survival rates for serious diseases;
- Avoidable health events and outcomes (such as cases of measles, suicide, and deaths from asthma); and
- Prevention efforts, including vaccination rates and cancer screenings

While the United States scored highest on four measures of quality of care, it was ranked second or third for 10, and last on five measures [4]. For example, the United States was the only nation among the five to have an increase in the national death rate for asthma in recent years. Overall, the U.S. ranks 29th in the world for "healthy" life expectancy, a measure that indicates not just how long people are expected to live, but also how much of that life span is expected to be spent in good health [87].

End-of-life care

The "too much, too little" challenges in our health care system are perhaps best highlighted in end-of-life care. For many Americans, this care can be expensive, of poor quality, fragmented, and often does not reflect the wishes of those who are dying and their families.

For example:

- More than half of Americans say that being able to be at home when dying is important, but only 15 percent of Americans die at home [8].
- 93 percent of Americans believe that being free of pain is important, but only 30 to 50 percent achieve this objective [8].

In many cases, doctors do not know with any certainty when a patient is going to die; it is not always possible to plan a "good" death at home [8]. However, the problems surrounding end-of-life care reflect some of the structural problems in the way we deliver and pay for medical care. The American health care system is better geared toward treating acute conditions [88]; as a result, many dying patients undergo medical interventions they may not need or want.

Insurance rules also limit access to the right kind of care for the dying. For example, Medicare limits enrollment in hospice services to those certified as being expected to live less than six months, a prognosis that is difficult to make, and which excludes patients who may be near death for longer than this arbitrary time frame.

Another reason the American health care system is ill-equipped to facilitate a "good death" is poor communication between patients and doctors in the last year of life [89]. And, because the needs of the dying straddle different care providers and health care settings, coordinating care among hospitals, nursing homes, home health agencies, and family members can be very difficult. If this coordination falters, patients might be faced with interpreting different diagnoses, using services and processing information on their own. In addition, there is a shortage of caregivers, both paid and unpaid, and critical non-medical assistance, like helping patients get their affairs in order, is often absent. [90]

It has been estimated that last-year-of-life expenses constitute 22 percent of all medical expenditures. Changing the way that this care is delivered may not necessarily reduce these costs, because high-quality care that effectively manages pain and serious physical and mental impairment can be expensive [91], but it would be an important step in getting better value from

our health care system, and better assuring ourselves humane and respectful assistance at the end of life.

Disparities are pervasive.

The American health care system gets poor marks for ensuring quality care across racial and ethnic lines. According to the 2005 *National Healthcare Disparities Report*, there is consistent evidence of differences in quality of care and health outcomes related to race, ethnicity, and socioeconomic status. The report found that, among the quality measures evaluated:

- African Americans received poorer quality of care than whites for 43% of the quality measures used.
- Asians received poorer quality of care than whites in about 20 percent of the quality measures used. American Indians and Alaskan natives received poorer quality of care than whites in almost 40% of the measures.
- Hispanics received lower quality of care than non-Hispanic whites in a little more than half of the quality measures used.
- People below the poverty line received lower quality of care in 85 percent of the quality measures used [39].

Reasons for these disparities are varied. Factors such as education and insurance coverage are intertwined with ethnicity and poverty. Poor communication between patients and providers can also lead to inappropriate care or unfavorable outcomes. For example, one study found that doctors were less likely to engage African American patients in conversation, and the tone of visits with African American patients generally was less friendly than with white patients [92]. Because more active participation of patients in conversations with their doctors has been linked to better treatment compliance and health outcomes, this could indicate that poor doctor-patient communication may be partly to blame for some racial disparities in health care.

V. Access Problems: Not Getting the Health Care You Need

"Hurricane Katrina has exposed another major weakness in our health care system. That is, our inability to assure even the basic needs related to health care are available to individuals and families who have been displaced from their communities and relocated all across the country."

— Aaron Shirley

Getting the right care at the right time is not just an issue of cost. Sometimes, the greatest challenge to patients isn't accessing good care – it's obtaining any care at all. Affordability is key, but other factors come into play, including the availability of physicians and other health care professionals, hospitals and other health care facilities, and also people's ability to get to these services, and to be treated appropriately when they get there.

Availability of services

While most Americans get health care when they need it, the availability of services varies a great deal across the country. Shortages of health professionals or facilities can occur because there are not enough people to support full-time medical practices, or even if there is a large enough population, people may have insufficient financial resources or insurance coverage to support providers' practices. The lower rates (compared to Medicare or private insurance) that state Medicaid programs pay physicians could also limit people's ability to find doctors [93].

In Mississippi, for example, more than half of the doctors are located in four urban areas in the state. In the rest of the state, including most of the rural, low-income areas, there are few, if any, doctors. Only 11 of 82 counties in Mississippi have enough doctors to meet the Council on Graduate Medical Education's standards, and about 1 million people (one-third of the state's population) live in counties that are classified as "underserved" [94]. But even when there are doctors and clinics in an area, people may not be able to get to them because of physical or financial challenges.

In some areas of the country and among some specialties, medical malpractice issues are contributing to access problems. Some doctors are choosing not to practice or not to care for the sickest patients because malpractice premiums and their perceived risk of being sued are higher [65]. Although malpractice legal costs and payments represent less than half of one percent of total health spending in the U.S. [64], for some doctors, fear of malpractice suits and the high cost of malpractice insurance are causing great concern [65].

Continuity of care and convenience

Although most Americans have a usual place to go to for health care, more than 15 percent of us don't. Young adults and Hispanic Americans in particular are less likely than others to have a usual place to go for medical care [22]. Being a "nomad" in the health care system can mean diagnoses are missed, chronic conditions left unmanaged, and services duplicated, resulting in poorer health outcomes.

People without a regular place to go for care may rely more on hospital emergency departments (ED) for non-urgent care. Frequent use of EDs could also signal problems with the availability of routine health care services in the community.

- About 30 percent of all ED visits are for problems which are not urgent [95].
- Between 1993 and 2003, the rate at which Americans used EDs increased by about 26 percent [95].
- The rate of ED use among African Americans in 2003 was 89 percent higher than for whites but only slightly more likely to be for non-urgent problems [95].
- The rate of ED use among Medicaid recipients was higher than for people with private insurance, Medicare, or no insurance coverage at all, and also somewhat more likely to be for non-urgent problems [95].

Another part of good access to health care services is ensuring ease of use. Not being able to get appointments when you need them, enduring long waiting times for visits, or not getting information about test results can all create barriers to getting the right care. All of these factors can contribute to disparities in access to care, just as they can to disparities in quality. The 2005 *National Healthcare Disparities Report* found pervasive differences in access to care across racial, ethnic and economic lines:

- African Americans had worse access than whites in 50 percent of the access measures used.
- Asians had worse access in a little more than 40 percent of the measures used. American Indians and Alaskan natives had worse access in half of the measures.
- Hispanics had worse access in about 90 percent of the measures.
- People below the poverty line had worse access to care in 100 percent of the measures used [39].

Millions don't have coverage.

"My son was born prematurely. He stayed in intensive care for six weeks. We didn't have health insurance, so not only were we very worried about this sick baby, but we were worried about how we were going to pay for this. The bill was far more than what we would make even in a year. My son, who was later diagnosed with cerebral palsy, required 24-hour care the entire time he was growing up and was often very sick. I spent my days at home with him while my husband worked at the auto body shop. I waited tables at night to make ends meet."

– Deborah Stehr

For most Americans, the overriding threat to getting the care they need is being able to pay for it. In 2004 245.9 million people had some form of health insurance coverage and in 2005 247.3 million people had some form of health insurance coverage. While the number of people with health insurance has increased the number without health insurance has also increase from 45.3 million people in 2004 to 46.6 million in 2005. [52]. Affordability is a powerful determinant of insurance status for adults. For some of us, the costs of needed medical care could lead to financial ruin. This is partly because an increasing number of Americans lack any type of health insurance. In addition, an increasing number have insurance that provides limited coverage that increases their out-of-pocket expenses.

What is health insurance?

In the United States, health insurance often covers a blend of predictable and unpredictable kinds of health care. As such, many people draw small amounts from the pool of insurance dollars every year, a few draw large amounts every year, and others draw large amounts just a few times over their lifetimes.

It helps to think of health insurance in the same way you think of other kinds of insurance, like homeowners' insurance, but there are important differences. People know that there is only a small risk that their house will burn down, but they buy insurance every year so that they are protected if the unthinkable happens.

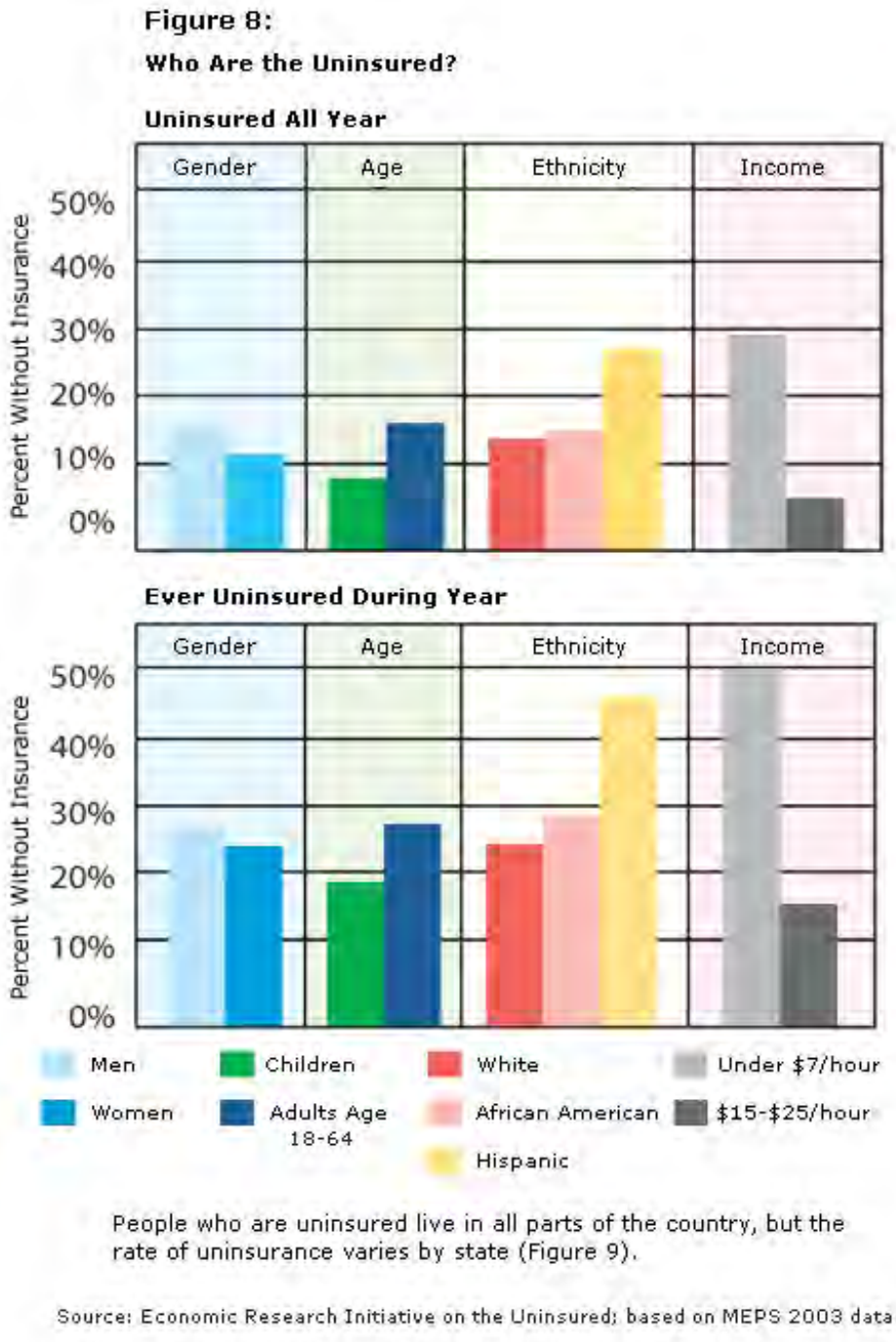
Some health problems—for example, injuries from car accidents or having a premature baby—do not occur very often but can cost hundreds of thousands of dollars when they do. Just like homeowners' insurance, when a lot of people buy health insurance, the costs for these rare, expensive events are spread out over the large group of people who bought policies, reducing the cost to the unlucky few who actually need the help in a given year. In this way, health insurance is a transfer of money from those who don't get sick or injured this year to those who do. The people who need care vary from year to year. Most of us will receive funding from that pool of money at some point during our lives.

In contrast, however, some health care costs are routine and predictable, like annual physical exams or teeth cleaning, or medicines to treat chronic diseases. When the need for care is more

predictable, people often think of insurance as a prepayment for something they are pretty sure they will need to use on a regular basis. If people decide to buy health insurance only when they know they are likely to need it, the costs can't be spread out among policyholders, because everyone is using services, and the costs of policies can become high.

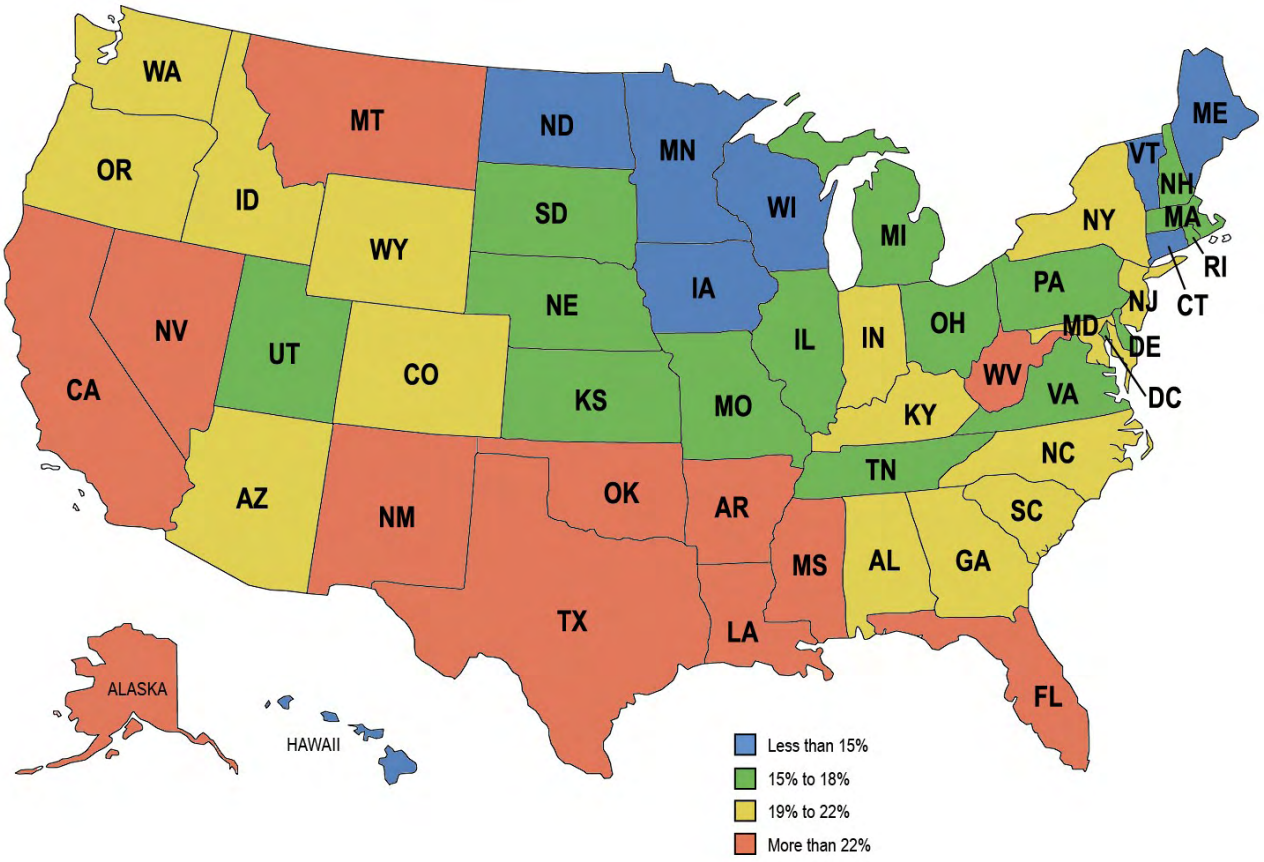
People who do not qualify for employer-based health insurance or public health insurance like Medicaid and Medicare may buy a health plan on their own through a private insurance company. However, the individual health insurance market is still relatively small and premiums often are prohibitively expensive (several hundred dollars a month or more). In most states, insurers can charge more or refuse to cover people with pre-existing medical problems.

Estimates of the number of uninsured Americans are measured in different ways. As stated earlier, 46.6 million Americans lacked health insurance at a point in time in 2005[52]. Yet, one national survey conducted in 2004 estimated that over 51.6 million Americans experienced a spell of "uninsurance" over a one-year period [96], and 29 million had been uninsured for more than a year [96]. Hispanics, non-citizen immigrants, and self-employed adults are more likely to be uninsured over an entire year. [9] (See Figure 8).



People who are uninsured live in all parts of the country, but the rate of uninsurance varies by state (Figure 9).

Figure 9
Percent of People* Uninsured Varies From State to State, 2003-2004



* Adults age 19-64.
Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

The likelihood of having insurance also is affected by the following factors:

- **Type of employment** – The likelihood that a person or family will be covered through an employer depends on the kind of job the employee has and the size of the firm in which they work. Employers in the service and retail industries are less likely to offer health insurance coverage. Employees working in these industries also pay more in premiums than employees working in goods-producing industries. Only half of firms in the Mountain region (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming) offer coverage, whereas three out of four firms in the East North Central region (Illinois, Indiana, Michigan, Ohio, and Wisconsin) do [97].

  Even though most adults with health insurance obtain it through an employer, many people who do work are uninsured. In fact, two out of three people who are not insured are in a family with one or more full-time workers. Three out of four are in families with incomes greater than the poverty line [9]. Many simply cannot afford health coverage when it is available, and some choose not to buy it (Figures 10, 11).

- **Health status** – Pre-existing health conditions affect whether people can get health insurance and how much they pay for it. Private insurers will often not sell to or will require very high premiums from individuals with pre-existing health problems. Many jobs have six

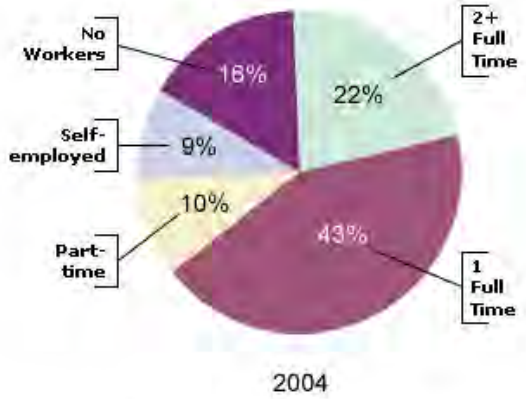
month or longer waiting periods before the insurance will cover any pre-existing conditions, and some insurance plans charge higher rates for all care related to pre-existing conditions.

- **Age** – Young adults are less likely than people ages 35 to 54 to enroll in a health plan offered by an employer or to work for a firm that offers one [9]. Although large employers (200 or more employees) are more likely than smaller ones to offer retiree health benefits, the percentage of large firms offering such benefits has dropped from 66 percent in 1988 to 33 percent in 2005 [46].
- **Ethnicity** – Hispanics are three times as likely as whites to be uninsured [9].
- **Eligibility for public programs** – One-fourth of children in families below the poverty line are without insurance, but only 8 percent of children below the age of 6 are without coverage, reflecting to a large degree their eligibility for Medicaid or SCHIP.

Figure 10:
Many Uninsured Are Not Poor

Source: Economic Research Initiative on the Uninsured, 2006

Figure 11:
Most Uninsured Are in Working Families



Source: Economic Research Initiative on the Uninsured, 2006

(Note: percentages may not add up to 100% due to rounding)

Sudden changes can eliminate coverage

Just as we are all at risk for developing sudden health problems, it can be difficult to predict when someone might lose their health insurance coverage. Even with existing protections provided by federal law, people can lose insurance coverage for several reasons:

- A change in their firm's benefits policy or a job change;
- The worsening of a chronic condition or the onset of a new illness or serious injury;
- A small increase in income or a change in marital status, which can cause people covered by Medicaid to lose their eligibility.

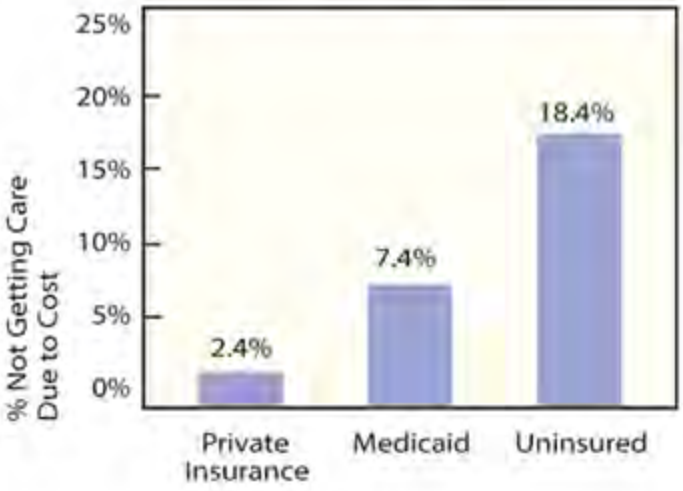
Sometimes the very things that cause us to need services may diminish our ability to pay for them. For example, when people develop diseases such as cancer or diabetes, get into serious car accidents, or give birth to babies who need special care, they may become unable to hold a full-time job, losing employer-sponsored health insurance as well as income.

No insurance = less care and more problems

- While most Americans are able to get the care they need, people who are sicker, have lower income, have less education, and who do not have health insurance are more likely to delay care or fail to get care altogether because they cannot afford it [10].

- In 2004, about one in 20 Americans reported that costs prevented them from obtaining needed care, and this proportion has been growing since 1998.
- Uninsured Americans are nearly eight times more likely than Americans with private health insurance to skip health care because they cannot afford it (See Figure 12).
- Half (49 percent) of uninsured adults with chronic health conditions go without health care or prescription medicines they need because of cost [98].
- Seniors who bear more of the cost of their health care use fewer services, sometimes resulting in poorer health [99].

Figure 12:
Costs Pose Barriers to Care for Uninsured*



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, 2003
*People under age 65

Not getting care when it's needed can cause serious health consequences. A recent study found that, of people who get into car accidents, those who are uninsured receive 20 percent less treatment and are more likely to die from their injuries than people with health insurance coverage [100].

If you do not have health insurance and need medical care, you also may experience other problems. Getting sick may cost you your job, and if not, you may lose many days of work and experience reduced productivity. This adds to the cost burden for our country's health care system; for example, it is estimated that indirect costs for people with diabetes amount to $40 billion a year; for those with arthritis, indirect costs are over $86 billion a year [101, 102].

It could be anyone - even you.

Even if you do have a health insurance plan, you might not necessarily have adequate coverage. In general, "underinsurance" refers to the lack of coverage for different types of needed care that someone will not purchase without financial assistance.[2]

[2] It is very difficult to define an adequate coverage, since it reflects both a person's need for and ability to pay for different services. Further complicating matters, a person's perception of his or her ability to pay is influenced by lifestyle and values. What is offered here is a general definition.

Common examples of services for which people tend to lack adequate insurance include various kinds of preventive care, mental health care, prescription drugs, and physical therapy. Policies that do not provide generous coverage for services that may be expensive but very important may also be seen as underinsurance, particularly for low-income families. For example, a policy with a $5,000 deductible or a 20-percent co-payment could result in bills of several thousand dollars for even a short hospital stay, which might be difficult for a typical low-wage worker to afford.

And, if you do have adequate health insurance, there's no guarantee your coverage will continue. The millions of Americans who move in and out of health insurance coverage each year illustrate the fact that even those with coverage have no guarantee that coverage will continue indefinitely.

VI. What is Being Done?

"I think we've got to watch out that we don't throw out the baby with the bathwater here in dealing with American medicine."

– Frank Baumeister

As we have discussed, there are serious problems with America's health care system: sharply rising costs, unreliable quality, and gaps in access to affordable health care – all of which pose certain risks to every American and the country as a whole. But as Frank points out above, we can build on what works well to find health care that works for all Americans.

Cost, quality, and access are not independent of each other. Our health care system is a lot like our natural environment – an "ecosystem," in which any significant change in one area has ripple effects throughout the others.

Comprehensive approaches.

In our work to date, we have heard about efforts by states, communities, and large health care systems to deal with the interrelated health system issues of cost, quality, and access. The preliminary hearings we held around the country taught us about interesting examples. These are not the only examples but they illustrate both the complexity and the challenges involved in improving health care. Such programs require ongoing financial commitment and administrative expertise across a number of organizations. Further, the programs we heard about are new, so we do not know yet how well they will work over the long-term. Because these programs were designed to work in specific localities, we do not know whether the programs would fit, or work successfully in other areas or communities. Nevertheless, they represent important examples of the types of initiatives we must learn from to arrive at measures to improve the larger health care system.

Dirigo Health. Through legislation enacted in 2003, the state of Maine is attempting to deal with the intertwined issues of cost, quality and access. Their plan illustrates how the issues are interconnected.

To increase access, Maine has expanded its Medicaid program and developed a new insurance product, Dirigo Choice, targeted to small businesses, the self-employed and eligible individuals. Employers pay 60 percent of costs and monthly premiums and deductibles for people with incomes below 300 percent of the Federal Poverty Level are discounted. These subsidies are financed in large part by savings resulting from cost control measures and from reductions in health care providers' bad debt and charity care.

The Maine Quality Forum functions as a quality watchdog providing more information to citizens about costs and quality. It also will adopt quality and performance measures and promote evidence-based medicine and best practices.

To control costs, capital expenditures for hospitals and ambulatory surgical centers and doctors' offices across the state have been put on a budget, and spending on new technology in these settings is highly regulated.

Ascension Health, a large non-profit health system, has initiated several collaborations between its partners and local communities to improve care and access for the uninsured. Twelve partnerships already exist around the country; each works to improve access through five steps:

1. Creating a community network to exchange patient health information electronically;
2. Filling in gaps in the existing safety net, especially regarding mental and dental health;
3. Improving the coordination of care for the uninsured;
4. Recruiting physicians to voluntarily provide primary and specialty care for uninsured patients; and
5. Achieving sustainable funding to support these activities. Ascension Health has already provided $7 million to these community partnerships in matching grants.

Targeted approaches

We also heard about other programs that are more narrowly focused. For example, some are designed specifically to control health care costs; other approaches focus on quality improvement; and still others concentrate on improving access to primary care services or expanding health insurance coverage to a greater number of people. While the goals of these programs might complement each other, they can be quite different in design and implementation. In addition, strategies that lead to lower insurance costs or more insurance coverage for some people might lead to higher premiums for others, or to higher public spending.

Controlling health care costs

Several initiatives have been designed by Medicare, Medicaid, private insurers, health plans, and employers to control system-wide costs. These strategies work in one of three ways: by influencing the amount of health care services we use, the types of services we use, or the price of those services.

Although what is considered "discretionary" or "unnecessary" is frequently subject to debate, some insurers limit the use of certain services sometimes by giving patients and doctors financial incentives to reduce their use. The rationale behind this approach is that some health care services are overused and do not contribute to better health:

- Some insurance plans and employers have increased the amount that patients must pay out of pocket for care that might be considered cosmetic or otherwise not medically necessary. The goal is to make patients aware of the costs and enable them to purchase their health care on a more informed basis.
- Both public and private insurers have placed limits on coverage for some types of medical equipment, such as certain motorized chairs or scooters, or on the number of new eyeglasses that will be covered in a year. Limits also may be placed on the number of nursing home beds or magnetic resonance imaging (MRI) machines that are allowed in an area. Some insurers pay specific types of providers a fixed amount for each patient independent of the number of services used, putting pressure on them to reduce the services offered.

A small but growing number of employers are changing insurance coverage in an effort to give employees more financial stake in choosing their care. Health savings accounts (HSAs) and other high deductible options are prime examples. In HSAs, employees can set aside a fixed amount of money, tax free, to pay for their health expenses; they get to keep what they don't spend and use these funds to pay for health care the next year. Both HSAs and other high deductible health plans that do not have this savings feature require employees to pay for the first $1,000 or more of their health care costs each year before their health insurance covers the rest.

Because employees have to pay for all their care out-of-pocket until they reach the deductible, they may be less likely to use some health services. Shifting costs to employees also means that people with more health care needs will have significant out-of-pocket costs. Further, if those who sign up for these high deductible plans are mostly healthy people with limited health care expenses, their premiums will remain low, while sicker people in conventional plans may have to pay higher premiums. HSAs could, therefore, reduce health care costs for some people, while increasing costs for others.

Some health plans offer financial rewards to patients and health care providers for using less costly options that may be just as effective as more expensive alternatives under some circumstances. Health plans frequently require patients and health care providers to try less costly treatment options first, moving on to more expensive options only if they are needed. One clear case is health plans that promote the use of generic medicines that are substantially less expensive than the chemically equivalent brand-name prescription drugs. As an example, the brand-name allergy medication Allegra® can cost nearly $90 for 60 pills, but its generic equivalent sells for $38 – less than half of the name-brand price [105]. In 2000, $229 million could have been saved in Medicaid spending if generic drugs had been used more widely.

To encourage people to use generic equivalents of prescription drugs, many health plans require patients to pay smaller amounts out of their own pockets for generics than for brand-name drugs. In fact, many health plans offer "tiered" prices for prescription medicines, in which co-payments or coinsurance are highest for specialty drugs, next highest for brand name drugs, and lowest for generic drugs.

Increasing efficiency: costs and quality

It is not always clear how incentives that affect cost and payment to health care providers affect quality. Some approaches being tried are trying to improve efficiency by decreasing cost and improving quality. For example, "pay-for-performance" programs pay hospitals, physicians and managed care plans more when they provide cost-efficient, high-quality services, such as providing recommended health screenings, or when a high proportion of their patients are satisfied with their care, or receive appropriate care for diabetes or heart disease [1]. Medicare has started a pilot project in which it will pay bonuses to hospitals that have the best performance in the treatment of heart attacks, heart failure, and pneumonia, as well as the top results for heart surgery and hip and knee replacements [1].

The Leapfrog Group, made up of over 170 organizations and companies that buy health care, is working with its members to reduce preventable medical mistakes by rewarding providers for improving affordability, quality, and safety, and providing information to consumers to help them make more informed health care choices [116]. Some public and private insurers have made performance ratings of physicians or hospitals available to the public [104]. Similarly, some health plans have asked consumers to pay more in premiums or face higher co-payments if they choose less efficient or lower-quality health care providers.

Culinary Health Fund provides health insurance to about 120,000 Las Vegas workers who are members of Culinary Local 226 (part of the Hotel Employees and Restaurant Employees International Union) as well as their families. Employees do not pay a premium for coverage – employers pay 100 percent of the cost.

Benefits include a free pharmacy of certain generic drugs as well as low co-payments for physician visits, medical services, and prescription drugs.

To control costs and provide incentives for better quality care, the Culinary Fund has, since 2002, rewarded physicians for providing high-quality care through a pay-for-performance system that uses semi-annual performance assessments that analyzes information on 32 evidence-based quality indicators, and pays bonuses to physicians who provide high-quality care. In addition, Culinary Local 226 and employers work together to negotiate prices with health care providers.

The Fund also requires that pharmacists use generic drugs whenever possible, and steers employees' spending with tiered payment strategies for benefits such as prescription drugs. Generic drugs have the lowest co-pay ($5), covered brand-name drugs listed in the plan's formulary have a $13 co-pay, and covered brand-name drugs that are not listed in the formulary have the highest co-pay of $28. To discourage use of emergency department (ED) care when it is not truly needed, the plan charges a patient making a non-emergency visit to the ED a $125 co-pay plus 40% of the visit's full cost. In contrast, a true emergency visit costs the patient only the $125 co-pay.

Incentives to improve access to care and insurance coverage

States and communities throughout the nation have tried many methods of expanding access to health care. These often aim to help uninsured and underinsured people get the care they need. Some communities have worked on improving access to care by increasing the supply of community health resources, including community health centers, free clinics, and community clinics. Other communities are focusing on giving people with limited access a medical "home,"

developing programs to link patients to primary care providers who can manage their care over time. Still other communities have created provider pools, often called donated care models, which spread the burden of caring for the uninsured or underinsured. There are also various local and regional associations that allow small businesses to buy insurance as a group to obtain insurance for employees.

MetroJackson ChamberPlus. In 1996 the MetroJackson Chamber of Commerce in Jackson, Mississippi created the ChamberPlus program to assist small businesses in providing health insurance to their employees. By combining small businesses into groups, ChamberPlus was able to negotiate much better prices for health benefits than the businesses were able to individually negotiate for themselves.

ChamberPlus has grown from the metropolitan Jackson area to cover 54 other localities in Mississippi. The program covers over 19,000 Mississippians associated with over 1,400 small businesses. Without ChamberPlus, approximately 60 of these businesses could not have afforded to provide health insurance to their employees.

There are several public sector strategies focusing on increasing health insurance coverage. As noted earlier in the report, increased enrollment in SCHIP and Medicaid programs in recent years has been particularly important to maintaining or improving access for children of low-income families. Some states also implemented parental expansion programs, opening up the eligibility requirements for Medicaid. Other states formed insurance pools to help people with high health care costs save money by working together or changed the state laws to help employers create insurance pools that can provide coverage at lower costs. A few states created reinsurance systems, helping private insurers deal with extremely high costs associated with some types of illness and injuries. One state, Hawaii, mandates that employers provide health insurance for all employees who work 20 hours or more per week, and sets out specific requirements for the benefits that have to be included in this coverage, including inpatient hospital care, emergency room, maternity care, as well as medical, and surgical care. These requirements have been in place since 1975 [115].

The public and private sectors have also worked together to create innovative local programs. A limited number of communities have developed and marketed subsidized private health insurance products, usually geared towards uninsured employees of small businesses. The program called Access Health in Muskegon County, Michigan, is an example of one approach (see text box). Although sustainability continues to be a challenge, the Access Health model has generated interest in other parts of the country. Six additional states have passed legislation that would allow similar pilots.

Access Health, established in 1999 in Muskegon County, is a community-developed health plan targeted to the working uninsured. The costs of benefits provided through Access Health are shared roughly evenly between the employer, the employee and the community. Businesses may participate if they are located in Muskegon County, have not provided health insurance for the past 12 months and have a median wage of no more than $11.50 per hour. Annual premiums for an adult now average $1,776, with 30 percent provided by the employer, 30 percent by the employee and 40 percent by the community. The employee share for an adult is $46 per month.

The program offers all services available in Muskegon County including local physician services, in-patient hospitalization, outpatient services, ambulance services, prescriptions, diagnostic lab and x-rays, home health, hospice care and behavioral health. People with pre-existing conditions are not excluded and do not pay higher premiums. There is a strong emphasis on prevention with participants having access to weight reduction programs, tobacco cessation services, aqua therapy and fitness resources. Care received outside the county and certain specialized catastrophic care such as transplants and severe burns are not covered.

Provider reimbursement is on a fee-for-service basis with providers contracting directly with

Access Health. The state of Michigan and the community's two hospitals agreed to allow Medicaid Disproportionate Share funds to help finance the public share of the program.

In 2004, 1,500 people from over 430 businesses received Access Health benefits. Virtually all local physicians participate in the program. Of the businesses eligible for the program, 38 percent participated.

But while local initiatives such as those we have described are attracting national attention, it is important to note that they are tailored to meet local needs, and to conform to the different rules and laws that affect health care and insurance in different states. This makes it hard to predict how well even the most successful initiatives might work in another community, or as a model for more widespread reforms.

Longer-term changes.

We have heard evidence that suggests that, over time, more efficient ways of administering care as well as general improvements in our health could ease some of the pressure on our health care system. Some analyses suggest that as much as 30 percent of all direct health care outlays are the result of poor-quality care, including the overuse or misuse of services, as well as waste [124]. The potential savings are difficult to estimate, and cannot be counted on to solve the growing, interrelated problems that face our health care system. However, investments now could reap substantial rewards in the future, in terms of more efficient health care, or improvements in the quality of life we all seek.

Modernizing care systems

The federal government is working with the private sector on a major initiative to apply information technology (IT) to improve the efficiency of our health care system. Automated and other computer order entry systems can reduce medication errors [86, 106, 107], automated reminder systems can increase the proportion of patients who receive appropriate health care [108], and e-mail communications can offer health care providers quicker access to information, clinical advice, and test results. This public-private collaboration is focusing on making it possible to safely share medical information among doctors, clinics, and hospitals located across the country [111].

New initiatives now being tested suggest that the benefits, including better care coordination across settings and providers, improved communication with patients, and reduced medication errors and duplicate diagnostic tests, could be substantial once the IT advances are fully implemented. A recent study by the Rand Corporation concludes that the widespread use of interconnected health information technology systems could save the nation's health care system $162 billion a year. However, that would depend on successful development and adoption of the new systems, and that has not proven easy to do [113]. The costs of introducing new information technology systems are initially high, and the organizations that have to put up the initial investment costs, such as doctors and hospitals, are not necessarily the one who harvest all the savings. Investing in a National Health Information Network is estimated to cost $156 billion over 5 years, and $48 billion in annual operating costs [109]. For now, it is difficult to predict the net effects of these new systems on health care costs overall.

Evidence from hospitals and health care systems that have developed programs designed to reduce medical errors have shown promising results. For example, having a pharmacist participate in patient rounds reduced preventable adverse drug reactions by 66 percent, while several new formalized systems for administering antibiotics decreased infection rates by over 90 percent. In addition, team training in labor and delivery reduced adverse outcomes in pre-term deliveries by half [110]. The future and expanded use of telemedicine could enable patients in underserved areas to receive expert care by well-trained specialists.

Health promotion and disease prevention

One way to reduce the amount of health care we need might be to take better care of ourselves. For many of us, better diets, exercise, or not smoking could reduce the need for some kinds of health care. Nearly two-thirds of American adults are overweight or obese [6]. Unhealthy lifestyles contribute to this statistic. Not everyone is able to exercise regularly, but many of us who are able to don't. Nearly 40 percent of adults are not physically active during their free time, and 1 in 3 high school students do not get the recommended amount of physical activity [41]. Lack of exercise is just one lifestyle habit that can increase the risk of certain diseases, such as heart disease or stroke.

Programs that are appropriate for a person's age and physical condition can encourage physical activity, healthy eating habits, and discourage smoking. Health plans and insurers have developed specialized programs for people who develop heart disease, diabetes, high blood pressure, osteoporosis, and certain types of cancer – some of the more costly diseases to treat. Many employers are also sponsoring wellness programs that help employees adopt healthier lifestyles. In 2005, almost one fourth of all employees in private industry in the United States had some form of wellness program available to them at work [103]. Disease prevention, which includes immunizations and screening to detect problems early when they can be treated more effectively, is particularly important for children, and can significantly improve health outcomes and quality of life associated with a variety of medical conditions.

However, because our health care system includes a lot of different health care providers and insurers who are often working independently of each other, it is difficult to identify how prevention or health promotion will affect health costs. For example, when a health plan does a good job of helping patients with diet or exercise, or with managing chronic conditions, the savings –from heart attacks or strokes or diabetic complications that don't happen – may not be seen for many years. By then, the patients may no longer be in that health plan (because they have changed plans, or become eligible or Medicare, or become uninsured). And, whether health promotion or disease prevention programs reduce total system costs remains unclear. If preventing disease or reducing its severity or practicing better health habits allow us to live longer, we still may not spend any less than if we were less healthy and had shorter lives [117].

The road ahead.

The work that the Working Group has examined reinforces the conclusion that we need to address the entire health care system, not just specific problems in cost, quality, or access, no matter how urgent they may seem from our different perspectives. Ideally, savings gained from improving efficiency and quality in the system can be used to make other needed changes. Some proposed health care initiatives can keep the amount and type of some health care services we receive the same, while controlling costs and improving quality. But we also can see that none of the initiatives that we have reviewed can provide all the answers to our health care system's problems. We need to engage all of you in a search for broader solutions. Our work is just beginning.

References

1. Centers for Medicare & Medicaid Services, Department of Health and Human Services. (2005, January 31). *Medicare "Pay for Performance (P4P)" Initiatives*.

2. McGlynn, E.A., et al. (2003). "The quality of health care delivered to adults in the United States." *New England Journal of Medicine*, *348*(26), 2635-2645.

3. Docteur, E. (February 8, 2005). "Other countries, other worlds: US health spending in an international context." PowerPoint. *My Health Is Your Business: Emerging Issues Forum*. Raleigh, NC. Retrieved September 26, 2005 from http://www.ncsu.edu/iei/docs/EIF_Docteur_2005.ppt

4. Hussey, P.S., Anderson, G.F., Osborn, R. et al. (May/June 2004). "How Does the Quality of Care Compare in Five Countries?" *Health Affairs, 23*(3), 89-99.

5. "To Err Is Human: Building a Safer Health System." (2000). Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Eds). Washington, DC: Institute of Medicine, National Academy Press.

6. National Center for Health Statistics, Centers for Disease Control and Prevention (2005). *Health, United States, 2005 With Chartbook on Trends in the Health of Americans* (DHHS Publication No. 2005-1232). Washington, DC: U.S. Government Printing Office.

7. Hoover, D., Crystal, S., Kumar, R., et al. (2002). "Medical expenditures during the last year of life: Findings from the 1992-1996 Medicare current beneficiary survey." *Health Services Research*, *37*(6), 1625-1642.

8. Christakis, N. (2005). *Presentation to Citizens' Health Care Working Group,* in *Health Care for All Americans*. Boston, MA.

9. Economic Research Initiative on the Uninsured (2005). *Fast Facts Tables*.

10. Schiller, J., Adams, PF., Coriaty, Nelson Z. (2005). "Summary health statistics for the U.S. population: National Health Interview Survey, 2003." National Center for Health Statistics, *Vital Health Stat,10*(224).

11. Sager, A., Socolar, D. (2005). "Health costs absorb one-quarter of economic growth, 2000-2005: recent federal report unintentionally obscures massive rise; physicians' decisions key to controlling cost." *Data Brief* (8). Boston: Health Reform Program, Boston University School of Public Health.

12. Centers for Medicare & Medicaid Services, Office of the Actuary. (2006). *National Health Expenditures Projections: 2005-2015*.

13. Hamilton, B.E., Martin, J.A., Sutton, P.D. (November 23, 2004). "Births: Preliminary Data for 2003." *National Vital Statistics Reports*, *53*(9). National Center for Health Statistics, Centers for Disease Control and Prevention.

14. National Institute on Deafness and Other Communication Disorders, National Institutes of Health. *Statistics about hearing disorders, ear infections, and deafness*. Retrieved July 26, 2005 from http://www.nidcd.nih.gov/health/statistics/hearing.asp.

15. National Center for Health Statistics, Centers for Disease Control and Prevention. *Fast Stats A to Z*. Retrieved from http://www.cdc.gov/nchs/fastats/Default.htm.

16. National Center for Health Statistics, Centers for Disease Control and Prevention (2002). *NCHS Data on Injuries*. Retrieved July 26, 2005 from http://www.cdc.gov/nchs/data/factsheets/injury.pdf.

17. National Center for Health Statistics, Centers for Disease Control and Prevention (2005). *Unpublished analysis from the National Health and Nutrition Survey, 2002*.

18. American Cancer Society (2006). *Cancer Facts and Figures 2006*. Atlanta: American Cancer Society.

19. Borger, C., et al. (February 22, 2006). "Trends: Health Spending Projections Through 2015*: Changes on the Horizon." Health Affairs Web Exclusive*.

20. National Center for Health Statistics, Centers for Disease Control and Prevention (2003). *Unpublished Analysis from the National Health Interview Survey*.

21. Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (2002). *Unpublished analysis from the Medical Expenditure Panel Survey*.

22. National Center for Health Statistics, Centers for Disease Control and Prevention (August 1, 2005). *Fast Stats A to Z: Therapeutic Drug Use*. Retrieved from http://www.cdc.gov/nchs/fastats/drugs.htm

23. National Center for Health Statistics, Centers for Medicare & Medicaid Services, Office of the Actuary (2003). *National Health Accounts*. Washington, DC; Government Printing Office.

24. Smith, C. (2004). "Retail Prescription Drug Spending In The National Health Accounts." *Health Affairs*, *23*(1), 160-167.

25. Smith, C., et al. (2005). "Health Spending Growth Slows In 2003.*"Health Affairs*, *24*(1), 185-194.

26. Rogers, S. and H. Komisar (May 2003). *Who needs long-term care?* Retrieved July 6, 2005 from http://ltc.georgetown.edu/pdfs/whois.pdf.

27. Centers for Medicare & Medicaid Services. *National Health Expenditure Tables*. Retrieved September 9, 2005 from http://www.cms.hhs.gov/statistics/nhe/historical/.

28. Spillman, B.C. and J. Lubitz (2002). "New estimates of lifetime nursing home use: have patterns of use changed?" *Medical Care*, *40*(10), 965-975.

29. Alemayehu, B. and K.E. Warner (June 2004). "The Lifetime Distribution of Health Care Costs." *Health Services Research*, *39*(3), 627-642.

30. Yu, W.W., Ezzati-Rice, T.M. (May 2005). "Concentration of Health Care Expenditures in the U.S. Civilian Noninstitutionalized Population Statistical Brief #81".*Medical Expenditure Panel Survey*.

31. National Multiple Sclerosis Society. *About MS: Who Gets MS?* (August 12, 2005). Retrieved September 6, 2005 from http://www.nationalmssociety.org/Who%20gets%20MS.asp.

32. United Cerebral Palsy. *Cerebral Palsy - Facts & Figures*. (October 1, 2001). Retrieved September 6, 2005 from http://www.ucp.org/ucp_generaldoc.cfm/1/9/37/37-37/447.

33. Druss, B., Marcus, S.C., Olfson, M, Dincus, H.A. (July/August 2002). "The Most Expensive Medical Conditions in America." *Health Affairs,21*(4), 105-111.

34. Centers for Disease Control and Prevention (February 2003). *The Power of Prevention: Reducing the Health and Economic Burden of Chronic Disease.* Atlanta: Department of Health and Human Services, Centers for Disease Control and Prevention.

35. American Diabetes Association (2005). *Diabetes Statistics for African Americans*. Retrieved June 28, 2005 from: http://www.diabetes.org/diabetes-statistics/african-americans.jsp.

36. March of Dimes (2005). *Babies born preterm cost businesses big money: hospital charges estimated at $7.4 billion annually*. Retrieved July 18, 2005 from: http://www.marchofdimes.com/printableArticles/14458_15365.asp.

37. Agency for Healthcare Research and Quality, Department of Health and Human Services (2005). "Medical Expenditure Panel Survey, 2002." *Unpublished analysis*.

38. Souryal, T., Adams, K., *Anterior Cruciate Ligament Injury.* Retrieved September 26, 2005 from http://www.emedicine.com/pmr/topic3.htm#section~author_information.

39. Agency for Healthcare Research and Quality, Department of Health and Human Services (December 2005). *2005 National Healthcare Disparities Report*. AHRQ Publication No. 06-0017. Washington, DC: U.S. Government Printing Office.

40. Institute of Medicine (1993). *Access to Health Care in America*. Washington, DC: National Academy Press.

41. Bernstein, A., et al. (2003). *Health care in America: Trends in utilization*. Hyattsville, MD: National Center for Health Statistics.

42. Population Division, U.S. Census Bureau (June 9, 2005). *Table 1: Annual Estimates of the Population by Sex and Five-Year Age Groups for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-01)*.

43. U.S. Department of Health and Human Services (2003). *Family Caregivers: Our Heroes on the Frontlines of Long-Term Care*. Washington, DC: Government Printing Office.

44. National Family Caregivers Association (2003). *Prevalence and Economic Value of Family Caregiving: State-by-State Analysis*.

45. Aaron, H.J., MacLaury, B., MacLaury, V. (2005). *It's Health Care, Stupid! Why Control of Health Care Spending is Vital for Long-Term Fiscal Stability*. The Brookings Institution.

46. Kaiser Family Foundation and Health Research and Educational Trust (2005). *Employer Health Benefits 2005 Annual Survey*. Chicago: Kaiser Family Foundation.

47. Congressional Budget Office (February 2005). *Budget Options.* Available from http://www.cbo.gov/showdoc.cfm?:index=6075&sequence=0.

48. The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2005). *The 2005 Annual Report*. Washington, DC: U.S. Government Printing Office.

49. Centers for Medicare & Medicaid Services, Department of Health and Human Services (September 16, 2005). *Medicare Premiums and Deductibles for 2006*. Retrieved September 19, 2005 from http://www.cms.hhs.gov/media/press/release.asp?Counter=1557.

50. Centers for Medicare & Medicaid Services (2003). *Medicaid Enrollment and Beneficiaries: Selected Fiscal Years*. Retrieved from http://www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg34.pdf

51. Centers for Medicare & Medicaid Services (April 2005). *FY 2004 Number of Children Ever Enrolled in SCHIP by Program Type.*

52. DeNavas-Walt, Carmen, Bernadette D., Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Government Printing Office, Washington, DC, 2006.

53. Newhouse, J.P.(1993). "An iconoclastic view of health cost containment." *Health Affairs Supplement,12*, 1524-1571.

54. *Statement of Mark Miller, Executive Director, Medicare Payment Advisory Commission*, in *House Committee on Ways and Means*. 2005.

55. Bureau of Health Statistics, U.S. Department of Labor (September 27, 2004). *Career Guide to Industries*. Retrieved from http://www.bls.gov/oco/cg/cgs035.htm.

56. Anderson, G.F., et al. (May/June 2003). "It's the prices, stupid: why the United States is so different from other countries." *Health Affairs*, *22*(3), 89-105.

57. Aaron, H.J. (2003). "The costs of health care administration in the United States and Canada--questionable answers to a questionable question." *New England Journal of Medicine*, *349*(8), 801-803.

58. Office of Inspector General, Department of Health and Human Services (January 2000). *Administrative Costs Reflected on the Adjusted Community Rate Proposals are Inconsistent Among Managed Care Organizations*.

59. U.S. Office of Management and Budget (2006). *Budget of the United States, Fiscal Year 2007. Appendix, 955-989.* Washington, DC.

60. MacKinney, A.C., et al. (October 2003). "Medicare Physician Payment: Practice Expense." *Rural Policy Brief, 8*(9). Rural Policy Research Institute (RUPRI) Center for Rural Health Policy Analysis.

61. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy.* March 2005.

62. Colombo, F., Tapay, N., (2004). *Private Health Insurance in OECD Countries: the Benefits and Costs for Individuals and Health Systems.* OECD Health Working Papers No. 15.

63. Butler, S.M., et al. (1999). "Crisis Facing HCFA & Millions of Americans." *Health Affairs*, *18*(1), 8 - 10.

64. Anderson, G.F., et al. (2005). "Health spending in the United States and the rest of the industrialized world." *Health Affairs,24*(4), 903-914.

65. Studdert, D.M., M.M. Mello, and T.A. Brennan (2004). "Medical malpractice." *New England Journal of Medicine*, *350*(3), 283-292.

66. Office of Inspector General, Department of Health and Human Services (March 31, 2005). *Semiannual Report*.

67. Lesser, C.S., Ginsburg, P., Felland, E. (2005), *Initial Findings from HSC's 2005 Site Visits: Stage Set for Growing Health Care Cost and Access Problems*. Washington, DC: Center for Studying Health System Change.

68. May, J.H., Cunningham, P., Hadley, J. (2004). *Most Uninsured People Unaware of Health Care Safety Net Providers*. Washington, DC: Center for Studying Health System Change.

69. Hadley, J. and J. Holahan (February 12, 2003). "How much medical care do the uninsured use, and who pays for it?" *Health Affairs Web Exclusive*.

70. Gilmer, T., Kronick, R. (April 5, 2005). "It's the Premiums, Stupid: Projections of the Uninsured Through 2013." *Health Affairs Web Exclusive*, 143-151.

71. Sanmartin, C., Ng, E, Blackwell, D, et al. (2003). *Joint Canada/United States Survey of Health, 2002-2003*. 2003, Health Analysis and Measurement Group/Statistics Canada and National Center for Health Statistics/Centers for Disease Control and Prevention.

72. Helman, R. and P. Fronstin (November 2004). "Public attitudes on the U.S. health care system: findings from the Health Confidence Survey." *Issue Brief No. 275*. Employee Benefit Research Institute.

73. Wells, K.B., et al. (1999). "Quality of care for primary care patients with depression in managed care." *Archives of Family Medicine*, *8*(6), 529-536.

74. National Center for Health Statistics, Centers for Disease Control and Prevention. *Early Release of Selected Estimates Based on Data from the 2004 National Health Interview Survey.* Retrieved June 30, 2005 from http://www.cdc.gov/nchs/data/nhis/earlyrelease/200506_03.pdf.

75. Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System*.

76. National Center for Health Statistics, Centers for Disease Control and Prevention. *Rates of Preventive Care Practices per 100 Adults with Diabetes, United States, 2003*. Retrieved from http://www.cdc.gov/diabetes/statistics/preventive/fAllPractices.htm.

77. Linder, J.A. and R.S. Stafford (2001). "Antibiotic treatment of adults with sore throat by community primary care physicians: a national survey, 1989-1999." *JAMA, 286*(10), 1181-1186.

78. Jencks, S.F., et al., (2000). "Quality of medical care delivered to Medicare beneficiaries: A profile at state and national levels." *JAMA*, *284*(13), 1670-1676.

79. *The Quality of Medical Care in the United States: A Report on the Medicare Program, The Dartmouth Atlas of Health Care 1999*. (1999). J.E. Wennberg and M.M. Cooper (Eds). Chicago, IL: American Health Association Press.

80. Fisher, E.S., et al, (2003). "The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care." *Annals of Internal Medicine, 138*(4), 288-98.

81. Fisher, E.S., et al, (2003). "The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care." *Annals of Internal Medicine*, *138*(4), 273-287.

82. Brennan, T.A. and L.L. Leape, (1991). "Adverse events, negligence in hospitalized patients: results from the Harvard Medical Practice Study." *Perspectives in Healthcare Risk Management, 11*(2), 2-8.

83. Leape, L.L., et al.(1991). "The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II." *New England Journal of Medicine*, *324*(6), 377-384.

84. Thomas, E.J., et al. (2000). "Incidence and types of adverse events and negligent care in Utah and Colorado." *Medical Care 38*(3), 261-271.

85. Zhan, C., Miller, MR. (2003). "Excess length of stay, charges, and mortality attributable to medical injuries during hospitalization." *JAMA*, *290*(14), 1868-1874.

86. Oren, E., Shaffer, E.R., Guglielmo B.J. (2003). "Impact of emerging technologies on medication errors and adverse drug events." *American Journal of Health-System Pharmacy 60*(14), 1447-1458.

87. Organization for Economic Cooperation and Development. *OECD Health Data 2005: how does the United States compare?* Retrieved June 17, 2005 from http://www.oecd.org/dataoecd/15/23/34970246.pdf.

88. Buntin, M.B., Huskamp, H. (2002). "What is known about the economics of end-of-life care for Medicare beneficiaries?" *Gerontologist*, *42*(Special Issue 3), 40-48.

90. Lynn, J., Adamson, D. (2003), "Living Well at the End of Life" in *RAND White Paper*. RAND Corporation.

91. Gilmer, T., Schneidermann, L., Bluestein, J., et al. (2005). "The Costs of Nonbeneficial Treatment in the Intensive Care Setting." *Health Affairs*, *23*(4), 961-971.

92. Johnson, R., Roter, D., N.R. Powe et al. (2002). "Patient Race/Ethnicity and quality of patient-physician communication during medical visits." *American Journal of Public Health,*. *94*(12), 2084-2090.

93. Zuckerman, S., et al.(June 23, 2004). "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation." *Health Affairs Web Exclusive*, 374-384.

94. Cossman, J.S., Ritchie, J. B., James, W. L. (January 2005). *Mississippi's Physician Labor Force: a look at primary care physicians*. Mississippi Health Policy Research Center, Mississippi State University.

95. McCaig, L., Burt, C. (2005). "National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary." *Advance data from vital and health statistics*; *No. 358*. Hyattsville, MD: National Center for Health Statistics.

96. Cohen, R.A., Martinez, M.E. (June 2005). *Health Insurance Coverage: Estimates from the National Health Interview Survey, 2004*. 1-19. Centers for Disease Control and Prevention.

97. Bureau of Labor Statistics, U.S. Department of Labor (January 2005). *National Compensation Survey: Employee Benefits in Private Industry in the United States, 2002-2003*.

98. Davidoff, A. and G. Kenney (2005). *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey*. Robert Wood Johnson Foundation.

99. Rice, T. and K.Y. Matsuoka (2004). "The impact of cost-sharing on appropriate utilization and health status: a review of the literature on seniors." *Medical Care Research and Review*. *61*(4), 415-452.

100. Doyle, J.J. (2005). "Health insurance, treatment and outcomes: using auto accidents as health shocks." *The Review of Economics and Statistics*, *87*(2), 256-270.

101. "Update: Direct and Indirect Costs of Arthritis and Other Rheumatic Conditions - United States." (2004). *Morbidity Mortality Weekly Report, 53*(18), 388-389.

102. American Diabetes Association (March 2003). "Economic Costs of Diabetes in the U.S. in 2002." *Diabetes Care*, *26*(3), 917-932.

103. Bureau of Labor Statistics, U.S. Department of Labor (August 2005). *National Compensation Survey: Employee Benefits in Private Industry in the United States, March 2005*.

104. Werner, R.M. and D.A. Asch (2005). "The unintended consequences of publicly reporting quality information." *JAMA*, *293*(10), 1239-1244.

105. Fischer, M., Avorn, J. (2003). "Economic Consequences of Underuse of Generic Drugs: Evidence from Medicaid and Implications for Prescription Drug Benefit Plans." *Health Services Research*, *38*(4), 1051-1063.

106. Bates, D.W., et al. (1998). "Effect of computerized physician order entry and a team intervention on prevention of serious medication errors." *JAMA*, *280*(15), 1311-1316.

107. Bates, D.W., et al. (1999). "The impact of computerized physician order entry on medication error prevention." *JAMA, 6*(4), 313-321.

108. Balas, E.A., et al. (2000). "Improving preventive care by prompting physicians." *Archives of Internal Medicine, 160*(3), 301-308.

109. Kaushal, R., et al. (2005). "The costs of a national health information network." *Annals of Internal Medicine 143*(3), 165-73.

110. Leape, L.L., Berwick, D. M. (2005). "Five Years After To Err Is Human What Have We Learned?" *JAMA*, *293*(19), 2384-2390.

111. Office of the National Coordinator for Health Information Technology, U.S. Department of Health and Human Services. *Call for Nominations for Collaboration on Health IT; Notice of AmericanHealth Information Community Published in Federal Register.* Retrieved September 19, 2005 from http://www.hhs.gov/news/press/2005pres/20050714.html.

112. Enthoven, A.C. (May 28, 2003). "Employment-based Health Insurance is Failing: Now What?" *Health Affairs Web Exclusive*. Available at http://www.healthaffairs.org. W3-237-249.

113. Hillestad, R, Bigelow, J., Bower, et al (2005). “Can Electronic Medical Records Systems Transform Health Care: Potential Health Benefits, Savings and Costs .” *Health Affairs*, *24*(5), 1103-1117.

114. Moses, H., Dorsey, E.R., Matheson, D.H.M., et al (September 21, 2005). “Financial Anatomy of Biomedical Research .” *JAMA*, *294*(11), 1333-1342.

115. California Healthcare Foundation (March 2004). *State Employer Health Insurance Mandates: A Brief History.*

116. “List of Bridges to Excellence Main Partners.” Retrieved September 27, 2005 from http://www.bridgestoexcellence.org/bte/bte_partners.htm

117. Lubitz, J. et al (2003). “Health, Life Expectancy, and Health Care Spending among the Elderly.” *New England Journal of Medicine, 349*(11), 1048-1055.

118. Holtz-Eakin, D. (April 27, 2005). “The Cost and Financing of Long-Term Care Services.” *Statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives.*

119. National Institutes of Health, U.S. Department of Health and Human Services (February 7, 2005). “Summary of the FY 2006 President’s Budget.”

120. Field, R.J., Plager, B.J., Baranowski, R.A., et al. “Toward A Policy Agenda on Medical Research Funding: Results of a Symposium “, May/June 2003, Special Report Health Affairs Vol. 22 No. 3 pp. 224-230.

121. Coalition for Health Services Research, “Senate Subcommittee Sets Funding Levels for Health Services Research” http://www.chsr.org/index.htm

122. Smith, C., Cowan, C. Heffer, S., et al. "National Health Spending In 2004: Recent Slowdown Led By Prescription Drug Spending." *Health Affairs* 25(1) pp. 186-196.

123. Centers for Medicare and Medicaid Services (February 2, 2006). "Medicare Drug Costs Drop Substantially." Retrieved February 3, 2006 from www.cms.hhs.gov/apps/media/press/release.asp?Counter=1766

124. The Midwest Business Group on Health, in collaboration with the Juran Institute, Inc. and The Severyn Group, Inc. “Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership. Chicago, Illinois: Midwest Business Group o Health (April 2003, second Printing).

Acknowledgments

The Citizens' Health Care Working Group would like to thank all the people across the United States who helped us organize community meetings and encouraged neighbors and friends to attend meetings and to provide ideas, information, and input to the Working Group in person, in writing, and over the Internet. The *Dialogue with the American People* lists close to one hundred meetings and describes some of the contributions of organizations who worked with us over the past 18 month. Hundreds more individuals and organizations offered assistance with every aspect of our work. We hope that all know how deeply appreciative we are for their contributions.

We also offer our special thanks for data analyses conducted by staff of the Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality; the National Center for Health Statistics, Centers for Disease Control and Prevention; and the Economic Research Initiative on the Uninsured at the University of Michigan. These analyses, including data reported in *The Health Report to the American People*, helped us to understand important issues of access to care, health care costs, and quality of care.

Citizens' Health Care Working Group Staff

George Grob
Executive Director

_____

Permanent Full-Time Staff

Jill Bernstein
Craig Caplan
Carolyn Dell
Jessica Federer
William Hyde
Margretta Kennedy
Andrew Rock
Connie Chic Smith
Caroline Taplin

_____

Interim/Part-Time Staff

Suzanne Amoonarquah
Normandy Brangan
Ken Cohen
Elyse Goldenberg
Lisa Goodnight
Jocelyn Hsu
Anne McGuire
Zakiya Pierre
Rebecca Anhang Price
Paige Smyth
Rachel Tyree
Lora Wentzel

_____

Contractors

America*Speaks*
Edelman
Neighborhood America
Public Forum Institute

_____

Consultants

Jon Comola
Marcia Comstock
Jack Molnar
Joy Quill

Citizens' Health Care Working Group

HEALTH CARE THAT WORKS FOR ALL AMERICANS