

**Citizens Health Care Working Group**

**Clarksdale, Mississippi Listening Sessions**

**April 11, 2006**

**Final Report**

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### **Introduction**

Two listening sessions were held in Clarksdale, MS, on April 11, 2006. The groups were similar to each other in terms of gender, age, race, and education. For the fourteen participants that attended the sessions, 79% were female and 21% were male. Twenty-one percent were between 25 and 44, 45% were between 45 and 64, and 21% were over 65. The group was predominantly white (63%) with the remaining 21% being African American. No participant indicated a Hispanic ethnicity.

The participants were highly educated with 7% completing only some high school, 7% being high school graduates or holding GED certificates, 21% having a Bachelor's Degree, and 64% holding graduate or professional degrees. The majority of the participants had employer-based insurance as their primary source of health care coverage (71%), while 14% relied on self-purchased insurance. Another 14% had some other type of coverage while 7% of the participants indicated that they had no health care coverage.

Clarksdale is the county seat of Coahoma County, which borders the Mississippi River and has a rich tradition as delta farming country. Data from the U.S. Census Bureau indicates that the population of the county is fairly evenly divided between males and females, but that white persons comprise only 29% of the population. Black or African American persons comprise 69% of the population, with the remainder being made up of other ethnic groups. Only 62% of the population age 25 years and over are high school graduates, as compared to 73% for the state as a whole. Likewise, only 16% have a Bachelor's degree or higher. This indicates that the participants of the group were better educated than the community as a whole. Also, the racial make-up of the participants had a greater percentage of white over African American than the county statistics reflect. Poverty rates for this county are also quite a bit higher than the state, with 36% of the county residents living below the poverty line as compared to 20% for the state. Since the majority of the participants were working full-time and had graduate degrees, it is likely that their income levels exceeded the county's average. While the participants themselves may not have reflected the same demographics of the community, it is worth noting that the majority of the participants were employed in local social service or community service organizations and dealt with the community's needs on a daily basis.

### **State of the U.S. Health Care System**

One of the defining concerns the two groups expressed was the need to empower health care consumers to take better care of themselves. One person stated, "Education is the key to responsibility of one's health outcomes, but also to lower catastrophic health conditions." In a discussion centering on the state of the U.S. health care system, the participants were fairly evenly split as to whether the system is in a state of crisis (49%) or whether the system has major problems (42%). One person indicated that they thought the health care system had no problems. The similar split was evident regarding the most important reason to have health insurance with 43% feeling that the main objective of health insurance was to pay for everyday medical expenses while the other participants (57%) felt that the most important reason for

health care coverage was to guard against high (in some cases, this was translated to catastrophic) medical costs.

### **Summary of Key Points Raised by Discussion Groups and Related Polling Data**

#### **Values:**

Participants in both sessions agreed that the top fundamental value for our health care system is accessibility. Participants voiced the belief that all should have access to health care services, without regard to who you are (race, age, status, etc.) Affordability also ranked high with both groups, being the second highest value for the evening and the third highest value for the afternoon, with “safe, high quality care” ranking second for the evening group. Both groups also felt that individual responsibility for health care should be promoted, coupled with appropriate education, including prevention practices, to empower appropriate choices.

Ninety-three percent of the participants agreed that it should be public policy that all Americans have affordable health care coverage. This indicator of support and the high-ranking value of “access” combine to indicate the participants’ concern for the large numbers in the region who are without adequate health care. Again, on the question of whether the current model of coverage based on who you are was preferred or defining a level of services for everyone was preferred, 93% of the participants favored a defined level of services for all. One person questioned the meaning of “everyone” in “defined level of service for everyone,” wanting to know if that truly meant everyone or only citizens.

#### **Benefits:**

Between the two groups, a total of fourteen services were suggested as additions to the Working Group’s hypothetical basic benefits package. Both groups ranked catastrophic care and treatment among the top three pieces to add. The morning group also included vision care and nursing home/long-term care among their top three. The evening group favored health education and oral health care. While vision care was on the evening group’s list, the ranking indicated it was not of great importance to the group as a whole. Both groups listed chiropractic care as a potentially removable benefit. However, one group’s ratings of that care indicated divided support for the removal. Two other benefits, substance abuse coverage, and home visits, were on the list to consider removing. However, the group ratings indicated a lack of consensus for removing either of the options.

When asked who should decide what is in a basic package, the participants indicated that they thought medical professionals should have the strongest voice (average rating 7.9 on a 10 point scale), closely followed by consumers (7.7). The remaining three potential stakeholders were rated much lower indicating the group thought a much lower level of input was appropriate: employers (6.5), government (6.5), and insurance companies (4.8).

#### **Getting Health Care**

The shortage of health care providers in rural settings was a common thread between the two group discussions as they considered difficulties faced in getting health care. Both groups noted a critical shortage of all health care services in the region, with specific comments made about the distance people had to drive to specialty services and the lack of providers within the

Veteran's Administration system. "We just don't have enough people!" "If you are acutely ill and don't happen to live in Jackson, you just have to wait." Another common concern for the two groups was the high number of uninsured. One group talked at length about concerns for the self-employed and small business owners who could not afford health insurance. Both groups felt that the lack of health insurance led to distinct disparities in health care services received. The cost of care was a concern for both groups. One participant stated that even with insurance, paying the co-pays and deductibles was a huge budget strain. Others expressed specific concern over the cost of prescription medication.

### **Financing:**

The majority of the participants (86%) felt that everyone who can afford to do so should be required to enroll in basic health care coverage. "Everyone should be required to enroll in a basic coverage because of the cost to society." Another participant noted, "Right now we are already paying for some people who do not have coverage." However, some concern was voiced for those who may refuse treatment, such as with certain religions, and for the right to choose, in general. Most (93%) thought that should such a system be developed to require all to participate, that some people should be responsible for paying more than others. The greatest support came for using family size as a criterion. However, the group noted that larger families might not be able to afford as much as smaller families. The concept of using health behaviors as a criterion also received support. "People who make healthy lifestyle choices shouldn't have to pay as much." The least support came for using income as a criterion. "If you make more, you shouldn't have to pay more than the next person unless you choose to make unhealthy choices.

A majority (83%) felt that tax rules should continue to favor employers who offer employees health insurance. The group also strongly favored continuation of government support for current programs that cover some people who can't afford it (93%). When asked how much more each would be willing to pay in a year to support efforts to provide access to coverage for all Americans, 21% indicated "none," 21% indicated between \$1 - \$100, 28% indicated \$300 or more, and nearly 1/3 indicated they did not know.

### **Trade-Offs & Options**

While all of the presented spending options received support, "investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics and disasters" was the highest rated option (9.3 on a 10-point scale), followed closely by "guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas" (8.93). The third ranking option was "guaranteeing that all Americans get health care when they need it, through public "safety net" programs (if they cannot afford it) (Rating: 8.86.) These options captured many of the concerns expressed throughout both groups, which focused on the need for better health education and health choices, increasing the number of providers in the rural region, and caring for those who have no access to health insurance. The top three rated "trade-off" proposals also reflect these concerns: open enrollment in national federal programs like Medicare or the federal employees' health benefit program (8.3 rating), require that all Americans enroll in basic health care coverage, either private or public (8.21) and expand neighborhood health clinics (8.21). In commenting on the open enrollment in national federal programs, one participant reflected, "There is a big difference between Medicare and the Federal Employees' Health package. It is the difference between 'skinny' and 'fat.'"

## **Closing Comments and Other Ideas:**

A number of other thoughts were shared throughout the sessions that are worth noting:

- Prescription costs drive a lot of health care costs. Consider putting a cap on drug costs and limiting marketing and “schmoozing” of drug companies.
- People need to be educated on how to use the system effectively (i.e. What constitutes an emergency? Where to go for services?)
- Standardize fees for services: doctor visits, tests. Same price for the same service regardless where received.
- Promote healthy behaviors. Create incentives to promote healthy behaviors; tax unhealthy foods: cigarettes, alcohol, and sugary and fatty foods.
- Allow people who cannot afford health care services to provide in-kind services. “Health equity” compared to “sweat equity” in the Habitat for Humanity model.