Jackson, MS, Community Meeting
February 22, 2006

Overview

The Citizens' Health Care Working Group collaborated with the Mississippi State University Extension Service and the leadership of the Jackson Medical Mall to conduct a community meeting on the health care system in America. The meeting sought to address four critical questions[1] on which the United States Congress is seeking the public's views. The diverse and energetically involved participants strongly endorsed the idea that there should be a system that assures that everyone has health insurance coverage. However, the audience also wanted to find ways to split the difference where choices were concerned, wanting everyone to have guaranteed access but not wanting a governmentally-prescribed mandate. Individual "choice," whether in selecting physicians, plans, opting out of a basic plan, or engaging in health investments, remained an expressed preference. Participants wanted both the benefits that a welfare state might provide as well as being able to retain consumer choice associated with a free market. The strong voice of the audience was that the health care system needed more, not less. The audience readily agreed on a number of benefits needed to enhance a suggested typical basic benefits plan; however, they balked at removing items from the initial list. Despite the urging by the moderator to consider trade-offs primarily within the context of the health care system, the major advocated trade-offs offered by participants involved reductions to non-health care spending (war, reduced taxes on the rich, and space exploration) rather than moderating health care spending. Insightful recommendations emerged during the closing discussions. This was a delightful and actively committed audience.

Laying the Groundwork

The 8:30am-12:30pm, Wednesday, February 22, 2006, meeting in Jackson was the kick off event for what will be a series of meetings to be held throughout Mississippi; eight additional rural sites will be the locations for additional; registration for these meetings is available on the Working Group's web site. Dr. Alan Barefield and Rachel Welborn, of the University Extension Service are organizing the rural meetings; they teamed up with Dr. Aaron Shirley and Mr. Primus Wheeler, Executive Director of the Jackson Medical Mall, to promote the initial meeting at the Mall. This combined urban-rural mix of meetings will provide the Working Group with a particularly valuable opportunity to carry out the statutory injunction to consider the rural issues of health care.

[1] 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 tradeoffs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?

A hundred people attended the meeting, reflecting the racial ethnic dimensions of the community, like Jackson, slightly over half the participants were African-American (58 percent) and half Caucasian, Asian or Other. The participants were younger, in general, than at other community meetings (46 percent ages 25-44) although equally well educated (57 percent had graduate or professional degrees); women predominated in numbers (76 percent) although the men present were equally outspoken. Volunteer facilitators at each of 14 tables of 6-8 participants led table discussions; individuals called out responses to questions posed by the moderator, participants used wireless key-pad units to express opinions and preferences on numerous questions. Audience responses were immediately flashed on an overhead screen, summary statistics generated and displayed, and opportunities for individuals and table facilitators to explain their responses, were provided.

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

Values

Seventy percent of the participants indicated that the three most important priorities regarding health care were: access for everybody (29 percent), early prevention intervention (21 percent) and universal health care with no disparities (19 percent). However, there was a murmur of agreement from the audience when an individual added that "health care should perform based on price." Reflecting an area where health care can not be assumed to be available or accessible to everyone, nine of 10 (91 percent) of the audience agreed that it should be public policy that all Americans have health care coverage, although, one individual asked "what do you mean by 'affordable,' you obviously don't mean free."

Most (92 percent) participants agreed that adopting a health care system assuring at least a basic set of service/coverage was preferable to the current system of categorical eligibility. The discussion revealed a variety of perspectives and concerns. Some participants favored supplementing the existing system or creating a "blended package of care for all." Others, expressing skepticism or realism, were concerned about what limits would be placed on a basic level of services and whether these might be too restrictive. Participants realized that there would need to be further work on details of a new system.

Benefits

Three services that the most number of participants felt should be added to the Working Group's hypothetical basic benefits package were: expanding reproductive health care (including STD testing and fertility treatments) (19 percent), health education and medical/nutritional therapy (18 percent), and vision care (18 percent). On the question of what services could be removed from the basic benefits package, the group gave a loud resounding "None!" (49 percent) although a sizable portion did conceded that chiropractic care could safely be dropped (39 percent) off the list.

Regarding who should decide on the basic benefits package, the strongest response was a general murmur of disbelief (“are you kidding”) at the mention of insurance companies. Participants split on the various choices, with a significant number agreeing that consumers ought to be making these choices.

Getting Health Care

Regarding difficulties faced in obtaining care, this community meeting audience identified a longer list, and did so more rapidly, than at any of the previous five community meetings. They identified 19 such difficulties including: rural availability of care, transportation, language barriers and cultural sensitivities, fear that making claims may result in loss of coverage, timeliness, ER overcrowding, refusal of care, and, of course, paying for care. Although no voting was done on this long list, “money” was called out several times as the central concern. Sitting back to review the list, a participant spoke up and said that another difficulty that pervades many of the other difficulties and may be the cause is race, to which there was a general murmur of assent and heads nodding. This comment is especially poignant, considering the evenly divided black-white mix in Jackson. It was also observed by several participants that race would trump money as the issue that impeded obtaining needed health care.

Financing

Three-quarters of the participants (74 percent) felt that everyone who could afford to do so should be required to enroll in basic health care coverage, either private or public. Those agreeing with this indicated that it would encourage greater responsibility and equalize the costs for all; would make health insurance more like care insurance, that everyone who drives must have. The participants had a number of insightful qualifications that they wanted to see made part of this policy proposal, however: they wanted to make sure that guaranteed eligibility and access were included; others thought that a system that automatically enrolled individuals was desirable, to assure coverage.

The participants expressed several, sometimes contradictory, points of view regarding whether there ought to be an “opt out” option to mandatory enrollment. Some said that individuals with other coverage shouldn’t have to participate in a mandatory basic health plan; others pointed out that allowing individuals to opt out could result in some of the same problems that currently exist where and individual without coverage needing catastrophic health care coverage must be provided for by the community at large or the health care system, thereby undermining the principle of cost sharing across all individuals. Participants at another table engaged in a heated and inconclusive debate regarding whether and how to address the health care needs of undocumented aliens.

A solid majority (60 percent) felt that some individuals should be required to pay more than others for health care coverage or services. Those in favor seemed to agree with the adage “from each according to his ability, to each according to his need.” Those who disagreed with the proposition about some paying more felt that “it pits people

against one another." They indicated that "It's going to cost the same regardless; w need to let everyone have an equal chance to make more money; we should not ask them to pay more simply because they were more privileged." Asked what criteria should be used to decide who should pay more, "income" was the most frequently cited; however, a third of the participants didn't express an opinion about this question, underscoring the disagreement of some, with the idea of some individuals having to pay more.

In response to a Yes/No polling question, although a sizeable majority (72 percent) indicated they agreed that the current employer-based health insurance system should be kept, participants indicated they might have voted differently had they been offered other choices, because they didn't feel the employer-based system was entirely reliable. A business person also indicated that the question was misleading because what looked like benefits to the business were really costs or pass-through benefits to the employees.

Another reflection of the strongly pro-public sentiments of the audience—despite comments of individual dissent—was the overwhelming agreement (96 percent) with the proposition that "government resources should be used to cover health care for those who can't afford it." Fifty percent of the audience indicated that they would be willing to spend up to $100/year to help pay for people who couldn't afford care; 15 percent would be willing to spend up to $300; and 13 percent would be willing to spend more. These numbers are roughly equivalent to the results from other community meetings.

Trade-Offs

The most dramatic resistance to the general range of questions presented to the audience came over the question of trade offs. As noted in the Overview, the participants wanted the trade-offs to come from outside the health care arena (although there one or two lone voices alluding to the need to address administrative overhead costs, inefficiencies, and greed as factors in the health care arena that needed to be addressed). Asked for a show of hands, of those who thought the additional funds for health care should come from elsewhere, almost all the participants raised their hands.

Closing Comments and Other Ideas

In closing, the participants offered a number of other ideas for addressing the needs of the health care system:

1. "Follow the money." Support Physicians for National Health Insurance. We need to understand the costs and where the money is going and how to reduce the costs.
2. Pursue the goal of assuring coverage for every child first and foremost – a uniform system across all 50 states assuring that children have the right to health coverage.
3. Provide states with more flexibility for how they can use resources.

4. Address the fact that 25% of health care spending is during the last year of life; “we need evidence-based medicine so that we’re doing what is important and worth doing.”
5. Find a way to make prevention profitable both for individuals and for the health care professionals because it won’t be pursued until it is profitable.
6. Define what affordable means; help those with varying socio-economic status.
7. Prevent environmentally-caused harm; help those subject to unhealthy environments.
8. Find ways to increase physician/provider participation in S-CHIP and Medicaid; address paper-work burden, financial constraints; reduce time between services delivery and payment, reduce the number of canceled appointments; increase client compliance.

Complete polling results from this meeting are available at:
http://www.citizenshealthcare.gov/community/mtng_files/cm_rep_jams.php

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