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August 21, 2006

Citizens' Health Care Working Group
7201 Wisconsin Avenue, Suite 575
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Dear Members of the Citizens' Health Care Working Group:

The American Nurses Association (ANA) congratulates you on your work completed thus far in formulating interim recommendations for health care reform on behalf of all Americans. The generous gift of time and expertise that each of you has given our country in this effort is remarkable and deserves our gratitude. Likewise, the vast amount of complex and exhausting work performed by the Working Group's staff has earned ANA's deep thanks. In particular, staff efforts to provide an informative, complete and timely website are a model for other organizations and ad hoc groups.

ANA is the only full service organization representing the interests of 2.9 million registered nurses in the United States. ANA's constituent members represent registered nurses in the 50 states, the District of Columbia, Guam, the Virgin Islands, and in the US Uniformed Services. The Association has followed the meetings and deliberations of the Citizens' Health Care Working Group closely, and nurses have been interested and involved in the various public forums through which the Working Group collected data and opinion. Indeed, health system reform is at the top of nursing's agenda because it goes directly to the heart of nursing's providing the best possible health care for the individual, family and community within a framework of compassion, equity and social justice. Nurses understand the value of the Working Group's mission and the potential power of the American public's voice.

ANA is quite pleased to be able to support much of the Working Group's report and recommendations. The Association is particularly gratified to note that the Working Group has embraced the idea of affordable, high quality health care for all Americans, starting with a core package of essential services on which everyone can depend.

ANA has offered several suggestions for modifying or expanding certain recommendations, based not only on ANA policy, but also on the qualitative and quantitative data derived from study of the publicly available reports available at the Working Group's website. ANA offers in-depth comments (attached) for your review and consideration.

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In addition, ANA has noted a few significant subjects integral to health system reform that the Working Group's recommendations do not address, along with suggestions as to how these concepts might be incorporated into the final version of the recommendations. Principal among these are health care workforce and long term care.

Regrettably, ANA must also voice concern regarding what can only be described as discrepancies between the data that the Working Group received from its community meetings, and the recommendations crafted from that public input. The Working Group clearly experienced ambivalence about its role as a "filter" for public opinion and its proper function under the statute. The expertise of individual members is essential to the high caliber of work produced by the Working Group. The specific statutory charge from Congress to the Working Group, though, is to report interim recommendations "based on the information and preferences expressed at the community meetings."

ANA believes that a proper balancing of roles would result in recommendations which, if at variance with significant public input, would be accompanied by a straightforward acknowledgement of this discrepancy, explaining why the Working Group believes its judgment is preferable to that of the public in each particular case. ANA strongly recommends this approach in the Working Group's final recommendations.

ANA believes deeply in the vital mission to which the Working Group has devoted so many months. ANA has also devoted many months to the Working Group's activities and deliberations, highlighting its work at the annual meeting of the ANA House of Delegates and updating nurse members on the Working Group's progress.

ANA offers suggestions and comments in the spirit of constructive commitment to the mission of bringing the voice of the American people to Congress and the President. The road ahead is difficult, but not impossible, and ANA stands ready to assist in any way it can to improve the health of our nation.

Sincerely,

Linda J. Stierle, MSN, RN, CNAA,BC
Chief Executive Officer
American Nurses Association

ANA COMMENTS ON “VALUES AND PRINCIPLES”

While the Values and Principles set out by the Working Group are not the core operational elements of the report, it is clear that they are meant to provide the framework and context in which the subsequent recommendations are to be implemented. The Working Group’s inclusion of this section, in addition to their original charge, is greatly appreciated by ANA and those who are seeking to base the health system reform debate on values upholding high quality patient care, respect and accountability.

The ANA’s policy is consistent with these underlying premises to the interim recommendations, as far as they go. However, there are two concepts present in ANA policy, whose absence from the Values and Principles section substantially weaken the power of the entire remaining report. These omissions threaten the perceived integrity of the Working Group’s process and the ethical foundation of the recommendations, as well as reflect more tangible epidemiological consequences of inadequate health policy-making.

First, at numerous community meetings, the concept of health care as a “right” was brought up repeatedly. When polled, it received substantial support from participants in some states (44% in Cincinnati, 45% in Albuquerque, for example). Yet neither the words nor the concept appear in the report. At the San Antonio meeting, a Texas physician with 30 years of practice behind him was quoted succinctly: “I think in this nation, we all need to adopt the mindset that health care is a right, not a commodity or a privilege.”

ANA agrees. The Association has repeatedly reaffirmed its strong position that health care is a basic human right. This is the foundation on which ANA’s health system reform policy is built. ANA supports a restructured health care system that assures universal access to a standard package of essential health care services for all citizens and residents. We do so not only because it is our common obligation to one another as fellow members of a society (the “shared social responsibility” to which the report refers), but also because “rights” convey an independent, inalienable status conferred by simple human existence.

There are those who believe that such bold words describing health care as a human right might be poorly received in some quarters. Their concern is misplaced, for America has already trod this path. The Universal Declaration of Human Rights, adopted by the United Nations in 1948, proclaimed that “everyone has the right to a standard of living adequate for the health and well-being of oneself and one’s family, including food, clothing, housing, and medical care.” This statement of high principle was adopted *at the urging of the United States*. It reflects the fundamental truths of our nation’s founding documents. In the face of significant public input, supported by a strong moral argument, ANA urges the Working Group to reconsider its decision to omit any reference to health care as a “human right” from its recommendations or discussion.

Second, ANA believes that the Working Group has a responsibility to suggest to the Congress and President, as part of its report, that non-citizen residents of the United States should be considered for inclusion under any health plan. The statute, obviously,

refers to “citizens” health care, and so it is logical that the Working Group limited its recommendations to the letter of the law. ANA urges the Working Group to move a step beyond.

ANA’s reasoning is threefold:

- a significant minority of community meeting attendees raised it as a concern (in the border state of Texas; for example, 35% of the participants believed that affordable, accessible health care should be available to illegal immigrants);
- the epidemiologic consequences of providing care for some, but not others, for communicable diseases – particularly for transient populations, and particularly in this regrettable era of potential bioterrorism – is medically dangerous and unacceptable; and
- denying health care based on one’s immigration status is ethically unsupportable for health care professionals.

The ANA recommends that the current language in the Values and Principles section be modified, at a minimum, to accommodate these two concepts, as follows:

- on page 6, 3rd bullet: “Health care is a right, and assuring health care is a shared social responsibility.”
- on page 6, 2nd and 4th bullets: where “Americans” is used as a noun, substitute “citizens and residents.”

There is a final proposal that ANA strongly recommends as an addition to the Values and Principles section. When brainstorming a list of values and principles during its business meeting, the Working Group originally included “wellness and prevention.” Later, it decided to take the idea of wellness and prevention and subsume it under the larger principle of “access.” ANA believes that this had the unfortunate consequence of precluding the Working Group from breaking through convention and considering the larger idea of a “wellness-based delivery system.”

Envisioning an American health care system in the longer term, as the Working Group attempts to do, requires a shift in focus from the current acute care, hospital-based delivery system. As Baby Boomers age, their changing expectations regarding aging, successful management of chronic conditions, and acceptable levels of continuing and long term care, will require a reallocation of resources, people, and education toward non-hospital settings, such as community care, ambulatory care, home care, and some residential facilities.

People who grew up in the last half of the twentieth century expect better primary care, prevention, wellness care, patient education and participation in decision-making, and management of chronic conditions. These expectations are consistent with the position of the US Department of Health and Human Services promoting greater self-care, self-awareness, and individual involvement in the management of chronic conditions. These are the hallmarks of a “wellness” orientation, rather than a “sickness” orientation, in health care delivery.

Acute care will always constitute a portion of the health care dollar spent in any system. For long term cost controls, though, and a healthier, more productive society, the system must be redirected so that money and other resources are fairly allocated up front to primary care and health maintenance. What worked in the past will not work for the future. ANA urges the Working Group to reconsider the importance of the “wellness and prevention-based delivery system” as a basic principle from which a cascade of other recommendations and forward-thinking ideas may flow.

ANA COMMENTS ON RECOMMENDATIONS

RECOMMENDATION #1:

“Guarantee financial protection against very high health care costs.”

The Working Group has successfully captured a dominant concern expressed in the various forums made available to the public throughout this process: fear of bankruptcy and destitution brought on by egregious medical expenses. In identifying the goal and offering several options for reaching it, the Working Group does not appear to endorse any particular approach.

The scope of possibilities available under the current language, though, is quite broad and, at the same time, perhaps unintentionally narrow. That a national program might be “private or public” precludes the possibility of combining elements of both private and public systems. ANA recommends a modification of language that would permit all alternatives.

Both the protection against “very high out-of-pocket medical costs” and “financial protection for low income individuals and families” are indirectly or directly based on assessing a family’s income and insurance status. The example provided is of concern because it seems to sidestep the distinction the Working Group makes elsewhere (and which it polled within the community meetings) regarding the purpose of insurance. Is insurance intended to pay for primary care and other services up to and including so-called “catastrophic” medical events, or is it meant to insure only against unexpected high-cost medical events and expensive long-term or chronic care? ANA would like to see a clearer distinction made throughout the Working Group’s recommendations between health services and health coverage.

RECOMMENDATION #2:

“Support integrated community health networks.”

ANA believes that the Working Group’s support of integrated community health networks is among the most important ideas put forward in the Interim Recommendations.

The immediate focus must, by necessity, be on identifying and serving vulnerable and “at-risk” populations, merging and stabilizing revenue streams, and coordinating

resources for effective and efficient deployment. The Working Group accurately identifies the challenge in pursuing this, while continuing to nurture innovation at the community level, where public-private partnerships are appropriate.

Nurses are a significant segment of the workforce delivering professional health care services at the community level. Nurse practitioners are a valuable, but underused resource for providing exactly the services required in clinics and community care centers, especially in underserved areas. Nurse practitioners provide primary care (including diagnosing and prescribing), preventive care, immunizations, wellness care and education, and assisting patients with maintenance of chronic conditions. ANA recommends that the Working Group add language to this section indicating the importance of fully utilizing the education and scope of practice of nurses and all other health care professionals to achieve maximum benefit for patients of the community care centers.

ANA sees even more potential in the community-based care paradigm. As described in the earlier section discussing “Values and Principles,” ANA is actively engaged in articulating a vision for a wellness and prevention-based delivery system for health care in the 21st century. Community-based care, local and even neighborhood level resources for families and individuals could well provide one of the chief vehicles for such a delivery system. Community health networks have been viewed in the past almost exclusively as health care “safety nets” for “vulnerable populations.”

ANA invites the Working Group to imagine a future in which people of all income levels would see an expanded concept of community-based health – where, for example, health education is available at the local school for children and adults alike, local transportation reliably carries no-driving residents to produce markets for fresh fruits and vegetables, child care services are coordinated with immunization and well-baby visits. The health needs of all citizens and residents would be gradually integrated to the point where the idea of a separate set of delivery mechanisms reserved for “vulnerable” populations would begin to diminish. This would mark the true success of health system reform.

RECOMMENDATION #3:

“Promote efforts to improve quality of care and efficiency.”

The elements of Recommendations #3 are consistent with ANA’s health system reform policy goals regarding improvements sought in quality of care and systemic efficiencies. ANA is in strong agreement that the electronic medical record system and health information technologies are a remarkable resource for the individual patient, health care professional and for statistical and anonymized data research purposes. Their availability and use as tools for analysis can lead to tremendous efficiencies and quality improvement. At the same time, the confidentiality of medical information and the privacy of the patient are ethical imperatives that drive any balancing of interests that is done in seeking personally identifiable information.

ANA is also a strong supporter of evidence-based best practices, and is pleased that the Working Group sought out the public’s preference for such health care services, as well.

ANA commends to the Working Group's attention the 2001 report by the Institute of Medicine (IOM), *Crossing the Quality Chasm: A New Health system for the 21st Century*, which identified six major aims that can raise the quality of health care. These aims describe quality health care as safe, efficient, patient-centered, timely, efficient and equitable. Each of these is described in some detail by the IOM, accompanied by policy recommendations and suggested strategies for implementation. ANA suggests that these hallmarks be integrated into the Working Group's recommendations, requiring consideration by the President and Congress.

There is one clarification that ANA would like to see explicitly articulated in the report, regarding the last two points under this recommendation. These relate to the availability of consumer-usable information (presumably comparing prices, quality, benefits, et al.) and health education. ANA wholeheartedly supports patient education and conversations with patients regarding their care, disease prevention, health promotion, maintenance of chronic conditions, and the like. This, in fact, comprises a substantial portion of a nurse's daily work.

Patient-centered care is distinct though, from what some are calling "consumer-driven care." ANA does not argue that information about health care options that are available, including price, quality, cost-sharing and efficiency, can help patients make informed decisions. Some suggest that physicians should be aware of the same information when making referrals and treatment decisions.

However, there is a troubling side to "consumer-driven" health care that deserves attention. It presumes that, with enough information, one can make the "correct" choice. It presumes that everyone is similarly situated in terms of baseline education and level of sophistication in piecing information together and drawing conclusions. Too much information can confound many a well-informed individual, as was discovered during the rollout of Medicare Part D. "Choice," a creditable goal, becomes a chimera.

The Working Group should include in its discussion, at a minimum, a caveat that patient information is only one part of a much larger equation in health care decision making, and should not be used to intimidate patients into making a "forced choice" at the hands of insurers, employers, or the government.

RECOMMENDATION #4:

"Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose."

ANA applauds the Working Group for bringing the subject of end-of-life and palliative care to the forefront. As nurses in critical care units, oncology units, emergency and trauma centers, hospice, long-term care facilities and a multitude of other settings, ANA's members are deeply sensitized to the inadequacies of the current system and how it handles intractable pain and death. Education, funding, and support services are

properly identified by the Working Group as key elements to improving this neglected aspect of health system reform.

ANA suggests two additions to Recommendations #4. First, while public and private programs are charged with supporting the much needed education of health care professionals, there also exists a deep need for patient/citizen education. Information can help individuals break through the discomfort of discussing the subject with family and health care providers, and provide guidance and comfort in difficult times.

Second, ANA urges the Working Group to modify the recommendation to explicitly include treatment of chronic and intractable pain among the services to be restructured in the way they are financed and provided. Too often, palliative care is associated only with end of life care, while the needs of those living with chronic pain go unanswered. ANA believes strongly that patients who require aggressive, medically appropriate prescribing to manage their pain should be permitted to receive such supervised care, and that advance practice nurses should be permitted to prescribe and administer such medications.

As a last note regarding Recommendation #4: while separating out the subject of pain management and end-of-life care highlights the issue and focuses attention on much needed reform, it also needs to be mentioned throughout the Working Group's report so as to take its place as a concept integral to the continuum of quality health care across the life span. ANA suggests that the values embraced in Recommendation #4 be included in the "Values and Principles" section, as well as throughout all the recommendations.

RECOMMENDATION # 5:

"It should be public policy that all Americans have affordable health care. All Americans will have access to a set of core health services. Financial assistance will be available to those who need it."

ANA policy endorses a restructured health care system that assures universal access to a standard package of essential health care services for all citizens and residents. This would seem, at first glance, to be in accord with the Working Group's recommendation. ANA's support for Recommendation #5, however, is uncertain, largely as a result of the Rationale and Discussion offered by the Working Group. The following discussion considers several elements of the Recommendation #5 individually, offering suggested modifications where appropriate.

ANA agrees with the clear majority of the U.S. public that favors a national system that guarantees health care for all Americans. ANA's position, as detailed in the earlier section on Values and Principles, is that this guarantee should extend not only to American citizens, but also to all residents, as well. In review, this policy is based on ethical, as well as epidemiological, demands of the health care professions. Thus, ANA strongly urges the Working Group to add the fact that a significant minority at some community meetings supported an extension of Recommendation #5 to all residents, including illegal immigrants, and add the ANA's rationale for inclusion, as well.

ANA believes that financing for coverage and services should be based on the individual's ability to pay. The concept of "affordable" is fluid and subject to wide variances in interpretation and relative values. ANA suggests that the Working Group adopt language incorporating the concept of "removing financial barriers to care." This phrase seems to capture more accurately the concerns expressed by the majority of respondents to the community meetings and polling instruments used by the Working Group.

The requirement that health care be accessible is, of course, a fundamental piece of any health system reform plan. ANA does not believe that the Working Group has paid enough attention to what "access" actually means in the health care context, or how access is operationalized and measured for evaluation. The description of "access" provided in the "Values and Principles" section of the Working Group's report is a good starting point. ANA would add that improved access can be achieved, in part, by expanding the availability of services rendered by all categories of health care professionals. This includes the idea of fully utilizing nurses and other health care professionals to the full extent of their scope of practice, as well as finding incentives for these health care providers to work in underserved areas or during non-traditional hours.

Availability also includes the idea of health care provided at convenient hours, locations, and with reasonable waiting times to accommodate working families, people with disabilities and people across the lifespan. Practical issues need to be considered such as transportation for those who have none, childcare availability for those who have no one to look after their children when visiting the doctor, and prescription delivery services for the elderly and infirm. Vulnerable populations will continue to need services to augment any basic package of essential services, such as home visiting physicians and nurses for women with high-risk pregnancies, and directly observed drug therapy for patients with tuberculosis and other communicable diseases.

While the Working Group has touched on the need for people to "be treated appropriately and in a respectful manner," ANA suggests that this concept be expanded before the final recommendations are sent forward. Respect for cultural distinctions, not only in language and general custom, but also in tradition specific to health care and the human body, are key to assuring that the patient and his or her family maintain their rights and dignity within the health care relationship.

Recommendation #5 includes discussion of the questions "what kind of health care system do Americans want?" and "how will we pay for health care for all Americans?". These are indeed perhaps the most complex of any of the questions posed by the Working Group, which was reflected in the sometimes conflicting responses from various audiences. ANA agrees with the analysis that some confusion may have existed among respondents regarding the distinction between health services and health insurance. This distinction has been further muddled by the switching back and forth between the two concepts in questions posed to respondents. Since the Working Group's final recommendations will be read by countless Americans of varying levels of knowledge in the subject, ANA suggests that this distinction be carefully laid out and preserved throughout the document.

ANA commends the Working Group for including many of the options proffered by participants as a means of achieving “health care for all.” It would have been more helpful if the options had been accompanied by analysis providing, for example, some sense of their rough ranking or a comparison of regions of the country.

ANA is deeply troubled that one particular reform option, commonly referred to as “single payer,” does not appear anywhere in this recommendation or discussion, despite the fact that it was repeatedly the subject of intense discussion at community meetings, in online surveys, and at Working Group business meetings. In fact, venues as varied as San Antonio, Texas and Hartford, Connecticut agreed that the #1 preferred proposal for ensuring access to high quality care and services for all Americans is to “Create a national health plan, financed by taxpayers, in which all American would get their health insurance.” (54.4% and 74.1%, respectively). While ANA is on record as supporting, ultimately, a single payer mechanism as the most desirable option for financing a reformed health care system, and so is especially disturbed by this discrepancy.

RECOMMENDATION #6:

“Define a “core” benefit package for all Americans.”

ANA supports the concept of defining a core or essential benefits package for all Americans. ANA commends the Working Group for explicitly including the idea of services that stretch across the continuum of care throughout the lifespan. While it may be implicit, ANA suggests that this recommendation be modified slightly, adding the words “including end-of-life care” at the end of the pertinent sentence, to integrate the values expressed in Recommendation #4.

The establishment of an “independent, non-partisan private-public group to identify and update recommendations for what would be covered under high-cost protection and core benefits” bears closer scrutiny. Members are appointed, but it is not specified who appoints them. The group is “independent,” yet clearly reports to some formal body, as its charge would be to “identify and update recommendations,” rather than issuing requirements. Which formal body would make the final determination on benefits?

ANA is delighted to note the emphasis given wellness, preventive and primary care in the Working Group’s discussion of “core” services. These services, along with patient education and management of chronic conditions and health problems “across a full range of inpatient and outpatient settings” represent a major portion of the value that nurses bring to the health care system. As skilled caregivers, care managers and patient educators, nurses are well prepared to provide these essential services in the health care system of the 21st century.

ANA is also very pleased that the Working Group has qualified the decision process regarding which benefits are included in the “core” package with the requirement that they meet evidence-based, scientific standards. Similarly, ANA applauds the Working Group for recognizing the necessity of including mental and dental health, as well as physical health, in the “core” package. Many suggest that vision and hearing care be

included, as maintenance of these basic senses is keenly important to most individuals' ability to remain independent. ANA would support that position.

An argument can be made for enforcing a rule that once a core benefits package is defined, private insurers would be precluded from duplicating such coverage under any national health plan. This would assure that everyone would be enrolled in the national health plan core package, with the consequence of equal cost and coverage. ANA believes this is a reasonable proposal.

While ANA is in favor of the "core" services concept, the Association is disappointed with the Working Group's discussion of the membership and character of the proposed group that would identify and update recommendations on these services. In its Rationale section, the Working Group describes the majority of participants as desiring consumers and health care professionals to play a major role in such a group. It goes on to say, "A smaller number of participants indicated that employers and insurance companies should also play a role in determining the content of the core benefits package."

This is an extremely misleading statement that, while technically true, does not do justice to the public feedback received at community meetings. Data from meeting reports posted on the Working Group's website tell a different story. A review of the surveys used at the community meetings shows that not all cities were polled on their preference regarding the composition of the panel in question. In those cities that were polled, participants were provided a "forced ranking," that is, they were given a list of potential participants and asked to list them from 1 to 6 in terms of whether they should be on the panel.

In a review of the individual data of every community meeting report available on the Working Group's website in which participants were polled, Insurers came out dead last in every single city, with the exception of aggregate data from rural Mississippi meetings, in which they edged out Employers for 5th place. In cities where percentages were noted, Insurers generally received either 0% or 1% of votes. Employers were ranked 5th in every city except Jackson, Mississippi (where they took 4th place, while State & Local Government, which took 5th place) and in the rural Mississippi venues, as previously noted. Again, when percentages were tallied, they were generally in the 1-2% range.

These statistics do not support a report that suggests that meeting participants were actively asking for employers and insurers to be part of the "core" services panel, albeit at a lesser rates than, say, health care professionals. ANA is disappointed with these distortions; this lack of transparency, in ANA's view, detracts from the credibility of the report and recommendations. ANA looks to the Working Group to correct this and any other statements or omissions that do not convey the truth – in spirit as well as letter -- of what the American public shared throughout this extraordinary process.

ANA COMMENTS ON SCOPE OF RECOMMENDATIONS

ANA notes with some concern the absence of any mention of health care workforce recruitment, education, utilization or retention in the Working Group's recommendations. We offer the Working Group a few guiding principles on this point. The lack of public input on the health care workforce is not surprising, on closer inspection; the public had no substantive opportunity to discuss the issue because no questions were asked of them in any format that addressed health care workforce issues. This omission deserves examination.

The cyclical shortage of nurses and other health care workers is a testament to the fragility and flaws in the current health care system. ANA urges the Working Group to either add a seventh recommendation, or to add a subsection under the "access" section, as follows: "For health care delivery to be effective, accessible and affordable, there must be an adequate supply of well-educated, well-distributed, and well-utilized registered nurses and other health professionals."

The strategies that the Working Group might look to in support of such a recommendation would address areas of supply (recruitment and retention), education, distribution, utilization and education. The federal government could have a direct hand in policy-making to encourage these initiatives, such as funding nurse education and recruitment at the same levels as medical student education, or providing extra incentives for work in underserved areas or during non-traditional hours. In addition, ongoing collaborative workforce planning is required to take into account the needs of communities and the demands of the health care "industry."

Similarly, the subject of environmental pollutants as a source of rising health care costs was not offered as a potential subject for discussion. The federal government's responsibility to the American people includes its obligation to assure that our health is not assaulted by our environment as a result of the government's poor stewardship of the natural resources of air, water and land. Part of health system reform is looking at the larger picture of how to save in health care costs. ANA would argue that rigorous enforcement of existing environmental standards and laws and enactment of environmentally sound, "human-friendly" laws will provide a substantial long-term cost benefit to the health care system, as well as benefit the future of our planet.

Lastly, ANA notes that the subject of long-term care is largely bypassed by the recommendations. While the subject was included in a question regarding the public's priorities, it is unknown how much discussion or input the Working Group may have received on this vital issue, as it is barely touched on in the report and recommendations. It is anticipated that the costs to the health care system, as well as to the individual, for long-term care are a substantial piece of the 21st century's health care bill. It would be helpful for the Working Group to expand any reference to long-term care in its discussion, and if it was not considered at community meetings, to explain possible reasons for this deficit.