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Institute of Social Medicine and Community Health

COMMENTS ON CITIZENS' HEALTH CARE WORKING GROUP INTERIM RECOMMENDATIONS FOR UNIVERSAL HEALTH CARE

The Institute of Social Medicine and Community Health (ISMCH) was pleased that Congress created a process for engaging the American public in a dialogue about reforming our health care system. In the past, health care reform has failed to address systemic changes in the fragmented health care delivery and financing system which has been driven by ideological commitments and lobbying interests that have enabled our health care system to remain the most profitable in the world without guaranteeing access to affordable health care for the whole population. However, we were distressed that the framework created by the Citizens' Health Care Working Group (CHCWG) for the public dialogue seemed to be rooted in the assumption that there is not enough money to provide comprehensive health care to the entire population.

When the US spends around twice as much money on health care per capita as any other country including more public money per capita than any country with universal health care, it is a disgrace to ask the American people which trade-offs they are prepared to accept since there isn't enough money to provide equal quality health care to the entire population.

We are heartened that throughout the country the Citizens' Health Care Working Group found that an overwhelming majority of the population recognize that our health care system is in major crisis, and that they look to government to ensure affordable health care for all as a matter of public policy. It is very significant that the overwhelming majority supported equal benefits for all.

Of course, when people are asked to choose between a health care system that protects people from catastrophic costs on the one hand, or routine first dollar costs on the other hand, it may appear that there are divergent opinions. But if you don't assume that our health care system can't fulfill both priorities, it is clear that the overwhelming majority want government policy to ensure that affordable quality health care is available to all.

Although the CHCWG discouraged people from saying it, most people view basic health care as what ever is medically necessary for an individual—not what can be shown to be medically necessary for everyone or the so-called “average patient”. It includes high tech medicine, like organ transplants, if that is what is medically necessary for an individual, but it excludes coverage for treatments when they are not medically necessary for an individual, even when they are profitable to provide.

The American people need clear indicators of what medically necessary care they are not getting, and how much they are paying for care that could be provided for less if the health care system was structured to spread costs efficiently, effectively, and equitably throughout the population.

CHCWG probed who should determine the content of a basic benefit package the way the system is structured now, but ignored the more important question of how the health care system should be structured to ensure that all medically necessary health care is available to all persons.

Since the poor cannot pay as much for health care as the rich, most respondents recognized that the financing of health care should vary with income as would happen through a tax-financed health care system. It would have been more revealing to ask the general public whether they think that rich people should be able to jump to the head of the line in the health care marketplace by paying higher premiums or higher out-of-pocket costs.

As to how much more people would be willing to pay for universal health care, this question is both inappropriate and misleading since the experience of many other countries reveals that there is enough money in the system to support universal health care, and that existing forms of cross-subsidization in the US are both highly inefficient and inequitable. It is regrettable that the CHCWG did not use its limited time and resources to explore this further.

Similarly, the questions about public spending priorities also reflected the CHCWG's preoccupation with maintaining the status quo rather than promoting all of these priorities through a universal health care system. It is significant that the largest group of respondents in every community supported guaranteeing health insurance for all as the top priority, and that the largest number also favored the creation of a national health program to ensure access to affordable high quality health care coverage and services for all Americans.

Unfortunately, the Interim Recommendations made by the CHCWG do not recognize the interdependence of the problems that the American people are concerned about, nor do they call for an explicit plan that guarantees that all Americans will have access to affordable health care by 2012.

Catastrophic insurance is treated separately from the comprehensiveness of the benefit package or the financing of health care and the mechanisms for cost containment. CHCWG assumed that comprehensive benefits for all would be too expensive and could only occur if the benefit package was reduced. CHCWG did not seek public input on strategies to reduce health care spending by using public mechanisms to reduce health care prices and improve health care efficiency, especially at the community level.

ISMCH is very interested in applying civil rights principles to public health authority at the state and community levels through licensing, quality assurance, and accreditation standards to increase the efficiency, effectiveness, and equity of health care delivery within a geographical area, like a community or region, or a state.

CHCWG seems to have focused on public policies that would be necessary to build an insurance market with competition on the basis of price and quality. Although there are recommendations for "shared responsibility" like sliding-scale premiums for low-income persons, the CHCWG seems to have emphasized strategies that are compatible with the current health care system, even though the overwhelming majority of the American public emphasized that the health care system needs to be fundamentally changed.

The CHCWG proposed several Interim Recommendations ostensibly to address the concerns expressed by the general public through a combination of community meetings, public hearings, and an on-line survey. The most significant recommendation was probably a commitment to universal health care for the whole population by 2012. While this recommendation is consistent with the urgency demanded by the majority of respondents throughout the country, the CHCWG report does not explicitly clarify the process for arriving at universal health care by 2012, nor indicate how the interim recommendations that have been made would incrementally lead to universal health care by 2012. Instead the CHCWG report lamely acknowledges that "to achieve

change, we need to find a way to reconcile contrasting views about the role of the marketplace and government, or competition and planning, and of individual and shared responsibility.”

ISMCH is concerned that the CHCWG recommendations for universal health care not fudge on the definition of “all”, the definition of “affordable”, and the definition of “health care”. While we like the goal of health care that works for all, we are concerned that recommendations which limit access to “all Americans” plays into the anti-immigrant xenophobia that inhabits our country at this time, and is likely to undermine the structural changes that are necessary to provide health care coverage to all persons who live in the US.

Secondly, ISMCH is concerned that the definition of “affordable” in a system of shared responsibility not impose a disproportionate burden on low income persons or persons with the highest health care needs. It is essential that the CHCWG not recommend an individual mandate without specifying the infrastructure at the federal and state levels that would be necessary to ensure both equal access to all medically necessary services regardless of one’s income, and efficient and effective mechanisms for cost containment to ensure that health care can be affordable for all. Reflecting the existing health care marketplace, the CHCWG recommendations seem to favor cost containment through restrictions on the benefit package, or cost-sharing requirements that are likely to discriminate against people with lower incomes and those with higher health care needs.

Thirdly, the definition of “health care” must include all services that are medically necessary for an individual, not those that are only medically necessary for everyone or for the so-called “average patient”. The affordability of the health care system will depend largely on structural changes which eliminate excess profits, reduce inefficiencies due to fragmentation in accountability, excess capacity, and barriers to access, and which increase effectiveness through use of evidence-based medicine, appropriate use of health information technology, cultural competency training and health education for patients and their providers, and non-clinical strategies for addressing the social determinants of poor health.

Besides recommending an unspecified core benefit package for all Americans, the CHCWG highlighted four interim recommendations that would presumably address some of the symptoms of the health care crisis and provide some of the funding for achieving universal health care. These interim recommendations were: catastrophic coverage, integrated community health networks, quality care, and restructured end-of-life care. While all of these changes could be important components of a system for universal health care, we are concerned that they be adopted in a way that strengthens universal health care instead of avoiding the structural changes that will be necessary to achieve universal health care.

For example, catastrophic coverage is crucial to protect people from very high health care costs, but it should not be used to protect bare-bones coverage for those who cannot afford a more comprehensive private benefit package, thus preserving inequalities in our health care system. Furthermore, catastrophic coverage should not be viewed as a higher priority over coverage for everyday health care costs, but as one among many criteria for ensuring access to affordable health care in a universal health care system.

ISMCH is also concerned that the CHCWG recommend “integrated community health networks” not just for safety-net providers serving low income persons in community health centers, but as a publicly accountable model for delivering the highest quality health care in the most efficient and effective way to all patients at the community level. Otherwise, the limited

public dollars in the safety-net sector of our health care system will perpetuate the unequal access to medically necessary health care that the American people want to overcome.

The quality initiatives that the CHCWG embraced are frequently advocated by entrepreneurs who want to sell Health Information Technology to providers by making a business case for quality. This theme is often reinforced by pay for performance strategies that propose financial incentives for achieving higher quality measures. While quality initiatives can certainly be efficiently promoted through universal health care, ISMCH is concerned that these quality initiatives not be used to increase the gap in health status between those who are well-insured and those who are uninsured or under-insured. In fact, ISMCH is promoting a civil rights approach to health equity to ensure that the disparities in health and health care are closely monitored and efficiently addressed by health care reform.

The CHCWG recommendations for “end-of-life” care are often proposed as simple ways to save Medicare dollars by avoiding high tech futile care that is frequently wasted on persons at the end of their lives. This may occur when health care providers see an opportunity to bill Medicare for unnecessary health care procedures that cannot be justified as improving a person’s health. This response to end-of-life care does not empower the individual patient to maximize the quality of his or her life when they may really want comfort care at home. ISMCH supports the CHCWG recommendations to expand coverage of palliative care, hospice care and other end-of-life services that comport with the wishes of the ill patient and his or her family. At the same time, ISMCH is very concerned that persons with disabilities at any age are not discriminated against by being deprived of any health care service that could improve the quality of their lives. Moreover, it is crucial that access to hospice care be available as part of a universal health care benefit to avoid pressure on severely disabled people or uninsured persons with chronic health conditions to “choose” to end their lives prematurely in order to avoid imposing a financial burden on their families. Otherwise, it would be a real tragedy for a society to deny providing appropriate health care to uninsured persons that could have prevented an illness or disability in the first place, and then make available a system of palliative hospice care without providing universal health care first.

In sum, the ISMCH would like to see the recommendations of the CHCWG finally put on the Nation’s agenda the crying need for universal health care in the US. Although the framework for the dialogue process introduced policy trade-offs that would not be necessary within a well-developed system of universal health care, to its credit the CHCWG reported the overwhelming support for universal health care that it found throughout the country. Having raised this expectation, it is imperative that CHCWG refine its policy recommendations to reflect the urgent public support for a universal health care system that guarantees a comprehensive health care benefit package for everyone at the earliest possible date.

Sincerely,

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