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Working for Health Care Justice

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Citizens Health Care Working Group
7201 Wisconsin Avenue
Bethesda MD 20814

Dear Members of the Working Group,

The nation owes you its thanks for the hard work you have done to make sense of health care in America and to explore ways to make health care work for all Americans. This is a challenge that America's political leadership has so far failed to address, though this may be changing. And your work will hopefully accelerate that change.

UHCAN is a national network that promotes comprehensive health care for all through education, strategies development and advocacy. We serve as a resource and strategic center for local, state and national groups across the nation which are working to achieve affordable, comprehensive health care for all.

Because we have recognized from the beginning the potential value of your effort, we have paid close attention to your process and to the input you have received. We, therefore, offer a rather lengthy set of comments on a broad range of topics related to your interim recommendations. These are divided into three sections:

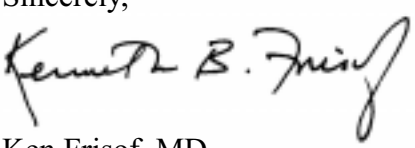
(1) An assessment of the strategy for change implicit in your commendations and a suggestion for a principled and practical strategy that we feel will achieve your goals more effectively.

(2) A concern about the degree to which your recommendations reflect the weight of the input you received.

(3) Specific comments on your values and principles and the six interim recommendations.

We trust that you will accept this three-part assessment in the spirit in which it is offered – constructive engagement on a complex , but solvable problem that must be addressed to make the U.S. a better and healthier nation.

Sincerely,



Ken Frisof, MD
National Director

Section 1: Perspective on strategy

UHCAN wholeheartedly agrees with your comment about how important it is to "reconcile contrasting views about the role of the marketplace and government, of competition and planning, of individual and shared responsibility." We highlight this in our educational PowerPoint, *Affordable Health Care for All: Moving beyond political deadlock.* Furthermore, we are pleased that your Values and Principles Section emphasizes the role of shared social responsibility – both in paying for care and in consideration of health care costs.

Most importantly, you state that you "do not believe that the most important barriers to achieving a heath care system that works for all are technical." We agree. The barriers are, indeed, political.

You present your six recommendations as a "strategy" for the United States to achieve the goal of Making Health Care Work for All. While each recommendation has merit, our comments here address the ways in which the six, taken as a group, may or may not be an effective *strategy*. We encourage you to consider a strategy that, while incorporating elements of your individual recommendations, also reconciles *contrasting views of how best to engage in health reform* by allowing different approaches to be tried in different regions of the country. We call this a Health Partnership Strategy.

We would summarize your recommendations as follows:

1. Prevent family pauperization from spending on health care.
2. Encourage improvements in delivery through integrated community networks.
3. Improve quality of care and efficiency.
4. Fundamentally restructure end of life care.

These four are seen as building towards the two larger and ultimate goals.

5. Make affordable health care for all national public policy.
6. Define a core benefit package.

The important question about the four preliminary recommendations is to what extent they constitute an effective strategy to lead to your two concluding recommendations. We see your four preliminary recommendations as being designed as separate "silos," unfortunately, each requiring separate Congressional debate and action.

This "siloization" of the recommendations hides the fact that they are inextricably interlinked. For example, improving efficiency in health care – reducing administrative overhead, reducing incentives to provide marginally useful services – is critical to avoiding pauperization from health spending. The improved coordination of care envisioned in the second recommendation reduces fragmentation and unnecessary duplication of services – also impacting on cost.

While you comment that the barriers to progress are not "technical," your first four interim recommendations are essentially technical solutions. We contend that to integrate the solutions

needed for America's health care, to take them out of their silos, state-based implementation, with federal financial incentives and policy support, is the way to go. We call this The Health Partnership Strategy - a strategy to move beyond *political* deadlock.

UHCAN believes that the commonly used phrase that "the American health care system is breaking down" is dangerously inaccurate. America does not have a single health care system, but rather, in noted health care policy expert Henry Aaron's words, "a collection of loosely linked systems." These are:

- Medicare for the elderly and disabled,
- Medicaid and S-CHIP for the poor, and,
- Employer-based health care for working families.

While all are under duress, the employer-based system is eroding the most rapidly because of fundamental and irreversible changes in the nature of employment. The contours of these systems, how they abut one another and link together, vary from state to state depending on Medicaid laws and regulations, as well as the nature and strength of employer-sponsored care.

The weight of law and tradition make it highly unlikely in the short term for one of the systems to completely disappear and be replaced by one of the others or something entirely new. Defining America's health care problem as stemming from our having a collection of loosely linked systems points to seeking solutions that knit them together eliminating the gaps between them. This fabric must both cover everyone and be strong enough to withstand pressures for excessive growth in spending. The fabric can have an array of shapes and sizes to fit the varied populations they serve. We believe that in the current political environment, this is best accomplished locally, through cooperation in design and implementation of local and state governments, by the private and public sectors, in partnership with the federal government.

Fundamentally, this means strengthening *systems of care*, an emphasis shared by your recommendations two, three and four. Your first recommendation on funding, however, does not appear to consider care system issues.

The creative federalism behind the Health Partnership Strategy has a long and distinguished bipartisan cross-ideological heritage. At the beginning of the twentieth century, progressive federalism in states like Wisconsin led to Workers' Compensation laws. The most popular phrase defining federalism, "states as the laboratories of democracy," was penned by Justice Louis Brandeis, one of the most liberal jurists in America's history. At the end of the century, conservatives embraced federalism as the approach to welfare reform and other domestic issues.

In the absence of federal action, a number of states have taken creative action to advance coverage over the last three years – Maine, Illinois, California, Maryland, Massachusetts and Vermont, to name some of the leaders. The last two are particularly important, because they were accomplished in a bipartisan fashion – with Democratic legislatures and Republican governors. None of these initiatives is perfect, and many will falter without a federal policy and financial environment to encourage them.

In sync with these state advances bipartisan health partnership proposals have been introduced in both houses of Congress. In the Senate, The Health Partnership Act, S.2772, was crafted by Senators Voinovich and Bingaman. In the House, The Health Partnership Through Creative Federalism Act, HR5864, was developed by Representatives Baldwin, Beauprez, Price and Tierney. Both bills set up a State Health Innovation Commission, composed of distinguished leaders from the federal, state and local government levels, to provide guidelines for and evaluate State Health Expansion and Improvement Proposals

The overall Health Partnership Strategy has political benefits at the federal and the state levels. In language adapted from the FAQ's on the www.health-partnership.org website:

- *National.* Members of Congress can more readily support legislation that allows for a variety of alternatives, including ones they oppose, if those they dislike are not imposed on their states.

- *State.* Politics is commonly described as "the art of the possible." Health care is so large and complex that there are too many "deal-breakers" at the national level for effective sustainable reform. At the state and local levels, there are fewer deal-breakers, so that meaningful reforms can be passed and implemented, especially if encouraged through federal financial incentives.

The Health Partnership Strategy is a catalytic strategy. It accelerates the growing momentum for real solutions to America's health care problems, solutions from which the entire nation can learn. It is gaining support from both those who ultimately envision a unified national system and those who prefer a more flexible decentralized model.

We strongly commend it to your attention .

Section 2: Comments on the connectedness of your recommendations and the input you received.

Congress charged you to prepare recommendations on "health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings." You have heard from over 20,000 Americans from all corners of the country and all walks of life in this democratic and inclusive process.

We believe that your Interim Recommendations, while positive in many ways, do not accurately reflect two very important messages you received from the great majority of participants in the public process. These are:

(1) Over two-thirds support for the goal to "Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance."

(2) Near universal resistance to the "zero-sum" trade-off ideas on which some of the questions posed were based, that is, the implication that greater access to health care might only be afforded and achieved by reducing benefits.

You have heard unequivocally from the public that they do not want business as usual in health care to continue. Yet, these two themes are not reflected anywhere in your Interim Recommendations.

We trust that in your Final Recommendations you will more effectively highlight the public support for an easy-to-navigate national health plan and public opposition to measures that seek to control costs by reducing access to categories of benefits.

Section 3: Specific comments on values, principles and interim recommendations

VALUES & PRINCIPLES

The Working Group's key principle is that health care is a "shared social responsibility." UHCAN believes that successful and sustainable reform will embody the principle of shared social responsibility both on cost and on access.

Successful reforms must share responsibility among those who pay for health care - individuals, employers, and state, local and federal governments - to assure affordability for all.

Successful reforms must promote commitments to stewardship of limited resources among those who provide care to maximize the value of every dollar spent on health care.

The principles of "shared social responsibility" rejects the market approach as the fundamental organizing principle of health care. So did survey respondents with 62% disagreeing with the statement, "We all should be responsible for setting aside enough money to pay for most of our health care expenses." [Online Health Care Poll, Q. 7a.]

RECOMMENDATION #1

While it is worthwhile to eliminate the uniquely American phenomenon of medical bankruptcy, this is only part of the affordability problem in health care. The goal needs to be to remove financial barriers to health care.
Shared responsibility for financing care cannot mean high patient cost-sharing. Making premiums affordable by requiring high deductibles or high co-pays at point-of-service would create shallow insurance that Americans could not afford to use.

The recommendation for a national program is also hampered by the statement that it should be public or private. It might combine both public and private elements. Medicare has won widespread support by combining private delivery of care with public coverage.

RECOMMENDATION #2

Providing high quality coordinated care to vulnerable populations through integrated community networks is a worthwhile goal.

But coordination has to be between ambulatory care and in-hospital care, between primary care and specialty care. The problems faced by providers in the current safety net stem from both under funding and obstacles to obtaining hospital and specialist care. Indeed, a true integration would mean the gradual disappearance of a separate sector called "the safety net." While we believe in expanding integrated community networks, we strongly feel that this should not entail modifying the Federally Qualified Health Center concept.

RECOMMENDATION #3

The five specific areas in which the promotion of better quality and greater efficiency are proposed are all reasonable and important. As stand-alone goals, their utility is limited.

To the extent that health care remains fragmented and discontinuous, they cannot achieve their potential. The promotion efforts in these areas need to be designed to accelerate the integration and coordination of care, to promote continuity of care, and to allow for choice.

RECOMMENDATION #4

These are laudable goals. While the provision of palliative care is a specially challenging phase in families' lives, the principles and concepts from this sector of health care need to be applied to everyone with chronic diseases.

RECOMMENDATION #5

This is the most important recommendation. We strongly believe that this goal must be achieved no later than 2012.

The Interim Recommendations unfortunately switch from values language of "shared social responsibility" to the concept of "financial assistance" to individuals in this recommendation. Shared social responsibility is another way of saying we're all in this together. Financial assistance conjures up programs in which the assistance can be cut when budgets are tight.

The statement that "benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security" reflects the belief that benefits that are broad in scope are indeed vital.

Survey responses clearly wanted broad, inclusive, comprehensive benefits, and rejected exclusion of types of care as a main tool to limit cost. [Interim Recommendations, Appendix C, Online Poll, Q.4.]

This recommendation leans on a market approach to containing costs. It emphasizes "consumer-usable…information on prices" rather than public policy tools such as:

- slashing administrative costs by eliminating the complexity of thousands of different insurers and plans,
- capping the share of health insurance premiums that can be used for administration, marketing and profit, and,
- federal government negotiations to cut drug prices for Medicare and all Americans, which over 70% of on-line survey participants support. [WG Int. Rec. Appendix C:4, 8e]

Coupling cost controls with coverage expansion would make broad and deep coverage affordable now.

RECOMMENDATION – FINANCING HEALTH CARE THAT WORKS

Linking financing strategies to principles of fairness and efficiency is very important. Efficiency in financing means reducing the paperwork shuffle, the administrative waste, the plethora of confusing and concealed prices.

Fairness means financing care in ways based on one's ability to pay, not one's health status – 47 % of survey responses support income-linked payment standards for determining who should pay more for coverage. [Working Group Interim Recs. Appendix B: 4]

This emphasizes the importance of the Working Group's mention of the graduated income tax as a potential revenue source.

Survey participants also reject making people pay more based on health behaviors or health status – 70% disagree with requiring people who use more health services to pay higher premiums. [Working Group Interim Recommendations Appendix C: Qq.7c]

RECOMMENDATION #6

Clearly some types of services are not medically necessary and should not have their costs shared.

For example, no one would argue that the costs of liposuction are a social responsibility. However, the delivery of non-core benefits is not what makes American health care so unaffordable.

The cost problem in American health care results from three main sources:

- excessively high prices for care in the U.S.,
- administrative costs of highly fragmented private insurance, and,
- too many core services performed in clinical situations where they are of little to no benefit.

Shared social responsibility for covering the cost of health care also entails social responsibility for containing costs, including prices. Cutting prices cannot be left to individual patients' comparison shopping.