League of Women Voters of the Cincinnati Area
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HEALTH CARE

Health Care in the United States is in crisis. Costs have soared. According to the Department of Health and Human Services, “The United States spends a larger share of its gross domestic product (GDP) on health care than any other major industrialized country.” <www.ahrq.gov/news/costsfact.htm> “Expenditures in the US surpassed $2 trillion in 2006, almost three times the $714 billion spent in 1990, and over eight times the $253 billion spent in 1980...US health care spending per resident was about $7026 in 2006, and represented 16% of GDP...Total health care expenditures grew at an annual rate of 6.7% in 2006, slower than in recent years...Since 2007, employer sponsored health coverage premiums have increased by 87%...” www.kaiseredu.org/topics>

The U.S. Census Bureau estimates that there were 45.7 million uninsured Americans in 2007 and even the insured have found their coverage inadequate when faced with a serious medical problem.

One study found that medical-related bankruptcies accounted for 63% of all bankruptcies filed in 2001.[1] A recent (2006 & 2007) study of home foreclosures in four states found that 49% of those surveyed had medically related expenses or loss of income, which resulted in the foreclosure. The Harvard-based authors noted “Our most striking observations begin with the realization that most of those suffering medical foreclosures are solidly in the middle class, with apparently affordable homes, and health insurance to boot.”[2]

But while the cost of health care is rising every year, the quality of care in the U.S. is decreasing. A study of seven developed countries (Australia, Canada, Germany, the Netherlands, New Zealand, United Kingdom and the United States) by the Commonwealth Fund (Health Affairs 26, no. 6, 2007) found the US to have the highest cost per capita for health care spending, the highest number of uninsured and the highest percentage of GDP spending. The U.S. was also the only country without universal coverage.

Participants in the survey were asked a number of questions about their care such as wait for elective surgery and acute care appointments. Although Americans were able to get *elective* surgery faster than citizens in some of the other countries studied (62% of Americans waited less than 1 month where the range for the other 6 countries was 32% in Canada to 72% in Germany), only 30% of Americans were able to get an appointment with their doctor on the day they called compared 41% in UK, 42% in Australia, 49% in the Netherlands, 53% in New Zealand and 55% in Germany; only Canada was worse than the US with 22%.

The list of questions is extensive and the entire study can be found on the Internet at www.commonwealthfund.org/publications/publications_show.htm?doc_id=568237

Another study by the prestigious London School of Hygiene and Tropical Medicine[3] found that the United States had the most preventable deaths of 19 developed countries in 2002-2003. These statistics were based on bacterial infections, treatable cancers, diabetes, heart disease, stroke and complications of surgical procedures. Diseases with a lifestyle (such as smoking) cause were not included in the final analysis. The United States had 109.7 deaths per 100,000 whereas Japan had 71.2 and Australia had 71.3. In 1997-1998, the US ranked 15th out of 19 total countries.

[1] Melissa B. Jacoby & Elizabeth Warren, “Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress,” (100 NW U. L. REV. 2006), pp. 535, 548-49, 551

[2] Christopher T. Robertson, Richard Egelhof, & Michael Hoke, “Get Sick, Get Out: The Medical Causes of Home Foreclosures,” *Health Matrix 18*, (2008), pp. 65-105.

[3] E. Nolte, Martin McKee, “Measuring the Health of Nations: Updating an Earlier Analysis Health Affairs,” *Millwood 2008,* Jan-Feb, 27(1), pp. 58-71

The League finalized a Health Care position in 1993 — 5 years ago. Many League members anticipate action on health care issues in the near future — locally, statewide and nationally. With that in mind, as well as the League National Convention's call to make sure all members understand our position, we are presenting the following copy of the position and discussion questions for February unit meetings. Please be clear that this is not an official League study and we cannot add points to our position or change the fundamental thrust of the position. Although some members might want to do a complete restudy of health care at this time, it would cripple our ability to act on any health care issues since a restudy would void our present position and put us into study mode – a process which can take up to 3 years to complete.

Health Care - The League's History
In 1990, the LWVUS undertook a two-year study of the funding and delivery of health care in the United States. Phase 1 studied the delivery and policy goals of the U.S. health care system; Phase 2 focused on health care financing and administration. The LWVUS announced its initial health care position in April 1992 and the final position in April 1993.

The Health Care position outlines the goals the LWVUS believes are fundamental for U.S. health care policy. These include policies that promote access to a basic level of quality care at an affordable cost for all U.S. residents and strong cost-control mechanisms to ensure the efficient and economical delivery of care. The Meeting Basic Human Needs position also addresses access to health care.

The Health Care position enumerates services League members believe are of highest priority for a basic level of quality care: the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health care), acute care, long-term care and mental health care. Dental, vision and hearing care are recognized as important services but of lower priority when measured against the added cost involved. Comments from numerous state and local Leagues, however, emphasized that these services are essential for children.

To achieve more equitable distribution of services, the League endorses increasing the availability of resources in medically underserved areas, training providers in needed fields of care, standardizing the services provided under publicly funded health care programs and insurance reforms.

The LWVUS Health Care position includes support for strong mechanisms to contain rising health care costs. Particular methods to promote the efficient and economical delivery of care in the United States include:

- regional planning for the allocation of resources,
- reducing administrative costs,
- reforming the malpractice system,
- co-payments and deductibles,
- and, managed care.

In accordance with the position's call for health care at an affordable cost, co-payments and deductibles are acceptable cost containment mechanisms only if they are based on an individual's ability to pay. In addition, cost containment mechanisms should not interfere with the delivery of quality health care.

The position calls for a national health insurance plan financed through general taxes, commonly known as the "single-payer" approach. The position also supports an employer-based system that provides universal access to health care as an important step toward a national health insurance plan. The League opposes a strictly private market-based model of financing the health care system.

With regard to administration of the U.S. health care system, the League supports a combination of private and public sectors or a combination of federal, state and/or regional agencies.

The League supports a general income tax increase to finance national health care reform.

The LWVUS strongly believes that should the allocation of resources become necessary to reform the U.S. health care system, the ability of a patient to pay for services should not be a consideration.

In determining how health care resources should be allocated, the League emphasizes the consideration of the following factors, taken together:

- the urgency of the medical condition,
- the life expectancy of the patient,
- the expected outcome of the treatment,
- the cost of the procedure,
- the duration of care,
- the quality of life of the patient after the treatment,
- and, the wishes of the patient and the family.

As the LWVUS was completing Phase 2 of the study, the issue of health care reform was rising to the top of the country's legislative agenda. In April 1993, as soon as the study results were announced, the LWVUS met with White House Health Care officials to present the results of the League's position. Since then, the League has actively participated in the health care debate.

The LWVUS testified in fall 1993 before the House Ways and Means Subcommittee on Health, the Energy and Commerce Committee and the Education and Labor Committee, calling for comprehensive health care reform based on the League position. The League joined two coalitions — one comprised of consumer, business, labor, provider and senior groups working for comprehensive health care reform, and the other comprised of groups supporting the single-payer approach to health care reform.

Throughout 1994, the League actively lobbied in support of comprehensive reform, including universal coverage, cost containment, single-payer or employer mandate and a strong benefits package. The League continued to advocate for the inclusion of the state single-payer option in any health care package and emphasized LWVUS support for the inclusion of reproductive health care, including abortion, in any health benefits package. League leaders participated in countless lobbying visits in Washington, held grassroots meetings with members of Congress and spoke out in the media.

Health care reform advocates, including the League, continued to press for comprehensive health care reform through September 1994. But congressional sponsors were unable to reach accord, and comprehensive reform was declared dead for the 104th Congress. The focus then shifted to the states, where Leagues have worked in support of health care reform, while fighting off attempts to cut back on existing health care.

The LWVEF initiated community education efforts on health care issues with the "Understanding Health Care Policy Project" in the early 1990s. The project provided training and resources for Leagues to conduct broad-based community outreach and education on health care policy issues with the goal of expanding community participation in the debate.

In spring 1994, the LWVEF and the Kaiser Family Foundation undertook a major citizen education effort, "Citizen's Voice for Citizen's Choice: A Campaign for a Public Voice on Health Care Reform." The project delivered objective information on health care reform to millions of Americans across the country. Local and state Leagues sponsored more than 60 town meetings in major media markets nationwide, involving members of Congress and other leading policy makers and analysts in health care discussions with citizens. In September 1994, the LWVEF and the Kaiser Family Foundation held a National Satellite Town Meeting on Health Care Reform, with more than 200 downlink sites across the country. The two organizations also undertook a major television advertising effort to promote public participation in the health care debate.

In 1997, the LWVUS joined 100 national, state and local organizations in successfully urging Congress to pass strong bipartisan child health care legislation.

In 1998, the LWVUS began working for a Patients' Bill of Rights, aimed at giving Americans participating in managed care health plans greater access to specialists without going through a gatekeeper, the right to emergency room care using the "reasonably prudent person" standard, a speedy appeals process when there is a dispute with insurers and other rights.

Also in 1998, the LWVEF again partnered with the Kaiser Family Foundation and state and local Leagues on a citizen education project, this time focused on Medicare reform, patients' bill of rights and other health care issues. In the first phase of the project, more than 6,500 citizens participated in focus groups, community dialogues and public meetings. Their views were reflected in *How Americans Talk About Medicare Reform: The Public Voice*, presented to the National Bipartisan Commission on the Future of Medicare in March 1999. The report emphasized that people value Medicare but recognize its flaws. Fairness, responsibility, efficiency and access were identified as important values for any reforms of the Medicare system.

In spring 2000, the LWVEF and Kaiser Family Foundation developed and distributed two guides, *Join the Debate: Your Guide to Health Issues in the 2000 Election* and *A Leader's Handbook for Holding Community Dialogues.* The project focused on five issues under debate in the election:

- the uninsured,
- managed care and patients' rights,
- Medicare reform,
- prescription drug coverage,
- and, long-term care.

Throughout the 106th Congress, the LWVUS lobbied in support of a strong Patients' Bill of Rights.

~ In July 1999, the Senate passed a watered-down version of patients' rights legislation opposed by the League.
~ In October, the House passed a strong, bipartisan bill that guaranteed basic health care protections supported by the League.
~ Despite several close votes in 2000, however, Senate opponents continued to block passage of real patient protection legislation.
~ At Convention 2000, League delegates lobbied their members of Congress to pass a strong, comprehensive Patients' Bill of Rights and send it to the President.

The League's efforts in support of passage of real patient protection legislation continued throughout the 107th Congress. Delegates to Convention 2000 met with their Representatives and Senators in support of the Patients' Bill of Rights, but the legislation was essentially shelved as Election 2000 drew near.

LWVUS lobbied federal lawmakers in support of the Bipartisan Patient Protection Act of 2001, legislation that would provide patients with administrative and legal recourse in dealing with insurers and Health Maintenance Organizations (HMOs). Despite action in both the House and Senate and pressure from the LWVUS and other health care advocates, the legislation died in the conference committee that should have resolved the differences between the two bills.

In the 108th Congress, League lobbied Congress in support of the Health Care Access Resolution, which expressed congressional intent to begin the debate on how to provide health care access to all. In November 2003, the League opposed the Medicare Prescription Drug bill that was signed into law by the President because its particular provisions undermined universal coverage in Medicare.

In May 2006, the League urged Senators to oppose the Health Insurance Marketplace Modernization and Affordability Act (HIMMA). While this proposal purported to expand health care coverage, it in fact limited critical consumer protections provided in many states.

GOALS:
The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents.

Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

DISCUSSION QUESTIONS TO PROMOTE UNDERSTANDING OF OUR POSITION

1. Does affordable insurance equal a basic level of health care?

2. Does having health *insurance* equal having health *care*?

BASIC LEVEL OF QUALITY CARE:

Every U.S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

1. What is beyond basic coverage?

2. Who would provide the insurance premiums for this extra coverage, especially if nationalized health care?

3. Who would regulate these extra policies?

FINANCING AND ADMINISTRATION:

The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League.

The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state and/or regional government agencies.

The League is opposed to a strictly private market-based model of financing the health care system. The League also is opposed to the administration of the health care system solely by the private sector or the states.

TAXES:

The League supports increased taxes to finance a basic level of health care for all U.S. residents, provided health care reforms contain effective cost control strategies.

1. Several states have attempted health care reform. Can we use our position to lobby on state wide health care reform?

COST CONTROL:

The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as:

- the reduction of administrative costs,
- regional planning for the allocation of personnel, facilities and equipment,
- the establishment of maximum levels of public reimbursement to providers,
- malpractice reform,
- the use of managed care,
- utilization review of treatment,
- mandatory second opinions before surgery or extensive treatment,
- consumer accountability through deductibles and co-payments.

1. Prioritize the bullet points in the position.

2. Are there other cost control measures you thing are important?

3. Should the government take on part or all of drug discovery/development costs?

EQUITY ISSUES:

The League believes that health care services could be more equitably distributed by:

- allocating medical resources to underserved areas,
- providing for training health care professionals in needed fields of care,
- standardizing basic levels of service for publicly funded health care programs,
- requiring insurance plans to use commu-

nity rating instead of experience rating,
- establishing insurance pools for small businesses and organizations.

1. Please prioritize the above bullet points.

ALLOCATION OF RESOURCES TO INDIVIDUALS:

The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together:

- the urgency of the medical condition,
- the life expectancy of the patient,
- the expected outcome of the treatment,
- the cost of the procedure,
- the duration of care,
- the quality of life of the patient after treatment
- the wishes of the patient and the family.

1. Who should be responsible for determining the above criteria?

— Material prepared by: Glenda Bernstein, Mary VanAusdall and Gretchen Langdon

SOURCES

"Impact on Issues 2006-2008 A Guide to Public Policy Positions" League of Women Voters of the United States. 67-70.

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Nolte, E., McKee, Martin. "Measuring the Health of Nations: Updating an Earlier Analysis Health Affairs," Millwood. (2008*):* Jan-Feb, 27(1), 58-71.

If you are interested in joining
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we meet
the 4th Tuesday of each month
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