

**CITIZENS HEALTH CARE  
WORKING GROUP  
HEALTH CARE THAT WORKS  
FOR ALL AMERICANS**

**Rural Listening Sessions Summary Report  
Greenville, MS  
April 18, 2006**

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**Citizens Health Care Working Group  
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**Citizens' Health Care Working Group**

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AMERICANS**

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UNIVERSITY  
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**Introduction**

Two listening sessions were held in Greenville, MS, on April 18, 2006. The groups were similar in gender and race composition, but quite different from each other in terms of age, race, and education. While both groups had a larger percentage of female participants, the evening group was almost all female (94%) while in the afternoon group, females made up 83% of the participants. Likewise, both groups were predominately African American, composing 83% of the afternoon group and 94% of the evening group. The remaining participants in both groups were white. The afternoon group was quite a bit older with 68% falling between ages 45-64 and 28% being age 65 or older, leaving only 5% under age 45. In the evening, however, over half of the participants were under age 45 (56%) leaving only 31% ages 45-64 and 13% over age 65.

The most of the participants of the afternoon group were college educated with 10% completing some college, 6% completing an associates degree, 18% a bachelors degree, and 35% a graduate or professional degree. Only 18% of that group had less than a high school degree. For the evening group, however, exactly half had not completed high school, some of which had only completed through elementary school. Nineteen percent of the evening participants had completed high school or GED programs, with the remaining 31% having at least some college experience. Thus, the afternoon group's education levels exceeded the county rates of high school graduates comprising 65% of the population and those with bachelor's degrees or higher being 19%. The evening group, however, was under the county rates for both high school graduation and bachelor's degree or higher attainment. While lower, the evening group's education levels came closer to matching the county's than did the afternoon group's levels.

The largest percentage of the participants in both groups had employer-based insurance as their primary source of health care coverage. However, for the afternoon, the percentage was 50% while the evening was 38%. Twenty-one percent of the afternoon participants had self-purchased insurance while that was not the case for any of the evening group. Twenty-eight percent of the afternoon group was on Medicare and three percent were on Medicaid. For the evening group, 19% were on Medicare and 31% on Medicaid. One out of five of the afternoon group did not have insurance, while only 6% of the evening group indicated no insurance coverage.

Greenville is the county seat of Bolivar County, which borders the Mississippi River and has a rich tradition as delta farming country. Data from the U.S. Census Bureau indicates that the population of the county is fairly evenly divided between males and females, but that white persons comprise only 33% of the population. Black or African American persons comprise 65% of the population, with the remainder being made up of other ethnic groups. Poverty rates for this county are also quite a bit higher than the state, with 33% of the county residents living below the poverty line as compared to 20% for the state. Given the high education levels in the afternoon group, it is possible that their income levels exceeded the county's average. However, the evening group, which matched the county more closely in demographics, may have had a

similar income rate. It is worth noting, however, that although the afternoon participants may not have matched county demographics as well, many of them were employed in local social service or community service organizations and dealt with the community's needs on a daily basis, and thus, are believed to be credible voices for the community.

### **State of the U.S. Health Care System**

In a discussion centering on the state of the U.S. health care system, the participants of the afternoon group were fairly evenly split as to whether the system is in a state of crisis (40%) or whether the system has major problems (56%). The evening group had a larger leaning toward the belief that the system had major problems (63%), with 25% believing it was in a state of crisis, and 13% stating that it had minor problems. The majority of the two groups voted in opposite directions regarding the most important reason to have health insurance with 30% of the afternoon group and 63% of the evening group feeling that the main objective of health insurance was to pay for everyday medical expenses while the other participants (70% of the afternoon and 38% of the evening) felt that the most important reason for health care coverage was to guard against high medical costs.

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

#### **Values:**

Both the afternoon and evening groups identified a number of common values. Both groups identified affordability as a key value, ranking it first with a score of 10 out of 10 for the evening group, and second with a score of 9.7 for the afternoon group. One participant stated, "A lot of times even if you have insurance, you still can't get health care because you can't afford it." The afternoon rated "providing equal quality care for all" as number one (9.8). The evening group echoed this thought by stating that "no insurance should not mean no health care," the group's second ranked value. Other common values identified by both groups were the ability to choose physicians and to choose between generics and name brand prescriptions, regardless of insurance type. On the issue of prescriptions, one participant stated, "we should not be forced to choose generics because they are not as potent as the 'real thing.'" Surprisingly, the group, as a whole appeared to accept this perception as true. Other values of concern to the group were providing for prevention, ensuring that there were enough physicians to care for the population, and eliminating health disparities.

A majority of the participants (86%) agreed that it should be public policy that all Americans have affordable health care coverage. On the question of whether the current model of coverage based on who you are was preferred or defining a level of services for everyone was preferred, 95% of the participants favored a defined level of services for all. One person commented that either direction would require changing the attitudes of medical providers for the system to work.

#### **Benefits:**

Between the two groups, a fairly long list of potential additions to the Working Group's hypothetical basic benefits package was suggested, all of which were rated 8.2 and above on a ten-point scale. At the top of both lists was comprehensive cancer treatment. Other suggestion common to both groups included unlimited dental care, unlimited prescription coverage, hospice, home health, long-term care (including nursing home and assisted living) prevention health services (including exercise, nutrition counseling and health education), and vision care. One note of importance: during the discussion on the need to promote healthy habits with an eye on

the high obesity rates for the region, one person stated, “They need to quit putting steroids in your food that pump you up.” The group as a whole seemed support this thought. The afternoon group listed chiropractic care as the only potentially removable benefit, but the group rating of that removal did not show support. The evening group was unanimous in stating that nothing should be removed. Unlike other groups, this group did not even want to discuss the possibility of eliminating any services; “Nothing!” was a quick response.

When asked who should decide what is in a basic package, the participants indicated that they thought consumers should have the strongest voice (average rating 9.2 on a 10 point scale), followed by employers (7.1) and medical professional (7.0). The remaining two potential stakeholders were rated much lower indicating the group thought a much lower level of input was appropriate: government (6.1) and insurance companies (4.8).

### **Getting Health Care**

While the difficulties in getting health care that the groups listed were not ranked, it is interesting to note that the afternoon and evening session responses read almost identically on the first few responses, indicating a true commonality in the challenges the groups face in that community. Among the first difficulties listed were cost (including those who experience difficulty even with insurance because of high deductibles), transportation (a common rural issue), and not being able to get appointments either because of the low number of providers in the region or because a provider would not accept the patient’s coverage. One person noted that physicians had a tendency to treat insured patients before Medicaid patients. Another commented that one doctor left a group practice, but the remaining two physicians would not pick up the first doctor’s patients. Portability was also discussed at length, particularly with Medicaid and the inability to carry coverage across state lines. During the Katrina disaster, this region became home to many who had fled the storm. Medicaid patients from out of state faced significant challenges in accessing local health care.

### **Financing:**

A majority of the participants (83%) felt that everyone who can afford to do so should be required to enroll in basic health care coverage. However, some expressed concern over how to determine whether or not someone could afford coverage. Sixty percent of the participants thought that if a system should be developed that required all to participate, then all participants should pay the same. For those who favored some paying more than others, the greatest support came for using income as a criterion. The concept of using health behaviors as a criterion also received some support. The least support came for using family size as a criterion.

A majority (79%) felt that tax rules should continue to favor employers who offer employees health insurance. The group also strongly favored continuation of government support for current programs that cover some people who can’t afford it (91%). When asked how much more each would be willing to pay in a year to support efforts to provide access to coverage for all Americans, almost half of the group (44%) said “none.” Only about one third indicated a willingness to pay anything more: \$1-\$100 (15%), \$100 – \$299 (13%), \$300-\$999 (4%), \$1,000 or more (4%). Quite a few either did not answer (13%) or answered “don’t know” (21%).

### **Trade-Off Priorities & Options**

While all of the presented spending options received support, “Guaranteeing that all Americans get health care when they need it, through public ‘safety net’ programs” was the highest rated option (9.84 on a 10-point scale), though the group noted that earlier discussions said “everyone” rather than “all Americans.” This option was followed closely by “guaranteeing that all Americans have health insurance” (Rating: 9.75.) The third rated option was “Preserving Medicare and Medicaid (9.68), with “Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters” close behind (9.67). The top three rated “trade-off” proposals were to (a) Expand state government programs for low-income people, such as Medicaid and the State Children’s Health Insurance Program, to provide coverage for more people without health insurance (9.5), (b) Require businesses to offer health insurance to their employees (9.2), and (c) Expand current tax incentives available to employers and their employees to encourage employers to offer insurance to more workers and families (9.0). While requiring businesses to offer insurance ranked high with the group, some stated that this should be for large employers that employ large numbers of part-time people.

Perhaps more so in this depressed Delta area of the state facing economic and health care access problems beyond those in other parts of Mississippi, participants were less willing to consider trade-offs. Basic health care, in terms of current levels of services and access, was considered insufficient to meet the needs of the region. Discussions focused on the need for more health care and the plight of people in the region attempting to pay for what they do receive. Comments such as the following were common. “With Medicare, you pay 20%; that could cost you thousands.” “You work all your life for what you have and they want to take it.” “All this tax money you pay and still have to pay medical bills.” There was a clear sense in the group that “we have paid enough!”

### **Closing Comments and Other Ideas:**

A number of other thoughts were shared throughout the sessions that are worth noting:

- Across the board implementation and support for prevention is needed: personal, family, businesses, schools, insurance, and government. Education must be a part of the process. Health insurance incentives were also suggested as potentially beneficial in encouraging healthy behaviors in consumers. Incentives for providers who help keep patients well and out of expensive acute care settings were also suggested.
- Cap costs:
  - Payments to specialists and other providers
  - Payments to pharmaceutical companies
  - End-of-life care spending
- Pharmaceuticals, physicians, insurance companies, and government need to work together to make healthcare affordable.
- Limit insurance companies’ power to make decisions on care received and ensure that services seemingly included in policies are covered.
- Limit allowable lawsuits.
- Many expressed concern for the high cost of prescription drugs. The afternoon group shared stories of patients and friends that had been given an expensive prescription. After taking only a few doses, if the person felt better, he/she would stop taking the medicine and “save it” for next time, hoping to avoid the cost in the future. The

participants believed this to be a common practice in the community. There was a related belief that expiration dates were on medication just to encourage consumers to throw the remainder away and purchase more.