CITIZENS HEALTH CARE WORKING GROUP

HEALTH CARE THAT WORKS FOR ALL AMERICANS

Rural Listening Sessions Summary Report
Wesson, MS
March 29, 2006

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Mississippi State University Extension Service

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Introduction

One listening session was held in Wesson, MS, on March 29, 2006. Wesson sits on the boarder between Copiah and Lincoln Counties. The session was conducted at the Copiah-Lincoln Community College. While the group was small (only seven attending), the richness of the discussion rivaled that of any of the other sessions. The group was evenly divided with four females and three males. One person was between 25-44 years of age, while the remaining participants were between 45 and 64. All of the participants were white.

The educational experience of the group was diverse, with two having less than a high school diploma, one having a high school diploma, one holding an associate's degree, and three holding graduate or professional degrees. Based on county demographics for the two counties, the percentage of participants with a high school diploma (71%) matched that of the counties (72% in Lincoln Co. and 69% in Copiah Co.), while the percentage with a bachelor's degree or above (43%) exceeded that of the counties (12% both Copiah and Lincoln Counties). About half of the participants had employer-based insurance as their primary source of health care coverage and about half relied on self-purchased insurance. One person indicated that he/she had some other type of coverage not listed.

Copiah and Lincoln Counties are located in the southwest quadrant of the state, an area heavily damaged by Hurricane Katrina, with the eye passing just to the east of the region. In addition to their own damage, the counties became home, temporarily and permanently, to many who fled the storm from the eastern Louisiana parishes. Data from the U.S. Census Bureau indicates that the population of the counties is evenly divided between males and females, but that white persons comprise 49% of the population in Copiah County and 69% in Lincoln. Black or African American persons comprise 51% of the population in Copiah County and 30% in Lincoln, with the remainder being made up of other ethnic groups. The percentage of people living below the poverty line in Copiah County (25%) exceeds the state percentage (19.9%), while Lincoln County is a near match (19.2%).

State of the U.S. Health Care System

In a discussion centering on the state of the U.S. health care system, almost all (86%) of the participants believed the health care system to have major problems while the remainder believed the system to be in a state of crisis. The group was fairly evenly divided as to whether they believed the most important reason to have health insurance was to pay for everyday medical expenses (57%) or to guard against high medical costs (43%).

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

Values:

"Everybody deserves to be healthy," the voice of one participant, set a tone for the discussion of fundamental values for the nation's health care system. The group listed a total of 12 values that they believed to be very important. The group backed that belief through a very close ranking of

the 12 values, giving a small range of average ratings from 7.43 to 9.86 on a ten point scale). While the list was close, top rating values included personal responsibility (9.86), basic preventive care for all (9.43), accessibility – available to all without limitations (9.29), and uniform standards for all (not dependent on whether or not a person has insurance) (9.0). As in other rural settings, the issue of limited access to health care services and providers was stressed.

The participants were divided essentially in half over whether or not it should be public policy that all Americans have affordable health care coverage. Part of the concern was over the word "affordable" and who would be allowed to decide the definition. Some were concerned that the result would be socialized medicine or that the government would manage their health care. Others voiced concern for children, immigrants, and the large uninsured population. One person stated, "Sometimes you have to walk through the greedy to get to the needy," typifying some of the challenges discussed. The votes were likewise split on whether the current model of coverage based on who you are was preferred or defining a level of services for everyone was preferred. One person stated that neither choice was good. "There is a problem with how things are today, but universal services won't work either." Another commented, "Whoever pays the money is going to want to control the dollars."

Throughout there was expressed agreement that individuals needed to assume a level of personal responsibility and invest in their own health care. However, as a woman with a child suffering from hemophilia stated, "You should not have to bankrupt yourself."

Benefits:

Participants recommended a total of nine services be added to the Working Group's hypothetical basic benefits package. The highest ranking of these were radiation and chemotherapy, plastic surgery for congenital and medically necessary reasons (not cosmetic), and long-term care (including alternative care such as assisted living). Other highly rated suggestions included catastrophic coverage, hearing, durable medical equipment, and home health care/hospice. Three benefits were suggested as potentially removable benefits. However, after rating, only two, (1) home and office physician visits and (2) substance abuse treatment received group support for removal.

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 8.0 on a 10 point scale), closely followed by medical professionals (7.71). The group thought a much lower level of input was appropriate from employers (4.14), insurance companies (4.14) and government (4.0). The group had a fairly divergent view of government's role running from the belief that government bid regulations would result in lower costs to the belief that government needed to "stay out" of health care.

Getting Health Care

The shortage of health care providers in rural settings was quite evident as participants began listing difficulties experienced in getting health care services in the region. Specifically, these situations were noted: No provider in reasonable driving distance, no specialists in rural areas, declining number of physicians serving the region, lack of nurse practitioners in the area, length of time it takes to get an appointment. Related barriers were that (1) some physicians are

unwilling to accept Medicare and Medicaid patients due to low reimbursement rates and/or class bias and (2) the lack of transportation services in rural settings, coupled with rising gas prices. Another difficulty discussed was the prevalence of "old people taking care of old people." With the aging population, many in rural areas are dependent on neighbors and family members to care for one another. As younger generations move out of rural areas to urban settings, the aged are left caring for the aged. Particularly for the elderly, the lack of transportation after a procedure can prevent the individual from getting the care they need.

The largest barrier to health care discussed was the lack of physician availability in rural Mississippi; as one participant said, "If you have no doctor, everything else in this discussion meaningless." This group also discussed the need for price visibility in the health care system. "If I buy a car, I look at prices but I never see health care costs and can't shop around."

Financing:
One-third of the participants (33%) felt that everyone who can afford to do so should be required to enroll in basic health care coverage. However, the group noted two difficulties: First, determining what is "affordable". Affordable is a subjective term and the group voiced concern relative to how and by whom it would be defined. Next, there was recognition that some religious groups are opposed to formal health care and "requiring" participation would be an issue for such individuals. Most (67%) thought that should such a system be developed to require all to participate, that all should pay the same amount for the same service. A bit of support was voiced for allowing income to be a guideline for different payment, but the overall voice was "get the same service, pay the same amount."

A majority (83%) felt that tax rules should continue to favor employers who offer employees health insurance, stating, "If you don't encourage employers, you will have more people uninsured." Two thirds (67%) of the group felt that the government should continue to support current programs that cover some people who can't afford it. One person remarked that we "need to take care of those who can't afford it, but we have misused the way we do it." The group agreed that those who can not care for themselves should always be able to get the care they need, but concern was voiced as to whether or not the current systems was the way to fulfill that goal. 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, half of the participants indicated an unwillingness or inability to pay any more. The remaining scattered their votes across the spectrum. Given the depressed economic situation in this rural southwest region of the state, it is not surprising that so many were unwilling to commit additional dollars, even in theory, to anything else.

Trade-Off Priorities and Proposals
From the presented list of spending priorities, "guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas" was the highest rated option (9.3 on a 10-point scale.) Only two other options received support much above the midpoint on the scale: (a) Funding biomedical and technologicalresearch that can lead to advancements in treatment and prevention of disease (rated 8.3) and (b) investing in public health programsto prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters (rated 7.5). The remaining options received a rank of 6.0 or less, indicating only

moderate group support. On the proposed trade-off proposals to providing health care, highest support was voiced for expanding neighborhood health clinics (8.0) and expanding current tax incentives to employers (8.0) and their employees to encourage employers to offer insurance (7.7).

Closing Comments and Other Ideas

Throughout the session and at the end a number of other thoughts expressed by the group are worth noting. This group strongly felt that individuals should be responsible for their lifestyle choices and the impact on their health. As one individual stated, "We punish people for substance abuse because we think it is a 'choice', but not the 350-pound diabetic at a Shoney's buffet going back for a third helping." The future health care system they envisioned incorporated preventive care and holistic medicine.

Responsibilities also included financial obligations. Providing health care for one's family was considered an obligation. Though some may truly require assistance, it was expected that individuals should do without to do what they could to assume responsibility for health care payments. As one individual stated, "If my child is sick, I need to buy Tylenol instead of a pack of cigarettes so my child does not wind up in the ER with a high fever." Additionally, the group felt that individuals should not expect first dollar coverage; they felt "nothing should be totally free or service will be abused". They voiced concern over employers that offer "Cadillac plans" with first dollar coverage and then have to cut back when it gets too expensive. In discussing the growing cost of health care, concern was voiced over lawsuits and malpractice costs controlling the price of medicine. Related to that concern was the opinion that physicians were practicing defensive medicine and increasing costs from fear of potential legal liabilities.

Some thoughts the group had on controlling costs included developing community homes as an alternative to nursing homes for the care of the elderly, a uniform prescription monitoring system to avoid prescription abuse, expansion of the practice of evidence based medicine, increased quality assurance, reduction in redundancy of medical equipment, government's need to limit rule changes, review of provider salaries, medical savings accounts, and increased Centers of Excellence for specialized care such as burn centers. The group was split on a discussion of whether or not Medicaid should be subject to a national standard as is Medicare. As one individual said, "I like that we can look at our individual state's need. Rural Mississippi is not the same as California."