TEXAS LYCEUM Journal

December Issue, 2004

Contents

President's Message


Walter Tomlinson

Dear Readers,

As employers battle rising costs of providing health insurance and employees face shrinking benefits and more of the cost burden, the ranks of the uninsured are increasing at an alarming rate. Texas now claims one of the largest uninsured populations in the country, with recent figures reflecting that at least 1 out of every 4 Texans lacks health insurance. As healthcare expenses soar and the rate of the uninsured increase, our emergency rooms are more and more frequently bearing the brunt of the first line of defense. These problems are real and there no longer is the safe haven of working for a large or mid-size company to be immune to these issues. Government policymakers at every level are looking to the near future reality that spiraling healthcare costs may potentially bankrupt other services.

Walter Tomlinson
President, The Texas Lyceum, 2004

Texas Lyceum Public Conference & Quarterly Meeting October 15-16, 2004 Houston, Texas

Health Care: A Right or a Privilege?

PURPOSE: To highlight the underlying debate central to health care delivery, policymaking and financing and raise public awareness of the important issues consequent to the health care system's fragile infrastructure.

Speaker List:

Mayor Bill White – Mayor, City of Houston
Eduardo J. Sanchez, M.D., M.P.H. – Commissioner, Texas Department of State Health Services
Vivian Ho, Ph.D. – Chair in Health Economics, Rice Baker Institute/Baylor College of Medicine
Laurence McCullough, Ph.D. – Professor, Center for Ethics, Baylor College of Medicine
John C. Goodman, Ph.D. – President/Founder, National Center for Public Policy Analysis
Kenneth I. Shine, M.D. – Executive Vice Chancellor for Health Affairs, The University of Texas System
Ralph D. Feigin, M.D. – Chairman, Department of Pediatrics, Baylor College of Medicine; Physician-in-Chief, Texas Children's Hospital
Camille D. Miller – President/CEO, Texas Institute for Health Policy Research
Dick Lavine, J.D. – Senior Fiscal Analyst, Center for Public Policy Priorities
Joseph Antos, Ph.D. – American Enterprise Institute
Gary Laugharn – Hewitt Associates West Region
Judge Robert Eckels – Harris County Judge
Paul W. Hobby – Founding Partner, Genesis Park LP
Jack Hadley, Ph.D. – The Urban Institute's Health Policy Center
Martin P. Sutter – Essex Woodlands Health Ventures
James "Jim" Chapman – Partner, Bracewell & Patterson, former U.S. Congressman
John E. Davis – State Representative

A message from the Texas Lyceum Chairman:
Rodney Nathan

The right or privilege of healthcare was the discussion for our Public Conference, but it was more than just a discussion. Access to healthcare continues to be a growing problem for millions of people in our state. We regularly read about or are told about on the news of the tens of thousands of people, who are without health insurance, the demands on our city and county emergency rooms or the illnesses that could have been prevented.

In true Lyceum fashion, our public conference presented several sides of the issue, not just to talk, but to help lawmakers, policy advocates, health professionals, concerned citizens to begin developing real strategies to tackle this problem. I want to thank all of those who took an active part in planning, supporting, sponsoring and attending the conference. As you read this issue of the Lyceum Journal, I encourage you to think about what next steps you as an individual can take toward helping us deal with this issue.

In 2005 the Texas Lyceum Association will celebrate 25 years of developing the future Leadership of the great State of Texas. What started as an idea has manifested into a clear way of identifying and developing top leadership for our state. We are truly grateful to the architects of this idea and we remain committed to being the stewards of the values, traditions and resources of our state.

Purpose of the Texas Lyceum

The Texas Lyceum Association is an association of Texans whose purposes are:

1) to identify and develop the next generation of top leadership in the State of Texas;
2) to educate its Directors by identifying and exploring the inter-relationships of the major issues facing Texas;
3) to help bring a better understanding of these issues to the state's key decision makers; and
4) to promote an appreciation of the responsibilities of stewardship of the values, traditions, and resources of Texas.

The Association acts as a catalyst to bring together diverse opinions and expertise to focus on national and state issues, and seeks to emphasize constructive private sector, public sector and individual responses to the issues.

To accomplish these purposes, the Lyceum conducts periodic public forums, publishes the *Journal* and conducts programs for the Directors to explore and discuss key economic and social issues of the state and nation.

The Texas Lyceum Association is comprised of a Board of Directors from across the state. These 96 men and women have demonstrated leadership abilities not only in their own community, but across the State. They are active, involved and interested; they are eager to contribute their talents and time to the betterment of Texas.

Editorial: Miles L. McCall, Director

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Healthcare: A Right or a Privilege? Why Have We Reached an Impasse?

Vivian Ho, Ph.D. – Chair in Health Economics, Rice Baker Institute/Baylor College of Medicine

Health care expenditures in the U.S. reached $1.7 trillion dollars in 2003, averaging $5,800 per capita. Most Americans do not feel as though they received $5,800 in health care services last year, because the distribution of health care expenditures is highly skewed. The elderly, those with chronic diseases, and other extremely ill persons require much greater health care than the average healthy, younger American. For example, during the years 1995 to 1999, the most costly 5 percent of Medicare beneficiaries accounted for 47% of total Medicare spending.

Despite this country's extraordinary expenditures on health care, 45 million Americans are without health insurance. Since the end of World War II, many Americans have been able to obtain affordable health insurance for themselves and their families through their employer. Employers could effectively pool health risks across a wide variety of workers and use their resulting purchasing power to negotiate reasonable rates with insurance companies. However, as health care expenditures have continued to their rapid growth over the last two decades, health insurance has become increasingly unaffordable. Fewer workers have been able to find jobs that offer health insurance, and even then, the premiums may be more than they are willing or able to pay.

The absence of health insurance affects Americans in many ways. The 2003 Institute of Medicine report on the Consequences of Being Uninsured concluded that uninsured children and adults suffer from poorer health and development, and are more likely to prematurely die than those with coverage. In fact, 18,000 unnecessary deaths are attributable to lack of health coverage every year. Even as uninsurance results in suboptimal health status and healthcare for the uninsured, it raises health care premiums for those who are covered. The uninsured often seek care in hospital emergency rooms, or when their diseases are more advanced and impossible to ignore. Health care in these cases is more costly than need be, and these costs are often indirectly passed on to the insured in terms of higher health care premiums or higher taxes.

Regardless of the policy options that we choose to address the lack of health care coverage in coming years, the challenge of increasing access to healthcare is inextricably linked to the enormous costs of healthcare that we bear today. For example, passage of the 2003 Medicare Modernization Act, which provides coverage for prescription medications for those age 65 and over, is predicted to cost the federal government $395 billion over the next 10 years. The most recent projections indicate that the Medicare program will be insolvent by the year 2019. We cannot expand access to health care if increases in health care expenditures continue to grow at an average of 7% per year, as they have over the last 5 years.

No doubt the debate on increasing access to health care will require answering difficult questions regarding who will receive access to what services, and who will pay for the greater provision of care? Yet I would like to draw attention to inefficiencies in our system, which are needlessly raising the costs of health care for all Americans. It is crucial that we do what we can to restrain cost growth in our health care system. Only then will we have the resources available to provide access to high-quality health care for all Americans.

First, there is overwhelming evidence that many Americans are receiving costly health care services which provide no value in terms of improved health status. The Dartmouth Atlas group has determined that regions providing more intensive care are not gaining net health benefits over regions providing less care. For example, regional survival following acute conditions such as heart attacks, stroke, and gastrointestinal bleeding are not correlated with more intensive health care spending. Differences in health care spending across regions of the U.S. cannot be explained by differences in health status, either. Health care providers, researchers, and policy makers, and health informatics experts must collaborate to identify these inefficiencies in the health care system. More importantly, we must develop new methods to identify and implement best practice guidelines, which enable clinicians to provide care in the most effective and cost-effective manner.

Second, the Medicare provider reimbursement system requires reform to align the incentives of health care providers with those of the elderly population needing care. The Center for Medicare and Medicaid Services (CMS) sets fixed prices to reimburse hospitals and physicians for the care provided to beneficiaries. If these prices are well above costs, then providers have more incentive to treat patients aggressively, in order to earn greater profits. If reimbursement rates are too low, then providers may be less inclined to provide beneficial care. These distortions ripple throughout the industry, because these Medicare reimbursement rates are often used as a guideline by health care insurers to reimburse hospitals for care provided to the nonelderly population.

The Medicare program must take a closer look at the prices it pays to providers, and make a concerted effort to set those prices closer to the marginal costs of providing health care. Moreover, the program must develop strategies to reward providers for delivering high quality health care. The current fee-for-service reimbursement system yields higher profits to hospitals that deny care to the sickest, high-risk patients and discharge patients "sicker and quicker." In an effort to counter this behavior, CMS has begun to adopt risk-adjusted reimbursement methods and provider quality report cards. Such changes have been met with resistance and criticism from providers, because these changes will lead to substantial shifts in resources in the industry. However, we cannot hope to control growing health care costs until we set payment incentives in a manner which encourages providers to deliver efficient, high quality health care.

Third, we need a global and coordinated response to illnesses such as obesity, diabetes, and cancer that are affecting Americans. More than 30% of adults in the U.S. are obese, which is contributing to rising rates of diabetes. We continue to spend large sums of money in the acute care sector after diseases have manifested themselves, without careful consideration of the root cause of many of our illnesses. For example, the Center for Medicare and Medicaid Services has announced that it will start reimbursing health care providers for obesity-related treatments for Medicare beneficiaries. Is this the most effective use of our public expenditures?

Research indicates that increased education can lead to improved health habits, better health, and longer life expectancy. In the long run, improvements in our public education system may be more cost-effective than providing more generous health insurance coverage for improving the health of Americans. Federal agricultural subsidies lower the cost of ingredients used in high-calorie processed foods, making these foods cheaper and more accessible to the American public. Recent data indicate

that fats and oils received 20 times more in agricultural subsidies than fruits and vegetables. Realigning subsidies to farmers so that they encourage production and consumption of healthier foods could significantly improve public health. Most of our cities and transportation systems are configured in a manner which discourages walking, cycling, and other forms of exercise. Investing extra resources in urban planning and public transportation may improve health status, again reducing the need for greater acute healthcare.

To conclude, we require dramatic reforms in the way we deliver health, health insurance coverage, and public health in order to restrain cost growth in the health care industry. We live in a remarkable age, where new technologies are extending life and improving the quality of life in ways we never imagined before. Yet we have a health care system which provides access to these systems in an inefficient, costly, and inequitable manner. We must redirect our resources towards those health care services which provide the greatest health care benefits. Only then can we control health care costs and increase access to higher quality health care for all Americans.

How are you going to pay for it? Sources of tax revenue for publicly funded health care

Dick Lavine, J.D. – Senior Fiscal Analyst, Center for Public Policy Priorities

The large and growing number of Texans who lack health insurance will be an important issue for all levels of government for the foreseeable future. Local governments will be forced to function as the provider of last resort. These counties and county hospital districts will, in turn, seek support from the state, which will look to the federal government for aid.

The question is: which of these levels of government is financially best able to generate the tax revenue necessary to meet the health care needs of Texas – local governments, the state, or the federal government?

Hospital Districts

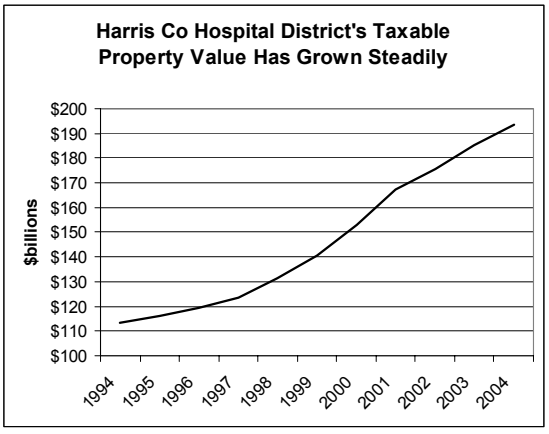
The Harris County Hospital District has the primary responsibility for providing health services to the indigent population of the most populous county in Texas, so will serve as an example of the issues facing all Texas local governments in financing health care. About half of the total revenue of the district comes from property taxes. A significant percentage of the remaining revenue is patient care funded by Medicaid and Medicare, programs that are supported by the state and federal government. This mix is similar to other hospital districts in the state, although Harris County is among the most reliant on property taxes.

Property tax revenue for the district has varied greatly over the past 10 years. Revenue peaked in 1993 at $216 million, then fell to $141 million in 1996, before doubling to $308 million in 2000. Property tax receipts in the most recent

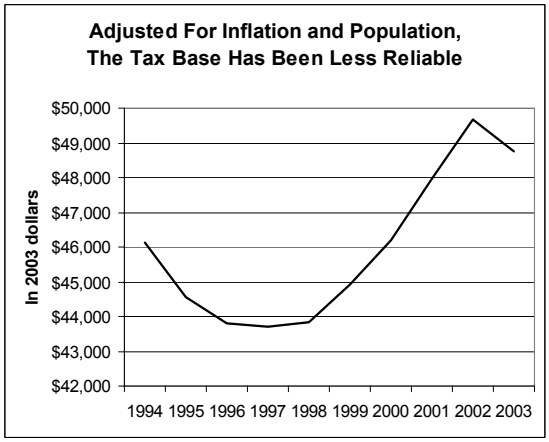
fiscal year totaled $346 million. However, these dramatic changes were not related to the underlying property values, which increased steadily over the period, but to wide swings in the tax rate adopted by the Harris County Commissioners Court. In 1996 the Court cut the property tax rate by roughly a third, from more than 18 cents per $100 in valuation to 12.4 cents. The rate was raised to more than 20 cents in 2000, then settled into its current level of just over 19 cents per $100 of valuation.

The important issue is not how much the Commissioners Court decides to raise through property taxes, but how much the property tax base is capable of generating over time. This requires an examination of property values, rather than just property tax revenues.

Property values in Harris County in the past 10 years increased at an accelerating rate through 2001. Since then values have continued to grow, but somewhat less rapidly – increasing by less than 5 percent a year most recently, compared to a peak growth rate of more than 9 percent annually. The following chart shows the taxable value (after exemptions) of property subject to taxation by the Harris County Hospital District.



Of course, property values tend to increase along with population growth and inflation. Since a greater population puts greater demands on the district, and since the higher cost of medical care requires greater expenditures to provide the same level of service, the fiscal capacity of the district can be better measured on a per-capita, inflation-adjusted basis. As the chart below shows, the hospital district enjoyed a rapidly growing real per-capita tax base for 5 years, although growth recently reversed. (Population and inflation data are not yet available for 2004.)



The dip between 2002 and 2003 may serve notice that the property tax base will offer less solid support in the future. Housing prices, bolstered by record low interest rates, are expected to flatten or even decline as the Federal Reserve raises interest rates. In addition, medical inflation is accelerating after a period of relative calm. Acting together, lower property values and higher health care costs could severely diminish the capacity of the hospital district's property tax base to support necessary expenses.

In addition, competition for property taxes with other taxing authorities could limit the willingness of the Commissioner's Court to raise the district's tax rate to compensate for any decline in inflation-adjusted, per capita property values. For instance, Houston Independent School District currently levies a tax of $1.45 per $100, 5 cents

short of the maximum rate permitted by the state, and could be forced raise its rate soon if the state does not change the school-finance system.

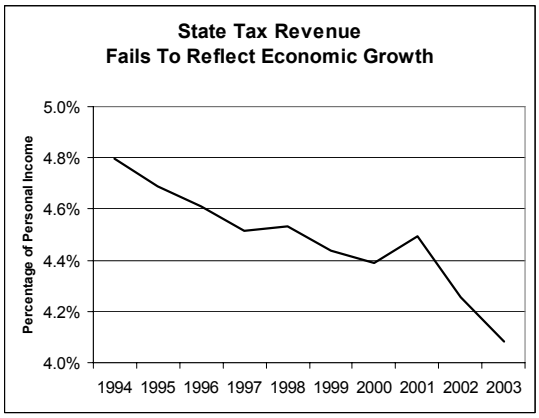
State government

Texas state government is funded primarily by taxes, which accounted for 44 percent of state revenue in fiscal 2004, and by federal funds, which provided 35 percent. Other income came mainly from licenses and fees, investment income, and the state lottery.

State taxes have recently diminished dramatically as a source of state revenue. As recently as 2001, taxes provided more than half of total revenue. As tax revenue shrank in importance, the state became more reliant on federal funds, which accounted for less than 30 percent of state revenue in 2001. This shift is due in part to continued weakness in tax collections, which fell for two straight years – from $27.2 billion in 2001 to $26.1 billion in 2003 – before rebounding to $27.9 billion in 2004. Stagnant tax revenues were replaced by a jump in federal income, from $16.0 billion in 2001 to $21.9 billion in 2004, driven in large part by increased state use of federal Medicaid and CHIP funding. This may be a warning that the state is losing the ability to support itself and becoming overly reliant on outside sources of revenue.

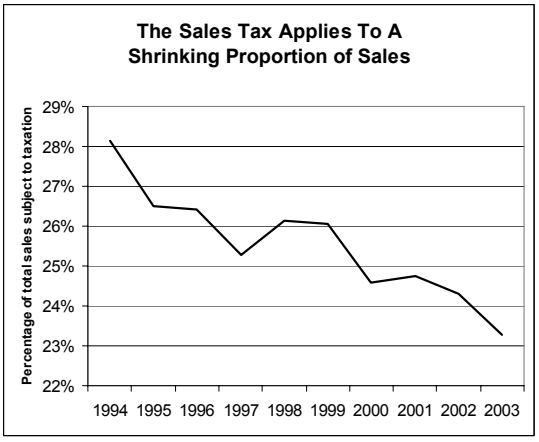
Our current state tax system suffers from an inherent weakness – it is unable to keep up with the economic growth of the state. This creates a "structural deficit," a growing shortfall between revenue and needs. A tax system should be able to grow with a state's economy, generating additional revenue without increases in tax rates. Over the past decade, the Texas tax system has consistently fallen behind economic growth.

As this chart shows, since 1994, state tax revenue has fallen as a percentage of statewide personal income – a standard measure of the size of a state's economy. Personal income reflects the ability of Texans to pay taxes. Growth in personal income also reflects a growing need for public services, since it relates to growth in population and inflation.

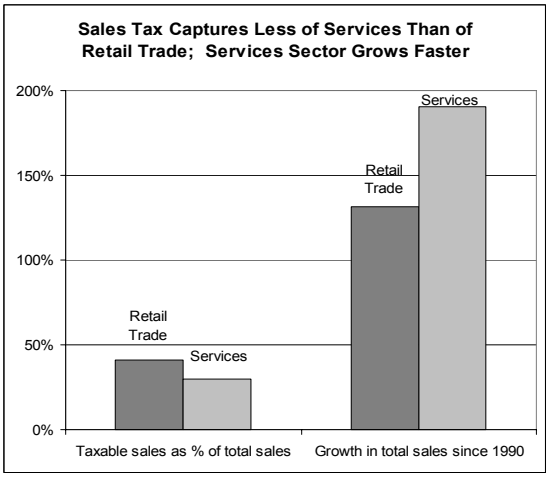


In the economic bust of the late 1980s, the state maintained revenue only by increasing tax rates. For instance, the state raised the sales tax rate from 4 ¼ percent in 1984 to 6 ¼ percent in 1990. Without rate increases since then, the state tax base has been unable to keep up with the growth of the state.

A major reason for this shortfall is Texas' heavy dependence on the sales tax, which accounts for 55 percent of state tax collections. Over time, as the next chart shows, the sales tax has applied to a shrinking percentage of all sales in the state. In other words, sales tax receipts have grown slower than total sales volume. In part, this reflects untaxed Internet and mail-order sales, but the essential problem is that the sales tax has not changed along with the economy.



Texas adopted a sales tax in 1961, when most sales involved goods – tangible items. However, in the modern economy, the fastest growing sectors involve services rather than goods. The sales tax applies to 40 percent of retail trade in goods, but only 30 percent of the sales of services. Over the past 10 years, as the next chart shows, sales of services have grown at a pace one and one-half times faster than the growth in retail trade in goods.

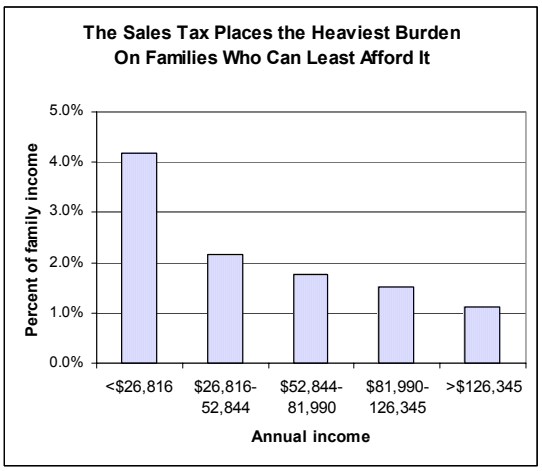


The state could modernize the sales tax by expanding the sales tax to cover services that are currently untaxed, including most business and professional services. The state comptroller has estimated that taxing services (except medical and dental services) could raise $3.2 billion per year. Another method of reaching the service sector is through a broad-based business tax. Properly constructed, a tax on business activity could accurately reflect the structure of the state's economy and expand at the rate of economic growth.

One approach to increasing state revenue that should be considered unacceptable is to maintain the current sales tax base, but simply raise the state sales tax rate from the current 6 ¼ percent.

The Texas tax system is extraordinarily regressive – taking a much greater percentage of the income from a low- or moderate-income family than from a higher-income family. By one recent ranking, Texas' state and local tax system is the 5th most regressive among the 50 states.

The main cause of this regressivity is the sales tax. Taxes based on consumption, like the sales tax, always fall harder on families with lower income, since they tend to spend all of their income, unlike higher-income families, which have money available for saving and investment. Texas currently exempts groceries, residential utilities, and medicine from the sales tax, but even with these exemptions for necessities, the sales tax remains unduly burdensome on families with below-average income, as demonstrated in the next chart.



An alternative that deserves more attention is a state personal income tax. Because an income tax levies higher tax rates on higher-income families, it could counteract the regressive nature of Texas' current tax structure. And since state income taxes, unlike sales taxes, are deductible from federal taxable income, the federal government would absorb a significant portion of the impact of the tax on higher-income families, who generally itemize their federal deductions.

An income tax is also capable of generating a large amount of revenue at relatively low rates. The Center for Public Policy Priorities has applied the tax rates, exemptions, and deductions of the Kansas state personal income tax, which ranks only 30th among the states in income tax revenues as a percentage of personal income, to Texas family income to demonstrate the income tax's potential. In the year 2000, this sample tax would have produced more than $17 billion in new state revenue! Under the provisions of Article 8, section 24, of the Texas Constitution, two-thirds of this revenue would be dedicated to reducing school property taxes and the remaining one-third would go to support education, easing some of the pressure on other areas of the state budget.

Federal government

As noted above, Texas state government now relies on federal income for 35 percent of its total revenue, up from less than 30 percent as recently as 2001. Two-thirds of this money goes to health and human service agencies. However, it would be dangerous for the state to rely on the federal government to continue supporting such a significant proportion of state spending in the future.

The Congressional Budget Office estimates that the federal budget deficit for 2004 will reach $422 billion – the fourth consecutive year of fiscal deterioration. If tax cuts are continued past their expiration dates (as was done in September 2004 for the child tax credit and certain other "middle-class tax cuts") and realistic assumptions are made concerning defense spending, federal deficits are likely to total $4.4 trillion over the next decade.

At this point in previous economic recoveries, deficits have begun to shrink rather than continue to rise. Projections of continuing large deficits indicate that the federal government, like Texas state government, is now facing a structural deficit that will persist despite economic growth, unless tax or spending policies change.

Conclusion

So where should one turn for tax revenue to support publicly funded health care? By default, the state appears to be the best source for future support. Hospital districts and other local units are generally limited to property taxes, which cannot be counted on to grow as quickly as the demand for services. The federal government is facing extraordinarily large deficits that will limit increased support for state and local government services.

However, the state will be able to generate necessary future revenue only if the Texas Legislature is willing to make fundamental structural changes in the Texas tax system. Even if these changes are made, demands for lower property taxes and higher public education spending will compete with the requirements of the public health care system and other vital state services. Despite these difficulties, for advocates of improved public health benefits, state tax reform remains the best hope.

Source of data:

Harris County Hospital District property tax values: Harris County Appraisal District
Medical inflation: Bureau of Economic Analysis, indexes for government consumption expenditures
Harris County Population: U.S. Census Bureau
State taxes: Texas Comptroller of Public Accounts, *Annual Cash Report*; *Tax Exemptions and Tax Incidence*; unpublished data

Covering the Uninsured as an Investment in Human Capital:

What Do We Spend, Who Pays, What Would Full Coverage Add to Medical Spending, and How Do the Benefits Compare to the Costs?

Jack Hadley, Ph.D., Principal Research Associate &
John Holahan, Ph.D., Center Director The Urban Institute, Washington DC

The Kaiser Family Foundation provided financial support for this research under the "Cost of Not Covering the Uninsured" Project.

How much medical care do the uninsured use and who pays for that care? How much do the uninsured pay themselves? How much is "uncompensated" care? How much of the cost of uncompensated care is financed by governments? How much more would the nation spend on medical care if the uninsured had full coverage?

These are critical questions in the debate over extending health insurance coverage to the uninsured because it is important to distinguish **real cost increases** due to expanded insurance coverage from **transfers of existing costs** from one financing source to another. Real cost increases occur because having insurance will increase the amount of care used by the currently uninsured and will require more resources devoted to health care.

Cost transfers, on the other hand, represent shifts from those who currently pay for the care received by the uninsured to the sources of financing that would exist under a system with expanded insurance coverage. While the issue of cost transfers is an important part of the political debate because it deals with the redistribution of both

payments and services, it is distinct from the question of how much more resources would be drawn into the medical care sector. By estimating how much medical care the uninsured currently use and who pays for it, this analysis seeks to determine the resources that are "already in the medical care system" and potentially available to help pay for the costs of expanded insurance coverage.

DATA AND METHODS

We employed two independent approaches to estimate the costs and sources of payment for care used by the uninsured because no single data source provides complete, unambiguous, and precise information. One approach used household survey data collected by the Medical Expenditure Panel Survey(MEPS) in 1998, 1999 and 2000 and extrapolated forward to 2004. The second approach collected information from surveys of providers' revenues and expenses, and from government budgets and agency reports to determine how much care they delivered to the uninsured and to identify the sources of funds that paid for that care.

In order to simulate the uninsured's health care spending under the assumption that they have insurance coverage, we estimated a series of statistical models that relate individuals' annual health care spending to measures of insurance coverage, socio-demographic characteristics, and health status with MEPS data for uninsured people and insured lower/middle-income people. To simulate spending for the uninsured under the assumption that they have full-year coverage, we set the variable measuring the percent of time covered by insurance to full-year coverage.

MUCH CARE DO THE UNINSURED RECEIVE?

Table 1 presents the estimates of medical care spending by insurance status and source of payment in 2004. People uninsured any part of the year received $124.6 billion in care, of which $40.7 billion was "uncompensated" care, i.e., care not paid for either out-of-pocket or by a private or public insurance source. This represents one-third of the care received by the uninsured, but only 2.6% of total personal health care spending of $1.54 trillion in 2004. Uncompensated care accounted for 59% of the care received by the full-year uninsured, with most of the rest ($18.1 billion or 35%) paid for out-of-pocket (Table 2). The other two-thirds of the care received by the full- and part-year uninsured comes from out-of-pocket payments ($32.6 billion) and, for the part-year uninsured, from insurance sources ($51.3 billion).

In our prior study of the cost of care received by the uninsured, we estimated that hospitals accounted for 63% of uncompensated care, clinics and other direct care programs (such as the VA and the Indian Health Service) provided 19% of uncompensated care, and private office-based physicians delivered the remaining 18%. Applying these percentages to our 2004 estimate of $40.7 billion in uncompensated care implies that hospitals spent $25.6 billion, clinics and other direct care programs $7.7 billion, and private physicians $7.4 to deliver uncompensated care.

HOW MUCH DO GOVERNMENTS SPEND ON UNCOMPENSATED CARE?

Table 3 shows the sources and amounts spent by government to pay for uncompensated care. Overall, we estimate that as much as $34.6 billion in government money, which represents up to 85% of the cost of uncompensated care, is arguably available to pay for uncompensated care.

Most government spending supports hospitals' uncompensated care. Under Medicare's prospective payment system for hospital inpatient services, hospital payments are adjusted for treating a high proportion of poor patients through the Disproportionate

Share (DSH) adjustment, and for the indirect costs of graduate medical education programs through the Indirect Medical Education (IME) adjustment. It has been estimated that the IME adjustment overcompensates hospitals by about one-third to one-half for teaching costs and that these payments also support teaching hospitals' care to the uninsured. Overall, we estimate that Medicare's payments through the DSH and IME adjustments to support hospitals that treat poor and uninsured patients were about $10.5 billion in 2004.

Medicaid also supports hospitals that treat a large number of poor patients through Medicaid DSH payments and through the use of supplemental or upper payment limit (UPL), mechanisms. However, some of the federal payment goes either to mental hospitals or is returned by providers to the state treasury, and another portion of the state contribution represents intergovernmental transfers and other financial transactions that may result in no net increase in state spending. Using information from a recent survey of states to adjust for the various transfers to non-hospital providers and between providers and state governments, we estimate that total federal spending on Medicaid DSH and UPL payments that arguably go toward uncompensated care are about $8.7 billion in 2004 after excluding payments to mental hospitals and nursing homes.

Hospitals also receive payments from state and local governments in the form of tax appropriations and spending for uninsured patients in local indigent care programs. In all, we estimate that hospitals received $7.9 billion in 2004 from state and local tax appropriations, grants, and payments for indigent care.

Finally, outside of hospitals, grants and appropriations for community health centers, clinics, the VA, and the Indian Health Service account for $7.5 billion of the $7.7 billion in uncompensated care delivered by these providers. The federal government is responsible for $6.1 billion of this total.

DOES UNCOMPENSATED CARE FULLY COMPENSATE FOR THE LACK OF HEALTH INSURANCE?

Even taking uncompensated care into account, the full-year uninsured received about 45% less care than the privately insured on a per capita basis, $1,629 compared to $2,975 (Table 4). This spending gap holds for both adults ($1,864 compared to $3,653) and children ($802 compared to $1,640). Thus, even though uncompensated care is the primary source of care for the full-year uninsured, uncompensated care does not make up for or offset the effects of being uninsured on access to and use of care.

HOW MUCH MORE WOULD IT COST TO COVER ALL OF THE UNINSURED?

Table 5 reports the simulated impact of having insurance coverage on medical spending by the uninsured. If the uninsured had full-year coverage, their per person spending would increase by 39%, from $2,034 to $2,836. The increase would be even greater for those who had been uninsured for the full-year, growing by nearly 70%, from $1,629 to $2,768.

Total spending for those who would gain coverage under a universal expansion would increase by $48 billion (Table 6). Added to the current spending level of almost $125 billion (which includes all uncompensated care, out-of-pocket payments, and insurance payments for those covered for part of the year) the new dollars would bring the total spending on the formerly uninsured to $173 billion.

HOW DO THE COSTS OF EXPANDING HEALTH COVERAGE COMPARE TO THE BENEFITS?

Research clearly shows that compared to the insured, the uninsured are more likely to delay seeking care and to have unmet health needs. Compared to persons who have health insurance, the uninsured receive less preventive care, are diagnosed at more advanced disease states, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates.

In some cases, a delay or failure to obtain care does not have any significant health or cost consequences. In other cases, however, uncompensated care eventually received from safety-net providers can wind up costing much more than if treated when symptoms first appeared or if illness were diagnosed before symptoms become severe.
Studies have shown that the uninsured are more likely to be hospitalized for preventable conditions, i.e., medical conditions that can be adequately treated on an outpatient basis and should not require hospitalization. Studies also suggest that the expansion of children's insurance coverage through Medicaid and SCHIP have led to reduced rates of avoidable hospitalizations for children, by as much as 22%.

Other studies show that uninsured people with cancer are more likely to be diagnosed at an advanced disease stage, which is strongly related to reduced survival, and that the uninsured are less likely to receive screening and diagnostic tests known to lead to early detection of cancer, heart disease, and diabetes – diseases with high mortality rates and high levels of disability and diminished activity status. Even among people who know they have hypertension or diabetes, use of appropriate medications and routine follow-up care is lower for the uninsured compared to the insured. In sum, a large body of research provides convincing evidence that the uninsured receive less preventive and diagnostic care, receive less therapeutic care even after being diagnosed, and, as a result, die earlier and experience greater limitations than otherwise similar people with insurance coverage.

Research also suggests that having health insurance leads to improved health and longer lives by means of better access to medical care. A conservative estimate based on the full range of studies is that a reduction in mortality of 5-15%, representing perhaps as many as 18,000 excess deaths a year, could be expected if the uninsured were to gain continuous health coverage. A more recent study indicates that if the near-elderly (52-64 year olds) had continuous insurance coverage up to age 65, not only would more people survive to qualify for Medicare, but their overall health status would be significantly better. As a the result, Medicare would actually spend about 9% less on care for new beneficiaries over the first few years they are in the program.

While difficult to quantify all of the costs and consequences associated with health reductions due to lack of insurance coverage, a comprehensive effort to do so estimated that the annual economic value of foregone health among the uninsured in 2000 was between $65 and $130 billion in that year. If the middle of that range ($97.5 billion) is inflated to 2004 dollars, the annual economic value of the foregone health due to lack of insurance increases to $103 billion—a sum considerably larger than the $48 billion in increased costs of expanding coverage to the uninsured.

Looked at from the perspective of cost-effectiveness ratios, it has been estimated that the cost per quality-adjusted life year (QALY) saved by having universal insurance coverage is about $115,000 (in 2001 dollars). This compares favorably to cost effectiveness ratios for two medical procedures considered to be very

worthwhile and beneficial: $136,000 for coronary angioplasty and $186,00 for annual mammograms for women between the ages of 55 and 65.

IMPLICATIONS FOR POLICY

Our analyses estimate that in 2004 the full-year and part-year uninsured will receive $40.7 billion dollars in uncompensated care. We also estimate that governments finance most of the uncompensated care received by the uninsured, spending about $34.6 billion on payments and programs largely justified to serve the uninsured and covering possibly as much as 80-85% of uncompensated care costs through a maze of grants, direct provision programs, tax appropriations, and payment adjustments. Most of this money comes from the federal government, primarily through higher Medicare and Medicaid payments to hospitals that disproportionately care for the uninsured.

Since most of the current subsidies for uncompensated care come through Medicare and Medicaid payments and state/local tax appropriations to hospitals, those funds should be relatively easy to transfer to a new program to subsidize the cost of providing insurance coverage for the uninsured, as long as insurance coverage is phased in before existing subsidy payments are phased out. If expanded coverage is financed primarily through federal revenues, then state and local governments would be relieved of a major source of counter-cyclical financial pressure on their budgets, since the demand for uncompensated care tends to go up during recessions when state and local governments' revenues tend to decline.

Another reason to prefer insurance over a patchwork of indirect and hidden subsidies to pay for uncompensated care is that payments would move with people and would be much better targeted to the providers actually providing the care. Current methods for allocating subsidies to hospitals, while generally on target, still overpay some institutions and underpay others relative to the amounts of uncompensated care they provide.

The additional $48 billion per year in medical spending induced by universal coverage, beyond what is currently being spent, can be viewed from several broader perspectives. The new dollars would constitute less than 3% of total personal health care spending in this country and would increase the share of GDP going to health care by 0.4%. In addition, compared to current government spending for public health insurance programs and the subsidizing private insurance in 2004, the additional spending to cover the uninsured is relatively small. Specifically, government spending for Medicare ($266.4 billion) and Medicaid ($280.7 billion) will total $547.1 billion and the tax subsidy for private insurance will be $188.5 billion

In considering the extra cost of covering the uninsured, it is important to re-emphasize that our simulations only provide estimates of the cost of expanding coverage to those who are uninsured. Plans to expand coverage will typically increase costs to the government by a greater amount because some people currently insured by private plans will inevitably switch to the new, government-subsidized plan. The estimate of increased government spending depends on both the cost of covering the uninsured (which we estimate) and the cost of the crowd-out or displacement.

Although increased government spending due to crowd-out is important because it affects who pays for care, it does not represent new resources drawn into the medical care system. Given the growing evidence of the beneficial effects of having insurance on health, and through better health, on labor force participation, earnings, and education, the cost of expanding insurance coverage may be a very

worthwhile investment when considered against the benefits of improved health, increased longevity, and potentially greater national income.

[1] This paper represents a distillation of three earlier studies: J. Hadley J and J. Holahan "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending," May 10, 2004 (http://www.kff.org/uninsured/7084.cfm) ; J. Hadley and J. Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs Web Exclusive,* June 4, 2003 (http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_060403.htm); J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *Health Affairs Web Exclusive*, February 12, 2003 (http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm). For details on methods and data sources, see J. Hadley and J. Holahan, "Cost and Sources of Payment for Medical Care Used by the Uninsured: Detailed Methodology Report," Washington: Kaiser Family Foundation, 2003 (http://www.kff.org/content/2003/20030205) .

[2] J. W. Cohen, "Design and Methods of the Medical Expenditure Panel Survey Household Component," Rockville MD: Agency for Health Care Research and Policy, MEPS Methodology Report No. 1, AHCPR Pub. No. 97-0026, 1997.

[1] The estimate of uncompensated care is based on the question "How much would providers have been paid if the uninsured had been covered by private insurance?" The difference between this estimate and the amount providers actually received in payment from explicitly identified sources other than private or public insurance is an estimate of the value of care delivered by private providers with no explicit payment linked to a specific patient.

[1] S. Heffler et al., Health Spending Projections through 2013," *Health Affairs Web Exclusive*, Feb. 11, 2004.

[1] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *op. cit.*

[1] These estimates were developed primarily from provider information on the sources of their revenues that can be attributed to or justified by care to the uninsured.

[1] Prospective Payment Advisory Commission, Report and Recommendations to the Congress: Washington, 1997, pp.28-29.

[1] T. A. Coughlin and B. Bruen, "State Use of Medicaid UPL and DSH Financing Mechanisms," Washington: The Urban Institute, 2002.

[1] Institute of Medicine, Coverage Matters, Washington: National Academy Press 2001; American College of Physicians, No Health Insurance? It's Enough to Make You Sick, Philadelphia: American College of Physicians, 2000 (http://www.acponline.org/uninsured/lack-contents).

[1] B. Strunk and P. Cunningham, "Treading Water: Americans' Access to Needed Medical Care, 1997-2001," Washington, DC: Center for Studying Health System Change, 2000 (www.hschange.org/CONTENT/421).

[1] J. Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* Vol. 60, No. 2 (supplement), pp. 3S-75S, June 2003. (Available at http://www.kff.org/content/2003/4115/supparticle.pdf.)

[1] L. Kozak, M. Hall , and M. Owings, "Trends in Avoidable Hospitalizations," *Health Affairs* March/April 2001: 225-32; C. Hoffman and D. Gaskin, "The Costs of Preventable Hospitalizations among Uninsured and Medicaid Adults," Washington, DC: Kaiser Family Foundation, 2001.

[1] L. Dafny and J. Gruber, "Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansions and Child Hospitalizations," Cambridge,

MA: NBER Working Paper Series, Working Paper 7555, February 2000: 1-43.

[1] J. Ayanian, B. Kohler, T. Abe and A. Epstein, "The Relationship Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *The New England Journal of Medicine* July 29, 1993:326-31; R. Roetzheim et al., "Effects of Health Insurance and Race on Breast Carcinoma Treatments and Outcomes," *Cancer* December 1, 2000: 2202-13; R. Roetzheim et al., "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes," *American Journal of Public Health* November 2000: 1746-54; R. Roetzheim, N. Pal, et al. "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute*, August 19, 1999 August 19: 1409-15.

[1] J. Ayanian et al., "Unmet Health Needs of Uninsured Adults in the United States," *JAMA* October 25, 2000 October 25: 2061-9.

[1] Families USA Foundation, "Getting Less Care: The Uninsured with Chronic Health Conditions," Washington DC, 2001; C. Huttin, J. Moeller and R. Stafford, "Patterns and Costs for Hypertension Treatment in the United States: Clinical, Lifestyle and Socioeconomic Predictors from the 1987 National Medical Expenditures Survey," *Clinical Pharmacoeconomics* September 20, 2000: 181-95; G. Beckles et al., "Population-Based Assessment of the Level of Care Among Adults with Diabetes in the U.S.," *Diabetes Care* September 1998 September: 1432-8.

[1] J. Hadley, "Sicker and Poorer," *op. cit.*; Institute of Medicine, *Care Without Coverage, Too Little, Too Lat.* Washington DC, 2002: 161-165.

[1] J. Hadley and T. Waidmann, "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," *Health Services Research*, April 2005 (forthcoming).

[1] W. Miller, E. Vigdor, and W. Manning. "Covering the Uninsured: What Is It Worth?" *Health Affairs Web Exclusive*, March 31, 2004.

[1] Institute of Medicine, *Hidden Costs, Value Lost* Washington DC, 2003: 112.

[1] D. Gaskin and J. Hadley, "Are Subsidies Allocated to Urban Hospitals in Accordance with Their Safety Net Roles?" IWP 97-108, Washington DC: Georgetown University, October 1999.

[1] Medicare and Medicaid budget projections are from http://www.cms.hhs.gov/statistics/nhe/projections-2002/t5.asp.

[1] J. Sheils and R. Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs Web Exclusive,* Feb. 25, 2004.

[1] J. Hadley, "Sicker and Poorer," *op. cit.;* Institute of Medicine, *Care without Coverage*, *op. cit.*

Table 1
Uncompensated Care[a] Received by the Uninsured
(2004 $s)

	All Uninsured	Full-Year Uninsured	Part-Year Uninsured
Cost of Uncompensated Care (billions)	$40.7	$30.1	$10.6
Adults	35.1	26.3	8.8
Children	5.4	3.6	1.8
Uncompensated Care as a Share of Total Care	32.7%	58.6%	14.5%
Adults	33.1	57.7	14.6
Children	29.3	63.2	14.2

Notes:
[a] Sum of Other Public Sources, Other Private Sources, and Donated In-Kind care from Table 3.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 2
Total Medical Care Spending,
By Insurance Status and Source of Payment
(2004 $s, billions)

Insurance Status	(1) Self	(2) Private[a]	(3) Public[b]	Uncompensated Care (4) Other Public[c]	(5) Other Private[d]	(6) Donated In-Kind[e]	(7) Total Spending
Full-Year Insured	$104.0 *(19.9%)*	$345.6 *(66.1%)*	$53.9 *(10.3%)*	$10.6 *(2.0%)*	$8.5 *(1.6%)*	$0.0 *(0.0%)*	$522.6 *(100.0%)*
Uninsured, Full-year	18.1 *(35.2)*	3.3 *(6.4)*	0.0 *(0.0)*	9.3 *(18.1)*	10.0 *(19.5)*	10.7 *(20.7)*	51.4 *(100.0)*
Uninsured, Part-year	14.5 *(19.8)*	31.1 *(42.5)*	16.9 *(23.1)*	2.4 *(3.3)*	2.8 *(3.8)*	5.4 *(7.4)*	73.1 *(100.0)*
All Nonelderly[f]	136.6 *(21.1)*	380.0 *(58.7)*	70.8 *(10.9)*	22.3 *(3.4)*	21.3 *(3.3)*	16.1 *(2.5)*	647.1 *(100.0)*

Notes:
[a] Includes Tricare/CHAMPVA and workers' compensation.
[b] Medicaid and Medicare.
[c] VA, other federal, state and local, and public programs.
[d] Other private sources and unknown sources
[e] Estimated from data on charges and expected payments if privately insured.
[f] Civilian, non-institutionalized population under age 65, excluding those with any Medicare coverage.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 3
Sources of Funding Available to Providers
for Uncompensated Care of the Uninsured
(2004 $s, billions)

	Federal	State/Local	Total
Government Funds Available for Uncompensated Care			
State/Local Government			
Tax appropriations to hospitals	--	3.3	3.3
Payments to hospitals from indirect care programs	--	4.6	4.6
Medicare			
DSH payments	7.6	--	7.6
Share of Indirect Medical Education	2.9	--	2.9
Medicaid			
DSH payments	6.2	1.6	7.8
Supplemental provider payments	0.7	0.2	0.9
Other Government Programs[a]	6.1	1.4	7.5
All Government Spending	$23.5	$11.1	$34.6
Estimated Cost of Uncompensated Care	--	--	$40.7

Notes:
[a] Includes Bureau of Primary Care Programs, National Health Service Corps, Maternal and Child Health, Indian Health Service, and Veterans Affairs Programs.

Sources:
Medicare and Medicaid estimates derived from CBO March 2004 Baseline with same assumptions about share of payments attributable to uncompensated care as described in Jack Hadley and John Holahan, "How Much Medical Care do the Uninsured Use, and Who Pays for It?", *Health Affairs* Web exclusive, February 12, 2003. Estimates of state local spending and other government programs taken from earlier estimates (*Health Affairs* , February 12, 2003) and adjusted to 2004 using the Consumer Price Index.

Table 4
Total and Per Capita Medical Care Spending,
By Insurance Status
(2004 $s)

Insurance Status	Population N (millions)	Population (%)	Total Spending[b] ($ billions)	Per Capita Spending[b] ($)
All Nonelderly Adults and Children				
Full-Year Insured	175.7	*74.2%*	$522.7	$2,975
Total Uninsured (full and part year)	61.2	*25.8*	124.5	2,034
Uninsured, Full Year	(31.6)	*(13.3)*	(51.4)	(1,629)
Uninsured, Part Year	(29.6)	*(12.5)*	(73.1)	(2,466)
Total Population[a]	236.9	*100.0*	647.1	2,732
Nonelderly Adults				
Full-Year Insured	116.5	*72.5%*	$425.6	$3,653
Total Uninsured (full and part year)	44.3	*27.5*	106.0	2,394
Uninsured, Full Year	(24.5)	*(15.2)*	(45.6)	(1,864)
Uninsured, Part Year	(19.8)	*(12.3)*	(60.4)	(3,047)
Total	160.8	*100.0*	531.6	3,306
Children				
Full-Year Insured	59.2	*77.8%*	$97.1	$1,640
Total Uninsured (full and part year)	16.9	*22.2*	18.4	1,087
Uninsured, Full Year	(7.1)	*(9.3)*	(5.7)	(802)
Uninsured, Part Year	(9.8)	*(12.9)*	(12.7)	(1,293)
Total	76.1	*100.0*	115.5	1,518

Notes:
[a] Civilian, non-institutionalized population under age 65, excluding those with any Medicare coverag
[b] Includes uncompensated care for the uninsured.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 5
Simulated Per Capita Spending If Uninsured Were Fully Insured,
By Baseline Insurance Status and Age
(2004 $s)

Insurance Status	Percent with any spending		Spending per capita	
	Baseline	Simulated, Full-Year Insured	Baseline[a]	Simulated, Full-Year Insured
All Uninsured	66.7%	79.9%	$2,034	$2,836
Full-Year	56.4	77.0	1,629	2,768
Part-Year	77.7	83.0	2,466	2,909
Uninsured Adults	65.9	79.5	2,394	3,388
Full-Year	56.0	76.5	1,864	3,188
Part-Year	78.1	83.2	3,047	3,634
Uninsured Children	69.0	80.9	1,087	1,367
Full-Year	58.0	78.7	802	1,296
Part-Year	76.9	82.6	1,293	1,419

Notes:
[a] Includes uncompensated care.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

Table 6
Cost of Covering the Uninsured:
Simulated Total and Incremental Spending
If Uninsured Were Fully Insured
(2004 $s, billions)

Insurance Status	Baseline Spending[a] (billions)	Simulated Spending		
		Total Spending	Incremental Spending	% Increase over Baseline
All Uninsured	$124.5	$172.7	$48.2	38.7 %
Full-Year	51.4	87.0	35.6	69.2
Part-Year	73.1	85.7	12.6	17.3
Uninsured Adults	106.0	150.0	44.0	41.5
Full-Year	45.6	78.0	32.4	71.0
Part-Year	60.4	72.1	11.6	19.3
Uninsured Children	18.4	22.7	4.3	23.5
Full-Year	5.7	9.0	3.3	58.5
Part-Year	12.7	13.7	1.0	7.8

Notes:
[a] Includes uncompensated care.

Source: Hadley and Holahan analysis of 1998 - 2000 MEPS.

[1] This paper represents a distillation of three earlier studies: J. Hadley J and J. Holahan "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending," May 10, 2004 (http://www.kff.org/uninsured/7084.cfm); J. Hadley and J. Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs Web Exclusive,* June 4, 2003 (http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_060403.htm); J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *Health Affairs Web Exclusive*, February 12, 2003 (http://www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm). For details on methods and data sources, see J. Hadley and J. Holahan, "Cost and Sources of Payment for Medical Care Used by the Uninsured: Detailed Methodology Report," Washington: Kaiser Family Foundation, 2003 (http://www.kff.org/content/2003/20030205) .

[2] J. W. Cohen, "Design and Methods of the Medical Expenditure Panel Survey Household Component," Rockville MD: Agency for Health Care Research and Policy, MEPS Methodology Report No. 1, AHCPR Pub. No. 97-0026, 1997.

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[1] S. Heffler et al., Health Spending Projections through 2013," *Health Affairs Web Exclusive*, Feb. 11, 2004.

[1] J. Hadley and J. Holahan, "How Much Medical Care Do the Uninsured Use and Who Pays for It?" *op. cit.*

[1] These estimates were developed primarily from provider information on the sources of their revenues that can be attributed to or justified by care to the uninsured.

[1] Prospective Payment Advisory Commission, Report and Recommendations to the Congress: Washington, 1997, pp.28-29.

[1] T. A. Coughlin and B. Bruen, "State Use of Medicaid UPL and DSH Financing Mechanisms," Washington: The Urban Institute, 2002.

[1] Institute of Medicine, Coverage Matters, Washington: National Academy Press 2001; American College of Physicians, No Health Insurance? It's Enough to Make You Sick, Philadelphia: American College of Physicians, 2000 (http://www.acponline.org/uninsured/lack-contents).

[1] B. Strunk and P. Cunningham, "Treading Water: Americans' Access to Needed Medical Care, 1997-2001," Washington, DC: Center for Studying Health System Change, 2000 (www.hschange.org/CONTENT/421).

[1] J. Hadley, "Sicker and Poorer: The Consequences of Being Uninsured," *Medical Care Research and Review* Vol. 60, No. 2 (supplement), pp. 3S-75S, June 2003. (Available at http://www.kff.org/content/2003/4115/supparticle.pdf.)

[1] L. Kozak, M. Hall , and M. Owings, "Trends in Avoidable Hospitalizations," *Health Affairs* March/April 2001: 225-32; C. Hoffman and D. Gaskin, "The Costs of Preventable Hospitalizations among Uninsured and Medicaid Adults," Washington, DC: Kaiser Family Foundation, 2001.

[1] L. Dafny and J. Gruber, "Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansions and Child Hospitalizations," Cambridge, MA: NBER Working Paper Series, Working Paper 7555, February 2000: 1-43.

[1] J. Ayanian, B. Kohler, T. Abe and A. Epstein, "The Relationship Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *The New England Journal of Medicine* July 29, 1993:326-31; R. Roetzheim et al., "Effects of Health Insurance and Race on Breast Carcinoma Treatments and Outcomes," *Cancer* December 1, 2000: 2202-13; R. Roetzheim et al., "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes," *American Journal of Public Health* November 2000: 1746-54; R. Roetzheim, N. Pal, et al. "Effects of Health Insurance and Race on Early Detection of Cancer," *Journal of the National Cancer Institute*, August 19, 1999 August 19: 1409-15.

[1] J. Ayanian et al., "Unmet Health Needs of Uninsured Adults in the United States," *JAMA* October 25, 2000 October 25: 2061-9.

[1] Families USA Foundation, "Getting Less Care: The Uninsured with Chronic Health Conditions," Washington DC, 2001; C. Huttin, J. Moeller and R. Stafford, "Patterns and Costs for Hypertension Treatment in the United States: Clinical, Lifestyle and Socioeconomic Predictors from the 1987 National Medical Expenditures Survey," *Clinical Pharmacoeconomics* September 20, 2000: 181-95; G. Beckles et al., "Population-Based Assessment of the Level of Care Among Adults with Diabetes in the U.S.," *Diabetes Care* September 1998 September: 1432-8.

[1] J. Hadley, "Sicker and Poorer," *op. cit.*; Institute of Medicine, *Care Without Coverage, Too Little, Too Lat.* Washington DC, 2002: 161-165.

[1] J. Hadley and T. Waidmann, "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," *Health Services Research*, April 2005 (forthcoming).

[1] W. Miller, E. Vigdor, and W. Manning. "Covering the Uninsured: What Is It Worth?" *Health Affairs Web Exclusive*, March 31, 2004.

[1] Institute of Medicine, *Hidden Costs, Value Lost* Washington DC, 2003: 112.

[1] D. Gaskin and J. Hadley, "Are Subsidies Allocated to Urban Hospitals in Accordance with Their Safety Net Roles?" IWP 97-108, Washington DC: Georgetown University, October 1999.

[1] Medicare and Medicaid budget projections are from http://www.cms.hhs.gov/statistics/nhe/projections-2002/t5.asp.

[1] J. Sheils and R. Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs Web Exclusive,* Feb. 25, 2004.

[1] J. Hadley, "Sicker and Poorer," *op. cit.;* Institute of Medicine, *Care without Coverage*, *op. cit.*

Business leaders urged to show leadership on health care

By Amy Snow Landa, Communications Director- Wye River Group
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The take-home message from the Texas Lyceum public conference in October was clear: as Texas business leaders, you have an opportunity to exert leadership in solving the urgent health care issues facing your communities, but only if you decide to step up to the challenge in creative and collaborative ways.

Lyceum members from around the state agreed that the need for leadership in health care policy grows increasingly acute as Texas communities face deepening crises in health care. In cities such as Houston, Dallas and El Paso, the growing numbers of uninsured and medically underserved residents, along with skyrocketing health care costs and overburdened hospitals, have reached critical levels.

As the crisis spreads throughout Texas, affecting not only low-income residents but also the middle class, there is no doubt that major changes are coming. Indeed, they are inevitable. The only question is whether the changes will be ad hoc, crisis-driven and short-sighted, or whether community and business leaders will mobilize in a collaborative and thoughtful effort to influence the direction in which health system change occurs.

We heard from business leaders at the Texas Lyceum conference that you want to be involved in determining the future direction of health care in this state and in your communities. Now the task is to develop a shared vision of the changes you would like to see, and a road map for how to get there.

Determining a common agenda for health care

The first step in exerting leadership in the health policy arena is to engage in dialogue among yourselves and with other stakeholders, and to set goals for crafting a common agenda and strategy. During the seminar, we were encouraged to find a surprising degree of agreement among participants about the changes that are needed in health care – despite the diversity of political and philosophical viewpoints that were represented.

One important area in which participants expressed agreement was that a social contract for health care does exist in this country. In fact, the consensus in support of this idea was much stronger than what we've heard in other communities in which we've facilitated discussions on health care. But Lyceum members were also quick to point out that the social contract for health care, in its current form, is insufficient. To have an effective social contract – one that really supports health – it's not enough to provide certain entitlements to certain sub-sections of the population – namely the poor, the elderly, and individuals with disabilities. Nor is it enough to say that anyone – regardless of their ability to pay – can expect to receive emergency medical care if they are very sick or injured.

Instead, participants strongly asserted that the social contract for health care should be expanded to include an explicit understanding that with certain rights to health care come certain responsibilities on the part of individuals. These responsibilities include making choices that will keep one healthy and that will minimize, as much as possible, our need for medical care. Our responsibilities also include making cost-conscious decisions about our use of health care resources. If we expect to

continue to have access to high-quality health care, we each have to recognize our own role in making that possible and sustainable.

It was suggested that government entities at the state and federal levels could play a greater role in enhancing individuals' sense of personal responsibility for their health and health care. This could be done by educating people on the importance of health promotion and disease prevention, and by improving access to preventive care, particularly for children and low-income adults. It was also suggested that more public dollars should be directed to preventive care, which would in turn reap cost savings by reducing the need for acute care. Employers and insurers can also play a significant role in supporting and encouraging health maintenance by better aligning incentives for consumers and providers.

Among seminar participants, there was also widespread support for improving health care by minimizing waste and inefficiency, ensuring that evidence-based medicine is practiced, and bringing greater transparency to health care, particularly in the area of pricing. It was also suggested that we need a more holistic view of health that includes not just physical health, but mental and behavioral health as well.

Filling the leadership void

Judging from the tremendous amount of agreement on the underlying issues in health care, and the high degree of interest in taking action on these issues, there appears to be tremendous potential for Lyceum members to exert leadership in the health policy arena at the community, state and national levels.

A number of business organizations, such as the Texas Association of Business, the U.S. Chamber of Commerce and others, are already extremely active, and often effective, in the health policy arena. However, it was suggested that there remains a leadership void in health policy – one that Texas Lyceum members could do a lot to fill, particularly if their interest in health policy has more to do with the broader interests of the community and less to do strictly with their own company's bottom line.

Business leaders do have a vested interest in their employees' health and in seeing that the dollars they spend on health care reap maximum value in return. Certainly, given that most Americans continue to receive health care coverage through their employers, businesses have an important role to play in any health policy discussion. However, it was suggested that the business community faces a problem with regards to public perception of its motives and goals if business leaders are seen as too overtly partisan and self-interested.

Lyceum members could play an important part in shaping the future of health care by adopting the role of community leaders who are less interested in partisanship and more interested in engaging in dialogue with other stakeholders in the community as well as seeing the "big picture" with regards to health care and leading their communities – in a broader sense – toward health care improvement.

Building on current efforts at collaborative leadership

There are already dozens of collaborative, community projects throughout Texas working on various issues in health care, particularly the problem of the uninsured. In Houston, the Healthy Neighborhoods Initiative, which involves the University of Texas LBJ School of Public Health and other stakeholders in the community, is

engaged in asking neighborhoods what their particular needs are with regards to health and health care. "The project is based on the belief that health care starts in the neighborhood," said one participant. The project facilitates collaboration at the community level and leverages its investments with other funders to bring needed resources to these neighborhoods.

In Midland, as in many other communities throughout Texas, local health care and business leaders have collaborated to address the rising number of medically indigent patients who were overwhelming the ER at the city's hospital. "They ended up setting up a women's clinic [to provide] prenatal care and a children's clinic," said a participant. It is a true community collaboration: a physician spearheaded the effort; the local newspaper donated space to the clinic, doctors and nurses are volunteering their time; and pharmaceutical companies have donated medication. "It really helped reduce the cost of indigent care at the hospitals," she said.

Recently, the Texas Institute for Health Policy Research has developed a statewide Shared Vision Project that involves 28 leaders from around the state of Texas. The project is meant to tie together community-based efforts at health care improvement and to make them more effective at the state and federal level. "When communities get together and try to take action, they often get thwarted by state and federal problems," explained Institute President and CEO Camille Miller. "So we need the community ideas coming up, but we need something to plug into up here."

The Shared Vision Project is working to develop goals for health policy at the state level that individual communities can "plug into" with their efforts. These goals "are nothing but bipartisan, supportable, common good kind of things," Camille said. The project is intended to be a long-term, sustainable effort to produce transformational change in health care in Texas, and Camille encouraged Lyceum members to get involved in the effort.

"Plugging in" to a national initiative

In her remarks, Camille also encouraged Lyceum members to forge a connection with the national Community Leadership Initiative that we've spearheaded through Wye River Group on Healthcare. "[Wye River] is giving us something to plug into at the national level," Camille said. "We really haven't had those conversations before, but none of us can do this by ourselves."

Our initiative currently involves 12 communities around the country, including San Antonio. Our goal in holding health care leadership roundtables in these communities has been two-fold: to listen to community leaders and the wisdom and experience they offer, and to use their input to develop a national health care agenda that transcends partisanship and sector competition.
We understand that the Lyceum plans to poll members in the near future to determine who is interested in working on strategies on health policy. If it turns out that the Lyceum decides to carry forward the discussion that was started at your October conference, we look forward to following your progress and offering whatever support might be useful. We also plan to stay in touch with Lyceum leaders to keep them abreast of our work at the national level and to involve them wherever appropriate.

The Deceptive Lure of National Health Insurance

John C. Goodman, Ph.D. -
President/Founder, National Center for Public Policy Analysis

Politicians, social activists and even some business leaders are arguing for a national, single-payer health care system. Many of these advocates assert that health care is a right, which must be guaranteed by government. For support, they point to the single-payer systems in Europe, Canada, and elsewhere. But a close examination of those systems finds that the reality doesn't live up to the promise.

In fact, no country with national health insurance has established a right to health care. Citizens of Canada, for example, have no right to any particular health care service. They have no right to an MRI scan. They have no right to heart surgery. They do not even have the right to a place in line. The 100th person waiting for heart surgery is not entitled to the 100th surgery. Other people can and do jump the queue.

When countries make health care free at the point of consumption, they expose themselves to a potential endless drain on their national resources. To prevent that from happening, these countries invariably limit health care spending by limiting supply. They do so primarily by imposing global budgets on hospitals and area health authorities and restricting the purchase of high-tech equipment. As highlighted in *Lives at Risk*, a book I recently co-authored, the result is rationing by waiting:

- In Britain, with a population of almost 60 million, government statistics show more than 1 million are waiting to be admitted to hospitals at any one time.
- In Canada, with a population of more than 31 million, the independent Fraser Institute found that more than 876,584 are waiting for treatment of all types.
- In New Zealand, with a population of about 3.6 million, the government reports that more than 90,000 people are on waiting lists for hospital admission.

Although there may be some waiting in any health care system, in these countries rationing by waiting is government policy. Patients may wait for months or even years for treatment. For example:

- Canadian patients waited an average of 8.3 weeks in 2003 from the time they were referred to a specialist until the actual consultation, and another 9.5 weeks before treatment, including surgery.
- Of the 90,000 people waiting for care in New Zealand in 1997, more than 20,000 were waiting for a period of more than two years.
- The London-based Adam Smith Institute estimates that the people currently on Britain's National Health Service (NHS) waiting lists will collectively wait about one million years longer to receive treatment than doctors deem acceptable.

Among the patients waiting, many are waiting in pain. Others are risking their lives. Delays in Britain for colon cancer treatment are so long that 20 percent of the cases considered curable at time of diagnosis are incurable by the time of treatment. During one 12-month period in Ontario, Canada, 71 patients died waiting for coronary bypass surgery while 121 patients were removed from the list because they had become too sick to undergo surgery with a reasonable risk of survival.

While critics of the U.S. health care system claim that we have too much technology, all the evidence suggests that our counterparts have too little — as a result of the conscious decisions of government officials. For example, computed tomography (CT) scanners, which are useful in the diagnosis and treatment of cancer, were invented in Britain. For years Britain manufactured and exported about half the CT scanners used in the world. Yet through the years the British government purchased very few scanners for the NHS, and even discouraged private gifts of the devices to the NHS. Today Britain has only half the number of CT scanners per million population as the United States. Britain's NHS has also skimped on the newer Magnetic Resonance Imaging (MRI) scanners that can detect disease throughout the body, including aneurysms or tears in the aorta, strokes and tumors. Britain has less than half as many as the United States.

Canada also compares unfavorably with the United States in access to high tech equipment:

- On a per capita basis, the United States has more than three times as many MRI units as Canada, and almost twice as many CT Scanners per capita as Canada.
- Per person, the United States has nearly four times as many lithotripsy units — which avoid expensive and invasive surgery by using sound waves to destroy kidney stones and gallstones.
- As of November 2001, Canada had only three public-sector PET scanners — and one of those only operated one evening a week — compared to 250 in the United States.

In addition, much of the medical technology that is available in Canada is archaic and ineffective. In Canadian hospitals, for example, 63 percent of all general X-ray equipment is severely outdated and half of all diagnostic imaging units require replacement.

From the very beginning of the British NHS, politicians emphasized that the paramount goal was equal access to health care for all its citizens. Yet more than 30 years into the program (in the 1980s), an official task force (the Black Report) found little evidence that access to health care was any more equal than when the NHS was started. Almost 20 years later, a second task force (the Acheson Report) found evidence that access had become less equal since the previous study. The problem of unequal access is so well known in Britain that the press refers to the NHS as a "postcode lottery" in which a person's chances for timely, high-quality treatment depend on the neighborhood or "postcode" in which he or she lives.

Canadian officials also devote considerable rhetoric to the ideal of equal access to medical care. How well have the Canadians done? A series of studies from the University of British Columbia in the 1990s consistently found widespread inequality in the provision of care among British Columbia's 20 or so health regions. For example, the rural Peace River region of British Columbia spends much less per patient on specialists than Vancouver health authorities. One might suppose the higher level of GP services would offset the lower level of specialist services in Peace River -- it doesn't. Vancouver residents also enjoy about 60 percent more GP services. These examples are not isolated:

- Spending on specialist services in Vancouver is almost four times as high as spending on specialists in rural Cariboo.
- Per capita spending on all services was almost three

times is high in Vancouver as in Peace River.

- Differences among the regions are especially striking in certain specialties — a seven-fold difference in spending on thoracic surgery, a four-fold difference in spending on psychiatric services and a three-fold difference in spending on dermatology.

Empirical studies show that when health care is rationed, minorities and the elderly are often pushed to the rear of the waiting lines. Native Canadians, for example, receive much less health care than Caucasians — despite their greater health needs. One study found the infant death rate was 13.8 per 1,000 live births for Indian infants and 16.3 for Inuit infants, approximately twice the rate (7.3) for all Canadian infants during the same period. Overall, the study concluded, Canadian aboriginal people "die earlier than their fellow Canadians and sustain a disproportionate share of the burden of physical disease and mental illness."

Australia also has a significant minority population (the Aborigines). Various studies have reported that death rates are higher for Aborigines in all age groups. In infancy, Aborigines are 3.1 to 3.5 times more likely to die than other Australians. In the 35 to 54 age group, they are six to seven times more likely to die than other Australians.
In New Zealand, the average life expectancy for native Maori men is 5.5 years less than for non-Maori men. The corresponding figure for women is 6 years. The disparities do not stop with life expectancy. Most diabetes is preventable (or manageable) through early diagnosis and intervention. However, its incidence among 45- to 64-year old Maori is 4 times that of comparable non-Maori. The incidence of high blood pressure among young (25-44) Maori men and women is almost twice the rate of non-Maori New Zealand men and women of European ancestry.

Despite the greater overall health needs of these populations, minorities in countries with national health insurance systems are routinely marginalized by systems that direct resources and services toward the more affluent, white, urban majority.

Another group at risk is the elderly. Although more than one-third of all diagnosed cancers occur in patients 75 years of age or older, most cancer-screening programs in Britain's NHS do not include people over age 65. Only one in 50 lung cancer patients over age 75 receives surgery.

New Zealand's guidelines for end state renal failure programs say that age should not be the sole factor in determining eligibility, but that "in usual circumstances, people over 75 should not be accepted." Since New Zealand has no private dialysis facilities, this amounts to a death sentence for elderly patients with kidney failure.
Despite these many defects, proponents of national health insurance often portray it as a morally superior system. "The United States alone treats health care as a commodity distributed according to the ability to pay, rather than as a social service to be distributed according to medical need," claims Physicians for Single-Payer National Health Insurance. This notion is an article of faith among supporters of socialized medicine. But is it really true?

Precisely because of rationing, inefficiencies and quality problems, patients in countries with national health insurance often spend their own money on health care when they are given an opportunity to do so. In fact, private-sector health care is the fastest-growing part of the health care system in many of these countries:

- In Britain, 13 percent of the population has private health insurance to cover services they presumably are entitled

for free under the NHS, and private sector spending makes up 15 percent of the country's total health care spending.

- In Canada, the share of privately funded health care spending rose from 24 percent in 1983 to an estimated 30.3 percent in 1998.
- In Australia, private health insurance coverage has risen from around 31 percent of the population in 1998 to almost 45 percent by March 2002.
- In New Zealand, 35 percent of the population has private health insurance (again, to cover services theoretically provided for free by the state), and private sector spending is about 10 percent of total health care spending.

The almost seven million people in Britain covered by private health insurance account for two-thirds of all patients in private hospitals. The 300 private hospitals account for an increasingly large share of total health care services, including 20 percent of all non-emergency heart surgeries and 30 percent of all hip replacements. In 2002 an estimated 100,000 patients elected to pay for private surgery rather than wait for "free" care.

Despite British claims that health care is a right that is not conditioned on the ability to pay, one million people waited for care while 10,000 private pay patients (about half of whom were foreigners) received preferential treatment in top NHS hospitals in 2001. Advertisements for one hospital boast that patients come from all over the world, and the rooms are well-furnished, with televisions that have Arabic-language channels. An investigation by The Observer found that the NHS earns approximately $500 million per year in fees from treating private patients.

Since Canada does not allow private health insurance for services covered by its Medicare system, Canadians who see the country's few private physicians or get treatment at a private hospital must pay most of the cost out of pocket. For example, Canadians sometimes choose to undergo cataract surgery on an outpatient basis in private clinics. Although the government will pay the surgeon's fee, private patients often pay $1,000 to $1,200 in "facilities fees" to obtain faster treatment than they can get at a government facility. There is also a budding private market in sophisticated scanning services. Private clinics that apparently skirt the law — on the theory that services are not "necessary" medical care — are booming and now constitute 10 percent of the MRI market. St. Paul's Hospital in Vancouver offers after-hours full-body scans for less than C$1,000. A Montreal clinic offers a private CT scan for C$250. Patients wait one or two weeks for these procedures, compared to six-month waits in the public sector. A private company in Vancouver that offers PET scans for C$2,500 is attracting patients from as far away as Newfoundland. To reduce waiting lists for cancer treatment, seven of the ten Canadian provinces are sending some of their breast and prostate cancer patients to the United States for radiation therapy. Canadians spend an estimated $1 billion on care in the United States each year. Sometimes the patient's home province pays the bill. In other cases, patients spend their own money.

Foreign governments do not merely deny lifesaving medical technology to patients in need. They also take money that could be spent saving lives and curing disease and spend it serving people who are not seriously ill. Take British ambulance service, for example. There are between

18 million and 19 million ambulance rides each year — about one ride for every three people in Britain. Almost 80 percent of these rides are for such non-emergency purposes as taking an outpatient to a hospital or a senior to a pharmacy and amount to little more than free taxi service.

While thousands of people die each year from lack of kidney dialysis, and (according to the World Health Organization) 25,000 cancer patients die each year because they do not get the most effective drugs, the NHS provides an array of comforts for chronically ill people with less serious health problems. For example, the NHS provides non-medical services to about 1.5 million people a year, including day care services to more than 260,000, home care or home help services to 578,000, home alterations for 375,000 and occupational therapy for 300,000.

The characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the market for health under the control of politicians. Why do national health insurance schemes skimp on expensive services to the seriously ill while providing so many inexpensive services to those who are only marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small numbers of voters). Democratic political pressures in this case dictate the redistribution of resources from the few to the many. Why do the rich and the powerful manage to jump the queues and obtain care that is denied to others? Because it could not be otherwise. These are the people with the power to change the system. If members of Parliament had to wait in line for their care like ordinary people, the system would not last for a minute.

A SHARED VISION FOR HEALTH CARE IN TEXAS

By Camille D. Miller- President and CEO of the Texas Institute for Health Policy Research (Institute).

In 1996, the Institute of Medicine (IOM) began an initiative to assess and determine how to improve the nation's health care system. Initial findings concluded that the national system is in need of a complete transformation. Texas' health care system has, in many ways, more serious obstacles to improvement than does the national system.

Our state's demographics and increasing incidence of chronic disease, for example, create daunting health care issues that will extend well into the future. Accordingly, the delivery of health care has to change to reflect the fact that there will not be enough resources to meet future health care needs.

Current policies to address some of the individual issues we face, such as the uninsured rate, workforce shortages, obesity epidemic, poverty and various other problems will not be enough to meet the needs of our growing population. We need an overarching shared vision for *health care* in Texas. The Texas Institute for Health Policy Research utilizes the *health care* definition of Texas Department of State Health Services Commissioner Eduardo Sanchez. Sanchez defines health care to include "public health and medical care."

On May 25, 1961 President John F. Kennedy told members of Congress he wanted to land a man on the moon. The vision of a moon walk became reality in 1969 because it was a shared vision, supported by the stakeholders involved, who committed themselves to see the vision to fruition. Sharing a vision, even a very lofty one, can catalyze dramatic achievement.

Addressing the myriad health care issues in a state as geographically, ethnically and socio-economically diverse as ours may seem like reaching for the moon, yet a shared vision for health care can lead us to improved access, effectiveness and efficiency. Recognizing the need to develop such a vision, the Texas Institute for Health Policy Research (Institute) launched the Shared Vision Project (Project).

To create this vision, the Institute is establishing a forum for dialogue among the leaders of Texas' health care providers, payers, and consumers for informed decision-making. This collaborative effort is a statewide effort that brings stakeholders together to provide leadership in developing innovative products and ideas to improve the state's health care.

Committed to overcoming "silo" policy development in which stakeholders isolate problems into single-issue solutions, the Shared Vision Project has developed a structure that, collectively, possesses the extraordinarily high skill, knowledge and ability levels of all of the stakeholders. To forge a new and mutual vision, each stakeholder involved in the shared vision comes to the table prepared to accommodate changes to achieve solutions for the common good.

One of the fundamental features of the Project is that stakeholders from every sector involved in health care issues are included in developing the vision, via a panel of 26 members supplemented by statewide stakeholder interviews. This precludes development of policies that focus on single issues, rather than moving toward the vision.

Another essential feature is the development of focused workgroups of expertise to provide consultation and facilitation in key health policy emphasis areas to all Project participants. These workgroups (workforce, health care delivery, information technology, community/public health, finance, and rural health) are establishing the principles, components, and formats for white papers and designing model demonstration projects outcomes that will be shared with the Project panel and, ultimately, distributed to health policy decision-makers.

The Project process is creating a strategic transformation of health care for Texas. This transformation process is a disciplined effort to define a shared vision and enact change and improvement. Project participants believe a strategic plan will allow all stakeholders to focus their energy, ensuring that everyone is working towards the same goals. The Project leaders will listen, tell and guide to "realign" Texas' health policy direction in response to a changing environment.

In addition to the vision process, the Shared Vision Panel is producing recommendations for short and long term policy options based on evidence-based research, and working with community collaboratives to implement pilot demonstration projects.

The Five Elements of a Shared Vision for Health Care:

Regional solutions
Access for all
Incentives for personal responsibility
Sound use of resources
Education about consequences

Regional solutions are needed to address regional differences in health care needs, but the panel agreed that these solutions should fall within the parameters of a statewide strategic plan. All health care is local – solutions will need to be developed and implemented on a local and regional basis.

Access for all. A more rational system for access for all is needed other than the emergency room.

Incentives should be developed for individuals taking personal responsibility for wellness. A shared vision should also address incentives for communities, medical professions, the workplace for positive health behavior and contributions.

Sound use of resources in addressing the health needs of a community/individual. The shared vision panel will address the resource benefits of investments in prevention and public health; accountability, cost-effectiveness; and, maximizing funds.

Education must be disseminated regarding the consequences of our current system. Evidence-based information is needed to develop a business case to support health care improvements. Clear answers must be created to the questions, "What's in it for me?" and, "What is the return on investment?"

These five elements were created by the Shared Vision Panel. Project participants will use these elements to weigh and measure the adaptability of proposed health solutions. This process provides evidence-based, applicable solutions to the critical issues our state and local communities face.

As Texas' health care needs become more acute, it will become ever more important for communities to collaborate to address their health care

needs. In addition, personal responsibility, sound use of resources and educating stakeholders about the consequences of not changing health care are critical components of making the vision reality.

The Institute is working with leaders, identifying resources, and developing a strategic plan to forge a shared vision for health care in Texas. The Project will ensure that policy decision-makers have a vision for the future with workable options and demonstration projects for improving Texas' health care.

About the Institute

The Texas Institute for Health Policy Research (Institute) is providing leadership in the development of health care solutions to shape the Texas health care environment. As a nonpartisan, nonprofit organization, the Institute takes a broad view of health care issues and their impact on people and their communities. From acting as a neutral convener, facilitating balanced health care dialogue, to creating a vision of improved health care, the Institute is a think tank – providing innovative, "outside the box" collaboratively developed options to improve the health of Texans and their communities.

The Institute welcomes and solicits ideas, people, resources and Friends of the Institute members. With an Institute staff of eight people, 30 board members and countless other volunteers throughout the state, through collaboration, we are doing together what none of us can do alone. To learn more about the Institute go to www.healthpolicyinstitute.org.

[1] Institute of Medicine (IOM). "Crossing the Quality Chasm: A Focus on the Health Care Quality Initiative," 2004.

[1] Murdock, Steve H., et al. *A Summary of "The Texas Challenge in the Twenty-First Century: Implications of Population Change for the Future of Texas*." The Center for Demographic and Socioeconomic Research and Education, Department of Rural Sociology, Texas A&M University System, December 2002.

[1] IOM. *Who Will Keep the Public Healthy?* The National Academies Press, Washington, D.C.: 2003, p. 4.

[1] Kennedy, John, F. "Special Address to Congress on Urgent National Needs (aka, the "Man on the Moon Address")," May 25, 1961.

Healthcare: A Right or a Privilege?

Suggested Readings Prior to Participation in the Texas Lyceum Public Policy Conference

By Ken Janda

Antos, Joseph, "Kerry, Bush, and the Uninsured", *Health Policy Outlook*, published by American Enterprise Institute for Public Policy Research.

Goodman, John C., "Bush Health Plan: Consumer-Driven Health Care". Brief analysis from National Center for Policy Analysis, Sept. 2004.

"John Kerry's Plan to Make Health Care Affordable to Every American", from Kerry for President web site.

Frist, Bill. "Key Health Policy Proposals", *Speech to National Press Club*, July 12, 2004.

"Health and Poverty", *Wall St. Journal*, Aug. 27, 2004.

Goodman, John C, "KerryCare" Commentary, *Wall St. Journal*, August 26, 2004.

Clinton, Hillary, and Frist, Bill. Editorial, New York Times, (seen in the Houston Chronicle a few weeks ago).

"The Revised Texas Revenue Primer", Center for Public Policy Priorities, Mar. '03. (CPPP web site)

"Four Million Uninsured Workers to be Given Access to Affordable Health Care by Coalition of FORTUNE 500 Companies", Press Release from HR Policy Association, May 2004.

"Demographic Profile of Uninsured Texans in 2002", Texas Health and Human Services Commission.

"Health Care and the 2004 Elections: The Uninsured", Kaiser Family Foundation, Sept. 2004.