

**RISING COSTS, LOW QUALITY IN HEALTH CARE:
THE NECESSITY FOR REFORM**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

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JUNE 3, 2008
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RISING COSTS, LOW QUALITY IN HEALTH CARE: THE NECESSITY FOR REFORM

TUESDAY, JUNE 3, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Stabenow, Salazar, Grassley, Hatch, Snowe, and Crapo.

Also present: Democratic staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Shawn Bishop, Professional Staff Member; Susan Hinck, Fellow; Tara Clay, Fellow; Mollie Lane, Law Clerk; and Elise Stein, Detailee. Republican staff: Mark Hayes, Republican Health Policy Director and Chief Health Counsel; Rodney Whitlock, Republican Health Policy Advisor; and Lyndsey Arnold, Intern.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

People generally, but perhaps mistakenly, attribute to Mark Twain the saying, "Everybody talks about the weather but nobody does anything about it." Health care reform is like that, too. People talk about it often in Washington, DC and across the country, but for some time now nobody has accomplished anything about it.

I hope and intend that the Finance Committee will prove that old saying wrong, at least when it comes to health care. I hope and intend that we can seize the opportunity to achieve what previous Congresses and Presidents were unable to do. We must find a way for all Americans to have access to affordable, high-quality health care.

Today's hearing will take stock of the current health system. We will look at the current system so that we can craft the right reforms and make the right changes. We thereby hope to yield the desired result: affordable, high-quality health care for all Americans.

Today we will hear about some of the major problems in the current system. We will hear about the difficulties that employers face in providing health coverage to their employees and their retirees. We will hear about hardships that employees have in paying for their insurance and for health care that is not covered, and we will

hear how the current system impedes American business in competing in the global market.

We will also look at the value of the health care that Americans buy. American health care is technologically advanced and sophisticated, but it is costly and it lacks focus on prevention, wellness, disease management, and other basic efforts to increase efficiency. We will hear how we can stretch our health care dollars further.

America spends more than \$2 trillion a year on health care, but 47 million Americans are uninsured. That means 1 of every 6 Americans does not have access to health care, except in overcrowded emergency rooms, so 1 out of every 6 Americans has to worry about every sniffle and every cough turning into something serious.

In some parts of the country the share without insurance is even greater. In my home State of Montana, it is 1 in 5 people who lacks health insurance, and in Texas, 1 in 4 is uninsured; clearly unacceptable.

The trends are heading in the wrong direction. The number of uninsured Americans increases every year. The cost of insurance continues to increase faster than the economy and faster than wages. Fewer employers offer coverage to their employees, and fewer employees are able to afford it. Benefits have been scaled back, co-pays expanded.

People are paying more and getting less, and the quality of care being provided is not as high as it should be. We can do better. We must do better. We have no choice. We can increase the number of Americans who have health coverage, we can lower the cost of insurance to help both employers and employees, and we can improve the quality of care to help everyone lead longer, happier, more productive lives.

We can make American businesses of all sizes more competitive by helping them to provide health coverage for their employees. By providing all Americans with affordable, high-quality health care, America can remain an attractive option for new job growth. We should not just talk about jobs leaving our shores because other destinations have health coverage that is less expensive; we need to do something about it.

Our efforts to reform need to include ways to control costs. America simply cannot sustain its current rate of growth in health care spending over the long run. We must find a way to bend the cost curve, otherwise health spending will consume our entire economy.

Our efforts at reform must also include ways to improve the quality of care. America trains the world's best doctors, operates some of the best hospitals, develops the most advanced medical technology, but our health outcomes lag behind those of other industrialized countries. We must demand better health care outcomes from our health system. Our efforts at reform must include a new focus on prevention, on wellness, and on chronic disease.

Health care should be about fostering good health, not just treating illness. We are gaining knowledge about how to prevent and manage diseases. If we expand and apply that knowledge, we can improve health outcomes and increase the cost of health care. Our current system leaves too many people without coverage. It hinders employers, it leaves employees exposed. Our current system is in

need of reform. We must do it right, and in order to do it right we need to ask experts for help.

Today we have a panel of such experts. This is the second of a series of hearings in health care reform that the Finance Committee will hold this year. These four witnesses can help us to understand the major issues in our current system and why we need reform. Their diverse perspectives can help us focus reform so that we reach our goal of having affordable, high-quality health care for all Americans. So today let us talk again about health care reform. Let us hear from the experts about how to do it right. Let us plan this year so we can act next year to actually do something about health care.

I will turn to Senator Grassley.

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Thank you very much for holding this hearing as a forerunner to your idea, and I am working with you on it, for the Health Care Reform Summit in 2 weeks.

In America, we pay a lot for health care. According to Kaiser, the United States spends more on health care, as both a percent of GDP and on a per capita basis, than other OECD countries.

Well, if we are going to be spending that much money for health care, we should have the best health care in the world, right? While health care spending continues to rise, it seems like the U.S. continues to lag OECD countries on indicators of quality.

Obviously that is unacceptable, and we want to improve that situation. We have certainly made some forward progress, at least on the Medicare front. Transforming the way in which Medicare pays for health care has been a bipartisan priority that the chairman and I share.

Last Congress, we introduced the Medicare Value Purchasing Act. This bill starts all Medicare providers on the path to being based more on quality of care instead of volume. We have accomplished much since the introduction of this act. Currently, a number of Medicare providers, including hospitals and ambulatory surgical centers, home health agencies, and physicians, report quality measures in return for a full annual payment update and bonus.

The reporting of quality measures is an important first step towards transforming Medicare from a passive payer of health care to a value purchaser. Hospitals by far are the furthest along in reaching this goal.

A Medicare demonstration project on value-based purchasing for hospital services shows promising results. Last year, the Secretary of HHS released a value-based purchasing implementation plan for Medicare hospital services. It is obvious that a lot of thought was put into coming up with this plan. I look forward to working with Senator Baucus and other members of the committee to implement value-based purchasing for Medicare hospitals.

When the Federal Government can play a role in improving quality, we ought to. We have a lot to learn from the private sector as well; in some ways, the private sector is ahead of us. We should also ensure that nothing we do interferes with that private sector effort. I am looking forward to this testimony.

Maybe parenthetically here, I am done with my statement, but I ought to say something that came out in the 17 town meetings I had last week. Iowa health care providers come, so I make this statement based upon, one, we are looking at the United States as a whole, but looking at how maybe people in the Midwest might see quality.

There is some quoting of annual—I think it is Dartmouth University—studies showing a lot of places in Iowa being very high in quality, second, third, fourth in the Nation, and maybe low in costs. So they keep asking me, how come, if we are doing such a good job delivering on health care, we are not getting paid more for doing it? So that is kind of where the rationale comes in, moving from quantity to quality for reimbursement.

So as we do look at the country as a whole compared to other OECD countries, we need to know that in some places in America, maybe we rank a little better according to OECD than what maybe the country as a whole does.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator, very much.

Now I welcome the witnesses. First, Dr. Paul Ginsburg, who is president of the Center for Studying Health System Change; second, Dr. Beth McGlynn, associate director of RAND Health. Our third witness, I guess, will be introduced by my colleague from Michigan.

Senator STABENOW. Thank you, Mr. Chairman, for giving me the opportunity just to welcome Ms. Felicia Fields from the great State of Michigan, representing Ford Motor Company. She has been with Ford Motor Company since 1986, rising through the ranks to become Ford Motor group vice president for Human Relations and Corporate Services since March 25th of this year, and, I would just add, named by *Automotive News* as the 2005 Leading Woman in the North American Automotive Industry.

So, welcome. Glad to have you.

The CHAIRMAN. Thank you very much, Senator. Ms. Fields, welcome.

Our final witness is Ms. Arlene Holt Baker, executive vice president, AFL-CIO.

As you all know, I am sure you know, it is our customary practice to have all of your statements automatically included in the record, and we ask each of you to speak about 5 minutes.

Dr. Ginsburg, why don't you begin?

STATEMENT OF PAUL B. GINSBURG, Ph.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, WASHINGTON, DC

Dr. GINSBURG. Yes. Mr. Chairman, Senator Grassley, members of the committee, thank you for the invitation to testify. I am going to focus on health care costs.

The affordability problem in health care is not some academic issue of the ideal percentage of GDP, but it is a real phenomenon that is limiting many people's access to health care and leading to financial harm for some who are ill. As health spending continues to grow more rapidly than our incomes, inability to afford health

insurance is moving up the income scale and is now becoming a middle-class issue.

Rising costs are increasingly straining government budgets, with revenues roughly constant as a percentage of GDP and there being existing commitments to finance health care. So when health spending trends outpace the GDP, other policy priorities are getting crowded out and, at the Federal level, deficits are higher.

Rising costs mean that initiatives by government to expand coverage are likely to become more expensive over time and to be partly undermined by increasing numbers of people needing assistance in affording health insurance as time moves on. It is almost like filling a bucket that is leaking badly.

We understand the drivers of rising health care costs fairly well. Advancing medical technology is by far the largest factor, and much of this technology improves patient outcomes. But often technologies are applied to many patients who do not have the potential to benefit, and the drug Vioxx is a classic example of this phenomenon. Our financing and regulatory system also leads to many technologies with unknown benefits diffusing widely.

Aging is a driver of rising health care costs, but its impact has been measured by many researchers and has been found to be modest, perhaps a half a percentage point per year. This is good news. It means that much of the health care trend is not out of bounds to attempts to lower it.

An overlooked factor as a driver of rising health care costs is small gains in productivity in the delivery of health services. The cost of automobiles has not increased rapidly and the cost of computing power has fallen over time because of substantial productivity gains each year. But we cannot expect to achieve such gains in health care when the providers are paid on a piecework basis for what they do rather than on the basis of providing an episode of care for patients or management of a chronic disease.

There are many possible policy steps to address costs. No one is likely to be powerful enough to achieve the slowing of the trend that is needed. Consumerism can certainly contribute, but I doubt it can do the whole job, especially in its current form. We need to pursue many approaches simultaneously, both to compromise differing ideologies, but also to protect against some of them turning out not to meet our objectives.

I urge attention to these three areas. One is a sharp increase in government resources going to clinical effectiveness research, with the directive to the entity to uncover technologies with either negative or low value for patients.

Second, we need to revamp the provider payment system so that acute episodes of care are paid for using a single payment to all providers involved, and where the management of chronic disease is paid for on a capitated basis. Since Medicare provider payment policies now influence Medicaid programs and private payers, the Federal Government is well-positioned to lead on this while remaining a payer rather than a regulator.

Third, there is a great deal of potential to improving personal health habits, but we do not yet have the effective tools to accomplish this. I urge you not to oversell some policy ideas that may be worthwhile in general but have very uncertain potential to contain

costs. Examples of these would be health information technology, quality improvement activities, and medical liability reform.

Here are my final thoughts. Containing health care costs is hard work, and it is hard both because every dollar spent on health care is someone's revenue and those people all have lobbyists to represent their interests.

Beyond what we can accomplish by increasing efficiency, containing costs means people not having all the services that they might like to. We need to define success in our cost containment endeavors by the percentage of foregone services that have little or no value, and by whether we think the sacrifices are being distributed equitably.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Ginsburg, very much. I appreciate that.

[The prepared statement of Dr. Ginsburg appears in the appendix.]

The CHAIRMAN. Dr. McGlynn?

STATEMENT OF ELIZABETH McGLYNN, Ph.D., ASSOCIATE DIRECTOR AND DISTINGUISHED CHAIR IN HEALTH QUALITY, RAND HEALTH, SANTA MONICA, CA

Dr. McGLYNN. Good morning, Chairman Baucus, Ranking Member Grassley, and distinguished members of the Committee on Finance. I am honored to testify before you today about the problems with health care quality.

On a personal note, I am delighted to appear before my Colorado College classmate, Senator Salazar. Go Tigers! [Laughter.]

I applaud the committee for putting quality on the health reform agenda. All too often, people assume that if we solve the problems with access and cost the quality problem will be solved. The most important message I can leave you with today is this: if we get everyone insured and we put a lid on health care costs, we will not have solved the quality problem. It is a separate problem, it requires separate solutions.

Many people say that the United States has the best health care system in the world. In 2003, my colleagues and I published in the *New England Journal of Medicine* the first national comprehensive study on quality of care for adults. We examined 439 indicators of quality for 30 different clinical areas. We found that, on average, American adults received just 55 percent of recommended care for the leading causes of death and disability. We spend more than \$2 trillion annually on health care, and we get it right about half the time. That may be the best in the world, but I hope you would agree that we can, and should, do better.

Quality problems are more pronounced for older and younger Americans. My colleagues found that the vulnerable elderly received only one-third of needed care for conditions unique to this population, for example, falls that lead to hip fracture, urinary incontinence, and dementia. My own team reported last year that children received just 47 percent of recommended care.

When we published these studies, people said to us, well, there may be problems overall in the U.S., but the care in my community is much better than that. We collected enough information to allow

us to construct quality scores for 12 metropolitan areas around the country. We found remarkably little variation in quality, ranging from 51 percent of recommended care delivered in Little Rock, in Senator Lincoln's home State, to 59 percent of recommended care delivered in Seattle, in Senator Cantwell's home State.

When we published these findings in *Health Affairs*, the *Seattle Post Intelligencer* headline read, "Seattle: Best of a Bad Lot," and I thought they got it about right.

I am sure Senator Kerry would be disappointed to find that Boston, that well-known medical Mecca, was second to Seattle at 57 percent. Performance in other communities that are located in States represented on this committee include 56 percent in Syracuse, 55 percent in Lansing, and 55 percent in Phoenix. The relatively small differences we found in these very disparate communities have led most people to conclude that their own community probably performs similarly.

The next comment we heard was, well, quality may be a problem nationally and even in my community, but my care is excellent. But in fact we found that everyone is at risk. We found no substantial advantages for population subgroups defined by gender, age, race, income, and insurance. We know these factors may make a difference in determining who gets in the door of a medical care system, but once in, it appears these factors convey relatively little advantage.

The consequences of these failures to deliver needed care are significant. The quality deficits we documented contribute to 29,000 preventable cases of kidney failure annually among persons with diabetes; 68,000 preventable deaths among persons with hypertension; 37,000 preventable deaths among persons who have heart attacks; 10,000 preventable deaths from pneumonia. Make no mistake: poor quality is deadly.

While we were conducting this study, my father was hospitalized with congestive heart failure for the third time in about 18 months. In looking at his medical records, which he would only ask for after he was discharged from the hospital for fear of upsetting his doctor, we found that he was not on the preferred medications for his conditions and he was not getting adequate doses of the medications he was receiving. My father was insured, educated, and had been a hospital administrator for more than 30 years, and even he is failing to get the care he needed.

I would like to close with an observation. The hearing today compares the problem of rising health care costs with the problem of low quality. Many people believe that improved quality will lower health care costs. While there are certainly examples of better quality being cheaper, there are many other areas where we would expect improved quality to increase costs.

The history of quality improvement for more than 5 decades shows that there is greatest interest in improving quality if it achieves cost reduction objectives. I hope this committee has the courage to support efforts to improve quality whether or not they save money. I hope you will commit to improving quality because it is the right thing to do.

In the future we may even spend more money than we do today, but we can substantially improve the value of that expenditure if

we focus on making real the claim that America has the best health care system in the world. We can deliver on that promise, and we must.

Thank you.

The CHAIRMAN. Thank you, Dr. McGlynn.

[The prepared statement of Dr. McGlynn appears in the appendix.]

The CHAIRMAN. Ms. Fields?

**STATEMENT OF FELICIA FIELDS, GROUP VICE PRESIDENT,
HUMAN RESOURCES AND CORPORATE SERVICES, FORD
MOTOR COMPANY, DEARBORN, MI**

Ms. FIELDS. Good morning, Chairman Baucus, Ranking Member Grassley, Senator Stabenow, and members of the committee. I commend the committee for this important hearing and am pleased to discuss our experience and challenges in providing high-quality health care coverage at Ford Motor Company.

Last year, Ford spent \$2.2 billion, or about \$1,000 per vehicle, to provide health care coverage for 535,000 U.S. employees, retirees, and their dependents. Of that, \$1.2 billion was for retiree care. While we are pleased to provide high-quality benefits to Ford employees and retirees, we have had to take significant steps to address this cost to help secure the financial viability of Ford.

Last November, Ford and the UAW ratified a contract establishing a new independent, voluntary Employee Benefit Association Trust to which Ford will contribute \$13.2 billion. This trust will administer post-retirement benefits to former hourly employees and active employees as part of the new contract effective September 2007.

These measures are necessary to continue offering health care benefits to our employees and retirees without compromising the company's financial viability; however, they still do not address projected health care cost increases. Therefore, we are working to create a culture of health and wellness as a central portion of our health care strategy. As the first step, we started providing resources and tools to improve employee health status and aid sound choices about health care services and coverage.

We recognized that one important tool employees need to improve health status and become better health care consumers is an information infrastructure. In 2004, Ford, in conjunction with others, created the Southeast Michigan E-Prescribing Initiative, one of the country's largest employer-driven e-prescribing efforts. In 2006, we led the formation of the Southeast Michigan Health Information Exchange to create the infrastructure for regional transmission of health care information among health care providers and patients.

We also recognized that many employees with chronic diseases need greater involvement by their primary care physicians; therefore, we took a leadership role in Michigan's participation in the Improving Performance and Practice Initiative to provide tools to ensure these patients receive recommended treatments and preventive services.

Despite these efforts, much more can be, and must be, done. I would like to leave you with some policy suggestions on how the Federal Government could assist. Much recent discussion on health

care reform has justifiably centered on the uninsured, however, too much of that discussion focused simply on expanding coverage, such as financing, modifying insurance markets, and mandates.

A better approach is to improve health care coverage affordability, evaluating the cost drivers, and addressing them. Simply subsidizing excessive health care spending does not offer a long-term solution to America's health care problems, and it may well exacerbate them. Instead, by first making health care coverage more affordable for the entire population, uninsured and insured alike, we benefit both immediately and over the long term.

Over the last several years generic substitution has allowed some control of prescription drug costs, yet one element of our prescription drug costs continues to increase rapidly: biologics. We urge Congress to enact legislation giving FDA approval to approve safe and effective biogenerics and eliminate perpetual monopoly pricing.

Incentive-based wellness programs are currently limited to 20 percent of cost of coverage. Raising this to a higher percentage would also allow greater incentives for people taking an interest in their wellness. This is good for them, good for us, and good for the country.

To prevent gaming of the system, we further suggest modifying regulations regarding voluntary behaviors to enable wellness programs to offer differential rewards and rewards based on outcomes. This would reward those who actually do the hard work to improve their health status and adopt better health policies.

Similarly, we recommend strong Federal leadership for establishing one set of standards for health care quality and one set of best practice guidelines for improving the population's health status. The Federal Government, including CMS, can provide a central leadership role by adopting constructive policies. These can, and certainly will, be replicated in the private sector.

Many systems benefit from adoption of health information technology, but are only achievable if infrastructure allowing electronic storage and exchange of such information exists. This infrastructure requires start-up funding and incentives for physicians to make the investment to participate. We suggest Federal assistance. As an employer offering health care in 50 States, the ability to offer uniform benefits is also vital.

Mr. Chairman, thank you again for the opportunity to share our experiences with this committee. Thank you very much.

The CHAIRMAN. Thank you, Ms. Fields.

[The prepared statement of Ms. Fields appears in the appendix.]

The CHAIRMAN. Next, Ms. Holt Baker?

**STATEMENT OF ARLENE HOLT BAKER, EXECUTIVE VICE
PRESIDENT, AFL-CIO, WASHINGTON, DC**

Ms. HOLT BAKER. Good morning, Chairman Baucus, Senator Grassley, and distinguished members of the committee. Thank you for the invitation to participate in this morning's hearing and to offer our perspective on behalf of working women and men on the need for health care reform.

I would like to commend the committee for launching this series of hearings on health reform and laying the groundwork for a na-

tional debate on how best to secure affordable, high-quality health care for all Americans.

The AFL–CIO represents 10.5 million members, including 2 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health care for more than 50 years.

Our members are among the most fortunate; through bargaining, they have good benefits from their employers. Yet even the well-insured are struggling with health care cost hikes that are outpacing their wage increases, and far too many working families just cannot keep up.

Earlier this year we launched an online survey that captured working families’ concerns about health care. More than 26,000 people took the survey over a 7-week period. Most are insured and employed, most are college graduates, and more than half are union members. These are the people, it would seem, most likely to have positive experiences with America’s health care system. Instead, their responses tell a sobering story about the breadth of the problems with health care in America.

Nearly all survey-takers with insurance, 96 percent, say they are “somewhat” or “very concerned” about affording coverage in the next few years. Almost two-thirds who have employer-provided coverage say their costs have gotten worse. More than half of survey-takers say their health insurance does not cover all the care they need at a price they can afford, and preventive care, if uncovered, is unaffordable for more than a third.

Almost 7,500 people posted their stories of health care system failures. One of these stories comes from Doreen in Venetta, OR. She wrote, “I worked for a manufacturer for over 15 years. My wages stayed the same for over 6 years. As I found myself paying more and more for health care, co-pays went up, deductibles went up, and the last year I worked there I was paying a portion of the premium. In late 2006, the company sent my production job to Mexico and China, and I was laid off. I could not afford COBRA premiums. I am 2 years away from Medicare and unemployed and on the faith-based health care system: I pray I don’t get sick. Oh, yeah. I’m a cancer survivor, and I haven’t done the yearly check-up in 3 years.”

These survey results and stories put a human face on the statistics that are perhaps numbingly familiar, yet all too telling. Health premiums are rising 3 times faster than wages and inflation, annual premium costs for family coverage have almost doubled between 2000 and 2007, and, as the number of uninsured grows, so too does the cost-shifting that occurs in our fragmented system.

More than \$900 of the average premium covers treatment for the uninsured. Year-in and year-out, health care costs are the toughest issue in bargaining, and workers regularly forego bigger wage hikes to fend off greater health care costs, demonstrating the value workers place on the security of health benefits they can count on to cover the care they need.

But these trends are unsustainable, and the status quo is unacceptable. Our employers are, for the most part, the good guys. Our unions work with them to make limited dollars stretch as far as possible to meet escalating health care costs, yet they increasingly

find themselves competing domestically and internationally with firms that do not bear the same cost pressures. Globally, U.S. firms pay more as a percent of payroll and as an hourly cost than our major trading partners.

Here at home, firms that provide good benefits to their workers and their families find themselves picking up costs for firms that either do not cover dependents or do not provide coverage at all. Even public employers that have typically provided good health benefits are struggling under growing cost pressures, especially as more States find their budgets hit by the economic downturn.

We regularly work with employers to tackle these problems. Value-based purchasing and electronic prescribing are two policies that make sense and have the support of many in the business, labor, and consumer worlds. We know we are not getting consistently high quality for the money that we spend, and disparities of care persist across our population based on race, ethnicity, language, and gender.

We can do better and we can save money at a time when 47 million Americans are uninsured and tens of millions more worry about losing the coverage that they have. It is crucial that we understand health reform as a process of transforming the way care is structured and provided, not just a debate over who pays the bills. But reform must address costs and coverage as well. We need comprehensive reforms that will not only improve quality, but lower costs and extend coverage for everyone.

Last year, the AFL-CIO launched a campaign to mobilize our members to push for national reform that will guarantee affordable, high-quality coverage for all Americans, and we will measure various plans and proposals against our principles of reform. These principles are built on group coverage and pooled risk rather than the flawed individual insurance market.

Everyone would get health care as good as they have now or better, and everyone must share in the responsibility for financing that coverage: government, employers, and individuals. Everyone would get a choice of health plans, including the right to keep their current coverage, or to choose another private plan or public plan. The government should act as a watchdog on cost, quality, and fairness. These principles are consistent with those of many other stakeholders, but we recognize that there will be other approaches. Our members and our employers have an important role to play in the national debate to come, and this committee will of course be at the center of that debate.

We look forward to working with you to enact legislation that will guarantee affordable high-quality health care for all Americans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Ms. Holt Baker.

[The prepared statement of Ms. Holt Baker appears in the appendix.]

The CHAIRMAN. Dr. Ginsburg, I would like to ask you how we might structure public/private institutions to look at comparative effectiveness as one way to curb excessive and inappropriate costs. Basically, a couple of questions. One is, what might this structure be? Second, what might such an institute focus on?

Dr. GINSBURG. Yes. There are two keys in this structure. One is to provide some insulation from micromanagement by both the Congress and the President. There cannot be influence on particular reports and analyses that the entity performs. Also, it requires a large, stable funding stream.

Areas of focus should be both those where there is a possibility that a technology is harmful to some patients that it might be used for, but also technologies where the benefits to some of the patients it might be used for turn out to be very small in relation to costs. The history of advancing medical technology in this country is applying it to too many patients, not only the ones who can benefit tremendously, but some who cannot. So I think that these should be some thoughts on the structure.

The CHAIRMAN. Right. But could you expand a little bit on your point about insulation from micromanagement?

Dr. GINSBURG. Sure. The Medicare program has a governance problem, where both the Congress and the White House, no matter what party is in control, get very involved in the details. In a sense, it is like a company having a Board of Directors of 535 pulling it in different directions. The entity for effectiveness research and for the Medicare program needs to have some insulation, where it gets broad directions and its gets oversight, but it is not subject to having each individual decision, like how much to pay for oxygen or whether to have competitive bidding for durable medical equipment, reviewed by the Congress.

The CHAIRMAN. There is a lot to be said for that. I feel, often, that this Congress is not qualified to make a lot of those individual decisions that we now do make. We are just not competent, in many cases, to know which of those micro-decisions are appropriate or inappropriate. As you say, a lot of it is just due to political pressure. We want to do what is right, clearly, and try to balance out different interests. But I sometimes think that something has to change, because we are bogged down too much in details. But if you have some thoughts on down the road on how to provide that insulation, we would surely appreciate it.

You mentioned something about a substantial resource lull. Could you expand on that a little bit, please?

Dr. GINSBURG. Yes. I think in recent years, when you look at the amount of resources the Agency for Healthcare Research and Quality spends on effectiveness research, it is very, very small in relation to either funding for biomedical research or to what the Medicare and Medicaid programs spend. It just seems as though there is a potential, with some ramp-up time, to accomplish a lot more, but resources are needed.

The CHAIRMAN. Do you think such an institute is necessary to get control of the costs?

Dr. GINSBURG. Effectiveness research?

The CHAIRMAN. Yes.

Dr. GINSBURG. Yes. I think it can contribute if the direction, if the focus is broad enough, is on value issues and cost-effectiveness issues and not only looking for technologies which turn out to harm patients. I think the key thing is the charge that Congress gives to the entity.

The CHAIRMAN. All right.

Dr. McGlynn, I was interested in your comment that quality is separate from coverage and cost. I was a little unclear about what the impediments, in your view, are to insufficient care, that is, why so few patients get the recommended care and what the solution might be, in 5 seconds. [Laughter.]

Dr. MCGLYNN. In 5 seconds. Let me start with, I think, the main thing, which is, we have this antiquated delivery system that was built at a time when there was not much we could do, and most of what we could do was in response to acute, frankly, self-limited illnesses. So we have this very reactive system. We have not done anything to change the fundamental delivery of health care, and yet the problems facing physicians are quite a bit different. There is relatively little planning. I think every time a patient shows up in a doctor's office, it is sort of like a surprise party. Nobody goes in with a sense of the things that need to be done for the particular patient that is in front of the doctor.

We also have this nutty idea that doctors are not subject to the same cognitive limitations of the rest of the world, so we have doctors who operate with handwritten medical records, and they either cannot read their own writing or could not possibly find the relevant information in the 17 minutes they have with the patient.

So I think we need some fundamental restructuring of the way that the health care system is delivered. I think it starts with health information technology. It is pretty hard for me to imagine how we would make significant progress if we do not introduce the benefits of computers into the health care delivery system. I do not think that is a panacea. I think there is a lot of evidence of how that cannot meet the promise, but it is pretty hard to imagine how we would make progress without that.

The CHAIRMAN. Thank you. Thank you very much.

Senator Grassley?

Senator GRASSLEY. Thank you very much.

I am going to start with Ms. Fields. You testified that Ford has taken steps to provide resources and tools to your employees that allow them to become better health care customers. What did you learn through your culture of wellness program? Can you document positive results over the period of time? I suppose it is a relatively short period of time that you have been involved. Will this ultimately save Ford money or is it perhaps already saving Ford some money, the extent to which you can document any of those things?

Ms. FIELDS. Yes, Senator Grassley, it has been a relatively short period of time. I can say that we have strong experience to draw on relative to the cost savings. We do know that, by involving employees in their care and also more proactively involving attending physicians working with employees around chronic disease, that over time we are going to reduce their risk of chronic disease. There is a very strong correlation between lowering risk and lowering cost.

So as we get the risk factors down in our employee population base, we can see the reductions that will go down in our health care spending. Also, everything related to wellness, relating to their involvement, the comprehensive way that we can be on the prevention side rather than the reaction side, obviously over time

will lead to a healthier employee, and also a reduction in cost over time.

Senator GRASSLEY. But even though you cannot actually see costs right now, you have still a very positive view towards what you are doing as not only increasing the quality of life for people, but also saving your plans money. Is that right?

Ms. FIELDS. That is exactly right.

Senator GRASSLEY. All right.

Dr. McGlynn, you testified that increasing access to medical information technology would increase the quality of care because patients would have access to their own information. Even with access to their own medical information, how do you go about changing what I consider a decades-old attitude of American patients not to really question their doctors, just to do what the doctor says? It seems to me you have to change the culture. How do you suggest that?

Dr. MCGLYNN. Thank you, Senator Grassley. I think the transparency initiatives, the public reporting of quality information has been critical in beginning to break down the public's perception that their doctor gets it right all the time. I have had these experiences in my own family with my father being unwilling to question his doctors. For him, having printed information like checklists of the things that should be going on for somebody with his condition from an authoritative source was critically important.

Publishing information that says that quality falls short in hospitals and in doctors' offices makes people believe that it is incumbent upon them to get into more of a dialogue with their doctor. So I think all of the transparency initiatives and putting tools like checklists in patients' hands are two things that could be done that would be important.

Senator GRASSLEY. All right.

Ms. Holt Baker, kind of the employee side of a question I asked Ms. Fields, but not quite exactly the same question. Since a lot of the companies your unions deal with have instituted wellness and prevention programs, and Ford being one of them, since your union represents millions of people, it would be interesting to gauge how many of them are taking an active role in their own health care and well-being. In your recent survey, what did you find about your members' willingness to do more to stay healthy?

Ms. HOLT BAKER. Well, Senator, our members certainly believe in wellness, and we believe that you have to take personal responsibility for that. But in the survey, what we discovered from the members, and others who were not members, their responses primarily were about their concern and their fear about the rising cost of health care, their ability to afford it, and for those who had it, the ability to hold onto it. So, certainly that was what was expressed most in those surveys that we had taken. We would concur that certainly wellness is very important, but we need to first move toward fixing this broken system, and in doing that we believe that the wellness programs also will be able to have better and more preventive efforts in those areas also.

Senator GRASSLEY. All right.

In a very short answer, because my time is up, to you and to Ms. Fields, what one measure could the Federal Government take that would do the most good to improve quality in the private sector?

Ms. FIELDS. It is hard to prioritize on, Senator Grassley. But I would say health information technology infrastructure is very important to our ability to get transparency, data consistency, and protocols that really support high-quality care.

Ms. HOLT BAKER. Senator, we think that Medicare has led the way on health care quality. One of the things I would say is that Medicare is laying the groundwork for private sector efforts, and more of those efforts to provide purchasers with greater information about quality of care provided would help private sector purchasers use their buying power.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Bingaman?

Senator BINGAMAN. Thank you all for being here.

Dr. Ginsburg, you suggested three things that we could do to deal with the cost issue. One of them was to pay for management of chronic diseases on a capitated basis. I gather Medicaid and Medicare, you are suggesting, should do that. Is this one of these areas where Congress needs to act? Why can CMS not do this?

Dr. GINSBURG. Certainly there is movement at CMS now, such as planning a demonstration of a medical home, which really is a step towards capitated payment for management of chronic disease. In that case the capitated payment would be for the services that typically are not paid under fee-for-service so that physicians can do those and not be financially penalized.

But I would imagine that the entire thing might be within the authority of the Medicare program to do, but, if it is a big change, it always helps to have a directive from Congress to say, this is the priority and we will back you if you go in this direction and ruffle some feathers in the process.

Senator BINGAMAN. But I gather a significant portion of our medical cost in the Medicare system, for example, is connected to these chronic diseases—diabetes, hypertension, congestive heart failure, these types of chronic diseases. If we were to just direct Medicare to begin compensating for treatment of those through this on a capitated basis, you think that would save some money?

Dr. GINSBURG. Yes. I think this would be one area where there would be both substantial quality improvements if this succeeded, and this is an area where quality improvements come with cost savings. They are not in conflict with each other.

Now, going all the way to full capitation payment, that is something down the road. There would have to be intermediate steps, and probably medical home is the first step to it, where you continue paying for things that are billable today on a fee-for-service basis and the capitation payment is for the coordination services, the educational services, whatever is important to the management of chronic disease that is not supported by our current payment system.

Also, I think, because of the position that Medicare is in today when it comes to provider payments, we are seeing that many of the advances in payment methodology that Medicare puts out are

adopted by Medicaid programs and often adopted by many private insurers.

So in a sense Medicare is in the unique position where it can reform its own payments and it does not have to require others to use its methods, and it is likely that they will because the program has the credibility and the size so that Medicaid programs or private insurers might be able to pursue payment changes that they would have liked to, but did not think they could pull off on their own.

Senator BINGAMAN. These are very large bureaucracies we are talking about here. I understand that you cannot turn around on a dime, but there is a frustration that I feel about, whenever we think about some kind of reform, first we have to take baby steps and see how that works, then we have to think about maybe taking another step, and sometime 2 or 3 decades from now maybe we will get it reformed. Is that the best we can do in this area? I mean, can we not just basically say, effective a certain date, the reimbursement or the payment for treatment of these chronic disease will be on a capitated basis?

Dr. GINSBURG. Yes. Yes, we can do that. In fact, my looking at our history is that the major progress that the Medicare program has made in provider payment has not come from years of demonstrations and little steps, it has come from big steps. Hospital prospective payments, paying on the basis of DRGs, was authorized in 1983 legislation. It was implemented in that same year, phased in, and it really transformed the hospital payment system.

Similarly, paying physicians based on a resource-based fee schedule was also legislated. It was phased in. Often I have seen demonstrations as something you do when you do not have the votes to move forward, but, if you do have the consensus to move forward, I agree with you that we should take risks, and then go back and fix things rather than proceed so cautiously that it takes us decades to get there.

Senator BINGAMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bingaman.

Senator Hatch?

Senator HATCH. Well, thank you, Mr. Chairman.

Welcome to all of you. I am pleased to have you here. This is naturally one of the biggest discussions we can possibly have; health care, of course, is on the minds of all of us.

Dr. Ginsburg, I found your presentation on the forces driving health care inflation and the appropriate solutions to this problem to be particularly informative. I appreciated your efforts at cost containment strategies that are, in your words, "compatible with American values."

Now, I worry about proposals for cost containment that rest on government decisions about what care will be available, and, while extending access to health care is no doubt important, I do not think that the American people will stomach expansion of care through the creation of a system in which the government dictates your coverage and the availability of care.

Now, your discussion of the failure of the health care marketplace to achieve cost containment through increased productivity, I find helpful. As I read your testimony, you believe that the Fed-

eral Government effectively incentivizes inefficiency and health care inflation by reimbursing particular services rather than episodes of care, if I have it right, and I think I do.

Given that the Federal Government is the largest purchaser of health care in the country and that it has an over-sized influence on the cost of delivery of private health, is it your view that the problem is us, the Federal Government, the Congress? In your view, is the manner in which the Federal Government participates in the health care system the most significant driver of health care inflation?

Dr. GINSBURG. I would call the problems I was speaking about in the payment structure in the Medicare program inadvertent. The intention of the Medicare program, and also Medicaid programs and private insurers, is that their payment methods should be neutral and should not provide incentives for providers to go in a particular clinical direction.

But because of the shortcomings in our keeping up the accuracy of our payment structures, we have inadvertently gotten to systems where hospitals have incentives to develop service line strategies, strategies where they have identified those types of cases that are most profitable, not because any payer intended them to be profitable, but probably because of some details in the reimbursement system.

So I think that the Federal Government is in an admirable position because it can focus on its own program, the Medicare program. To the degree that it succeeds in having Medicare payment structures for hospitals, physicians, and others more accurately reflect the relative costs today of providing the different services, others will follow on their own. The net effect will be that some of the pernicious, unintended incentives will be diminished.

Senator HATCH. Well, thank you. I am going to submit questions because we cannot get very much done here. But this has been a particularly invaluable panel, as far as I am concerned.

Ms. Holt Baker, let me just ask you a couple of questions. I will probably be writing to you for some of the details, and will probably submit some questions to you that way and will follow-up with you after the hearing, because you are particularly important in this discussion because of how many people are involved. You are not the only one who is important, but you are very important as far as I am concerned.

Now, I noticed that President Bush was trying to set certain levels of care. I would be interested in your answers to these questions: what percentage of employees in the AFL-CIO have health coverage with yearly premiums of up to, say, \$15,000, or \$18,000, or \$20,000? I would kind of like to know that, because we have to know where we are before we can really try to resolve some of these problems that currently exist. I see them as huge problems. But go ahead. I am sorry.

Ms. HOLT BAKER. Senator, I will be glad to get you the exact percentages there, but certainly we would recognize that our employers do have some of the better premiums because we have negotiated this over the years.

Senator HATCH. Well, I acknowledge that. But can you give us a range of what the premiums are a year for most?

Ms. HOLT BAKER. Well, the average premium a year, the cost, annual average, is \$12,000 a year, about \$1,000 a month.

Senator HATCH. Across the whole automotive industry?

Ms. HOLT BAKER. Across the board. Across the board. As we have indicated, about \$900 of that goes toward the uninsured.

Senator HATCH. Sure.

My time is up, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Senator HATCH. Thank you all. I wish I had more time to ask questions.

The CHAIRMAN. Don't we all? [Laughter.]

Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus and Senator Grassley, for holding this hearing.

I think the question is very apparent here in terms of higher costs and low-quality health care. When you look at some of the comparisons to what is going on in other countries, you have to ask the question whether we are all wrong here, and maybe we are being too tepid as we look at reform initiatives, and maybe we ought to look at some of the bigger-picture issues in terms of reform.

To me, and when I compare the statistics that staff provided us and that you have testified to relative to what is happening, for example, in the United Kingdom versus what is happening here, I have to ask the question, well, why not look at places where we are delivering high-quality care at a much lower cost and simply adopt that system for the United States of America?

I know there are lots of political reasons not to do that, and you will probably tell me. So I would like you to tell me what it is that we could learn from those countries where we essentially have achieved a higher quality of care at a much lower cost. When I look at the statistics that were provided to us by staff, when you look at the United States' rank out of the OECD countries, the United States ranks 37 out of 191 of those countries, yet we are spending 16 percent of our GDP on health care costs. If you look at the United Kingdom, ranking 18th out of 191, they are only spending 6 percent of GDP.

So starting with you, Dr. Ginsburg, then coming across the table, what can we learn from those international experiments that we could bring into our health care system?

I will preface this as well that I think this dialogue here in this committee is important today, but I think this Nation has to engage itself in a major dialogue about where we go with health care reform because it simply is not working, it is broken. I think, Dr. Ginsburg, you said it is kind of like trying to fill a leaky bucket. We have all tried to do that. Lots of reforms try to do that. So how do we change it in a way that is going to be meaningful to the 300 million people of America, and what do we learn from these other countries?

So why do we not just start with you and just come across the table. Dr. Ginsburg?

Dr. GINSBURG. Yes. Well, there is a lot that we can learn from systems in other advanced countries, but we need to think of it not as if we were going to choose their system instead of ours. We are

going to continue our system and we are going to modify it. The notion that—

Senator SALAZAR. Why is that so? Why is that a premise that you make?

Dr. GINSBURG. Well, first of all, take a single-payer system. I do not think our country would be as successful at implementing such because of our culture, because of our political system. But when you start looking at the delivery of care in these systems, that is where we can learn things that can be applied here.

We can say, look, at certain conditions, hospitals in Germany seem to be doing a much better job than hospitals in the U.S. How can we take what we have learned about what is working in Germany and put that into our system? I think that is where the potential is. I am optimistic because today Americans are looking abroad more, not in debates about whether their system is better than ours, but what is transplantable from their system here.

We also have the potential to learn from policymaking in other countries. For example, Japan faces similar problems with rapid volume growth for some services, such as imaging. The Japanese have adopted routines in which services experiencing very rapid volume growth receive automatic reductions in payment rates. The rationale is that rapid growth in volume is likely to be a reflection of payment rates being too high.

Senator SALAZAR. I appreciate your comment. Dr. McGlynn? And welcome, Colorado College classmate.

Dr. MCGLYNN. Thank you. Well, I think the one thing we can learn from the UK is the aggressive—

Senator SALAZAR. For those of you who do not know much about Colorado College, it is at the foot of Pike's Peak. It is where "America the Beautiful" was written in Colorado, and produces some of the greatest Ph.D.s. I do not know about lawyers and Senators. [Laughter.] Thank you.

Dr. MCGLYNN. Thank you. As I was saying, I think one of the key things to learn from the UK experience is that, when they went to increase their health spending by 30 percent, which is really what they did, recognizing that they were not spending nearly enough on health care and it was giving them very bad outcomes in the area of cancer mortality, cancer survival, they announced a date certain by which, to be eligible for their pay-for-performance program, general practitioners would have to have IT systems in place that would routinely report on, originally 75, now 135 measures of quality.

Overnight, they went from having a penetration of HIT in primary care similar to what we have in the U.S., which is around 10 percent, to over 90 percent. What they have seen is a rapid acceleration in the management of chronic disease in primary care, and really a sort of countrywide engagement in discussions not only about what the health care system could do, but more importantly I think, what regular people can do to manage their own health. I really think a useful further discussion for the committee is health versus health care, to recognize that it is not all about services.

Senator SALAZAR. Thank you, Elizabeth.

Mr. Chairman, may I ask 15 seconds just from the other witnesses on that other question?

The CHAIRMAN. Yes.

Senator SALAZAR. Could you take 15 seconds apiece, Ms. Fields and Ms. Holt Baker?

The CHAIRMAN. Go ahead. Fifteen each.

Ms. FIELDS. Yes. I would have to leave it to my esteemed colleagues relative to their knowledge of plans in other countries. Certainly at Ford Motor Company we do have global participation with benefit structures, and I am not very close to all of those structures, but I do know that the differences in the plans are not just about the health care that is provided and the differences, whether they are single-payer systems.

A lot of what we consider as a company relates to how those plans impact other areas of cost for the company and those tax structures, so it is not just what we can learn from those systems, but it is also going to be the impact of the way that health care and costs and the entire package for employees impacts everyone.

Senator SALAZAR. Thank you. Thank you.

Ms. Holt Baker?

Ms. HOLT BAKER. Yes, Senator. I can tell you what we have certainly learned from our surveys and in talking to our members. What they emphasize is that, whatever system we have, it has to be a system that is uniquely American, in their minds. When they think about "uniquely American," it has to include, certainly, the employers, the government, and individuals. That is a lot of what we hear. So again, as we think about what we are doing, I also would concur with Dr. Ginsburg and his remarks on that.

The CHAIRMAN. Thank you very much, Senator. I deeply appreciate that.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

Not to be outdone by my friend from Colorado, I want to just emphasize that Ms. Fields is from the beautiful State of Michigan, surrounded by Great Lakes, not to be outdone in their beauty. So, we would welcome you to come and to visit. [Laughter.]

I appreciate very much all of you speaking about health IT, which personally I think is fundamental to us moving forward on quality in addressing so many issues. Specifically on e-prescribing, Ms. Fields, you speak about that in your written testimony, as do you, Ms. Holt Baker. We think about e-prescribing in terms of cost savings, but I wonder if you might speak about it as it relates to other benefits in terms of quality and so on.

I do have to say, I appreciate that Ford is involved with GM, Chrysler, and the UAW, Blue Cross, and so on in Michigan in a project which has been in place since 2005, the SEMI, the Southeastern Michigan E-Prescribing Initiative, which has some very significant early results in terms of benefits to patients and so on. I wonder if you might speak to that.

Ms. FIELDS. Yes, Senator Stabenow. As you mentioned, there are certainly cost benefits—the alerts that go through the system that help physicians understand how to reduce costs through generics. But we have had over a million drug-to-drug interactions that have

been alerted and have saved our employees from being exposed to dangerous drug interactions because of this e-prescribing.

As was referenced earlier, just the quality of moving to electronic e-prescribing versus the inability of pharmacists to sometimes read and decipher those handwritten prescriptions. So we know that the communication is much better now with our physicians, between them and pharmacists. The productivity has improved. They are more efficient. We know that our employees are getting better care. So there is a lot more than just cost associated; it is protecting the health care of our employees.

Senator STABENOW. All right.

Ms. Holt Baker?

Ms. HOLT BAKER. I would say, Senator, that for us, e-prescribing will save lives. That, in itself, is so premier. We certainly support the legislation that you have introduced, or are co-sponsoring with regard to e-prescribing, in particular with Medicare.

Senator STABENOW. Thank you.

Anyone else want to respond specifically on e-prescribing? I know, Dr. McGlynn, you talked about the physician and being unable to read handwriting, and certainly it addresses that.

Dr. MCGLYNN. Right. Let me just say, we looked at e-prescribing systems, and one of the big lost opportunities right now is the ability to use those systems to detect under-use of needed medications, and that is, frankly, a bigger problem with probably more mortality associated with it than the drug-drug interactions, which are certainly important.

So we would urge that there be some further development of these systems to raise those opportunities. There are some things that can be done, like regular refilling of prescriptions, for example, in the context of these systems where the patient actually does not have to do quite as much to get a monthly renewal of a prescription, for instance. So I think there are a lot of opportunities still to be realized from those systems.

Dr. GINSBURG. Yes. I am very optimistic about the potential for e-prescribing to improve the quality of care and benefit patients. The point I was making before as relates to this is that whether we will save money with e-prescribing or not, I am not sure. It is worth doing even if we do not. But what we should not be doing is saying: I have solved the cost problem because I am in favor of e-prescribing, in the sense that it is easy to go to things that are perhaps valued anyway, or valued for a different reason, and somehow infer that there is going to be a big cost containment return from it.

Senator STABENOW. Thank you.

Mr. Chairman, I want to thank you for, in the Medicare bill, including and working with us on e-prescribing because it is a really important step to getting us closer as we are looking at electronic medical records and health IT. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Dr. Ginsburg, and also Dr. McGlynn, I want to ask you a very different kind of question. We will spend, projected, about \$450 billion on Medicare in 2008. As one of you indicated, virtually everybody who comes into our offices who has

anything to do with health care is not talking about decreasing health care, they are asking for more money. Everything is more money.

Dr. McGlynn said what is important is, no matter if it costs more, that the quality of health care be better. That may have been a small range or a large range she was thinking of, but with that in mind I want to put this to you. Approximately 25 percent of Medicare spending is for care in the last year of life. About 5 to 10 percent of people account for 50 percent of that money. A Dartmouth study came out recently and said that we could save, for example, \$50 billion just in the last 6 months of life.

Now, that is a very delicate subject. Jack Danforth and I started, in 1989, addressing this through a durable medical power of attorney, all that kind of stuff. All the names have changed, charts at the end of the bed routinely ignored by doctors. I would just briefly describe my mother, who died from Alzheimer's in 1992. She had it for 10 years. She was not with us for the last 5 years.

Now, the hospital would not release her because of the Hippocratic oath. I have read the Hippocratic oath. There is nothing in that about stopping care, it is only "do no harm." So the question of what "do no harm" means when you are taking money away from other people because you are spending it on the last, all the oxygen tanks, all the nurses, all of those things that go on—I want to ask you both, we never talk about this subject because we are afraid to.

Now, advertising is just constantly pumping, 80 to 90, 90 to 100. If you get to be 90, you get to be 100, and then be over 100. We are celebrating the length of life. But in this 5 to 10 percent, many of those are in dementia and beyond, Alzheimer's and lots of other things where there is no positive outcome, there cannot possibly be a positive outcome. Children can stop the hospital from releasing if there is one child out of four. In our case there were four and we all wanted her to be released from the hospital. The hospital would not do it.

We took her out, took her home where she had spent 50 years of her life, and she got a lot of morphine and died very peacefully about a month later. But the doctors would not let her out. When they came to our house, they literally had beads of sweat on their brow because they felt that they were violating either New York State law, which I know nothing about, or the Hippocratic oath.

So what is the sense of "do no harm" in terms of quality of living and the enormous amount of money that is spent and could be saved in that last 6 months of life involving about 5 to 10 percent of people?

Dr. GINSBURG. Yes, Senator. I think this is an awful problem when lots of resources are being used against the wishes of the patients or the family. I actually feel fortunate so far because my mother, who has severe dementia and who is alive, her physician's philosophy is, I am going to do things to keep her comfortable, but I am not going to do aggressive things.

I am keeping my fingers crossed. I know that is what she would want. I am keeping my fingers crossed that, if she should somehow wind up in the hospital, that her wishes could still be respected. But I really do not know what to tell you as far as how to resolve

this thing, where enormous resources are used against the wishes of patients.

Senator ROCKEFELLER. I am not going to question anything about your mother, but, when you get to dementia at a certain stage, to keep somebody comfortable, I am not sure if that is quality of care. Or you say, that is what she would want. How do you know that? When you get to a certain state of dementia you cannot possibly communicate that to your children or to your doctor.

In my mother's case, she finally, in an extraordinary thing, bit down on her feeding tube and would not release that feeding tube, which was her way of saying "I want out of here." The doctors would not go along with that, the hospital would not go along with that, so we had to take other steps. So to say that, "I do not know how we can address this," Dr. Ginsburg, is not worthy of you. You are too smart and too deep and too thoughtful for that.

Dr. McGlynn, what would you say?

Dr. MCGLYNN. As a starting point, Senator Rockefeller, I would recommend that we invest much more heavily in hospice and palliative care programs. I sit on a hospital board. We have recently introduced, in the last 5 years, both of those programs into our hospital. The advantage is that the doctors who run those programs and deeply understand the issues that you are talking about have been much more effective in educating other doctors on our hospital staff about helping the doctors learn to let go. They are trained to cure. It is very hard for them to turn that off, even when it is not—

Senator ROCKEFELLER. No, they are trained to "do no harm."

Dr. MCGLYNN. No, they are actually trained not to let go. I think they take an oath to do no harm.

Senator ROCKEFELLER. Yes.

Dr. MCGLYNN. It is not so clear to me that that is exactly how they are trained.

Senator ROCKEFELLER. All right. But it is a factor. It is a factor.

Dr. MCGLYNN. It is a factor.

The other thing is, these physicians are very skilled in working with families and getting families to come to accept the reality of the situation in front of them. So I think we need to look at those kinds of programs, because I think we are really talking about a culture change that is necessary, and we need people who can lead that culture change.

At least the results I have seen from those programs locally and when my father was at the end of his life, those programs were hugely important in terms of easing the transition. My family was lucky in that, much like yours, we all agreed about where we were at, my father included. He was quite aware that he was at the end of his life, and the hospice program was terribly helpful in allowing him to come home and die at home, which is where he wanted to die.

There were some odd things. He had an implanted defibrillator which we could not get anybody to turn off without taking him back to the hospital and taking him into surgery, which was totally unnecessary. But the hospice provider was a good intervention step between the desires of other doctors on his team and kind of what his desires were.

The CHAIRMAN. If I might, just following up on this subject, what incentives can you all think of for hospice care, palliative care, living wills, consultation in a very sensitive way, but very appropriate way, to deal with this?

Dr. MCGLYNN. A starting point might just be to make as a condition of participation in Medicare, meaning for a hospital to be reimbursed under Medicare, they would have to have such a program. I think that there are things like that that just, anything that can get it introduced into the environment is positive. We have a shortage of these kinds of providers, so I think it may take some incentives to have more people trained.

There is a challenge in that we do not often know, and have a hard time predicting, when we are in the last 6 months of life. I mean, those research analyses are sort of looking over your shoulder after it has happened. There is some difficulty in the way that the Medicare hospice reimbursement is organized in that you have to be pretty sure you are in the last 6 months to be eligible for reimbursement under that program.

That, I think, causes people to be a little nervous about it. There is sort of a psychological barrier to recommending, for a Medicare patient, that they be referred to that program because it really is declaring you are at the end, and that is a very hard thing for a lot of physicians to do. So we might also look at whether that represents an unnecessary barrier to entry into these programs.

The CHAIRMAN. But what if they come back?

Dr. MCGLYNN. What?

The CHAIRMAN. What if you come back? Say you are referred to one of those and it turns out that you are not at the end?

Dr. MCGLYNN. Well, palliative care is nice because those programs do not necessarily require that you are at the end of life, but it is moving into more comfort and maintenance rather than necessarily rescue. I think it is all right if you come back. My grandmother lived 8 years. The doctor said there is no medical reason she should be alive, she is just too stubborn to die. We have to acknowledge that is going to happen, and we should not put barriers in the way of people like that. Another good friend of ours lived 5 years after she was given 2 months to live. I mean, those things are going to happen, and we should not treat that as somehow fraud or mal-intent, or whatever. It is hard to predict when someone is going to die.

The CHAIRMAN. How does this help with the cost problem?

Dr. MCGLYNN. I think, because for the bulk of people, moving them out of intensive treatment, moving them out of hospitals, moving them out of intensive care units is much more possible with these programs, and that is less expensive. I mean, if you can reduce the number of physicians they are seeing, if you can reduce the intensity of the care setting that they are in, that is a lot of what contributes to these huge costs at the end of life. These programs allow for that transition.

The CHAIRMAN. On this subject?

Senator ROCKEFELLER. On this subject, yes. You say people come back, or it is not possible to predict. That is going to be true in some cases where it is simply an aging process. But there is no coming back from Alzheimer's. There is no coming back. And a

number of other diseases. It will not happen. It is as predictable as the sun will come up and go down that people are at the end of their life. Their children know it, their doctors know it, the hospitals know it. Hospice, if there is one around, knows it. That is why they are there.

My question is simply about your idea of making more quality care in spite of the price, that, if you do not try to artificially prolong because of hang-ups with children, or hospitals, or doctors, or lawyers in whatever State—I mean, this doctor was afraid of getting sued, as simple as that.

Dr. MCGLYNN. Yes. Right.

Senator ROCKEFELLER. Then you make Medicare money available. For example, Chairman Baucus and I spent a year trying to figure out a way to fund the CHIP program. Now, that is not Medicare, that is Medicaid, but the point is the same. You are making more available for others while you are doing nothing to help with this 5 or 10 percent.

Dr. MCGLYNN. My point is only that it is hard to predict the exact time at which somebody is going to die sometimes, and that we should not somehow put barriers in the way of getting that prediction wrong, because, if we do, that will keep more people out of easing into those systems. That is really the only point. It is not that, in the cases I was citing, those people were not on a fairly certain path. It was just hard to predict how long it was going to take.

The CHAIRMAN. I would like to turn to another subject, too. That is the tax treatment of employer-sponsored health benefits. President Bush obviously has proposals to limit the exclusion. Some of the presidential candidates suggest limits. I think it is clear that the current treatment of employer-provided health care, because it is not taxable to the employee and is deductible to the employer, that that has a couple of consequences. One is, different health care. The more you work for a bigger company, to some degree the better your health care plan. The more you do not, to some degree the health care plan is not so good.

Second is the cost problem, because there is no limit currently on what can be deducted or provided. So let us just talk about this subject a little bit and the degree to which that perhaps should be modified or changed.

Dr. Ginsburg?

Dr. GINSBURG. Yes. Actually, I am very encouraged. For the almost 30 years that I have been aware of, policy analysts have talked about this issue of the tax treatment of health insurance and what it does to the type of insurance that people have, which is not a surprise. This is the first time it is really getting attention in the political arena.

Our existing policy, I think, leads to health care costs being higher than they would be otherwise, and it is a particularly regressive aspect of our tax system because the people who are better off get the bigger benefits, both because they are in higher tax brackets, but also because they have the most expensive health insurance.

So the Wyden-Bennett bill is really taking that tax expenditure and reprogramming it, converting it from the exclusion to tax credits, to target it more on the people who need support to be able to

pay for health insurance. Discussions about that, and this whole approach of reprogramming it, could be very fruitful for our country.

The CHAIRMAN. All right.

Dr. McGlynn?

Dr. MCGLYNN. It is not my particular area of expertise, but I agree that it would substantially change the generosity of benefit packages. I think we just would have to look at making sure, as we move there, that the incentives are aligned with what we are trying to accomplish, the incentives and new packages.

We know when people are responsible for paying for their own care that they reduce both necessary and unnecessary services, so I think we cannot ignore the fact that that decision does not always go in the direction of best value.

The CHAIRMAN. Ms. Fields?

Ms. FIELDS. Yes. And I also agree with Dr. McGlynn. It is very much about getting the tax structure to support, however it is paid, employees or employers, to make sure that everyone is—

The CHAIRMAN. Should we limit it? I mean, let us kind of drill down a little more here. Do you recommend and think there should be some change from current law?

Ms. FIELDS. I am not necessarily proposing that. I have a point of view, to be honest.

The CHAIRMAN. And what is that? That is why you are here.

Ms. FIELDS. Yes. [Laughter.] Well, relative to the tax law, what I do know is, wherever the burden is held, it has to be more affordable for everyone. So we do not have the perfect view on where the shift should occur, but it has to be affordable for all, and everyone has to participate in it, including our employees.

The CHAIRMAN. Good.

Ms. Holt Baker?

Ms. HOLT BAKER. Well, our concern would be if we eliminate this tax exclusion.

The CHAIRMAN. Right. Nobody is talking—well, some are talking about eliminating it. I would just ask you to kind of stand back, with a little more perspective, and just kind of talk about it. Can it be modified or not? If it is, how can we modify it in a way that is not detrimental to the people you are representing?

Ms. HOLT BAKER. Well, certainly we feel that we just really cannot do any harm because our biggest concern is 160 million Americans right now who have employer-based health care coverage. So that would be our biggest concern, is we cannot do any harm.

The CHAIRMAN. What about a limit, a cap, say? Right now there is no limit.

Ms. HOLT BAKER. I think, Senator, we would have to look at it. We would have to really look at it.

The CHAIRMAN. That is a wise response.

Ms. HOLT BAKER. All right.

The CHAIRMAN. Dr. McGlynn, you have already answered this, but, if you could go deeper into it, people just not getting the recommended care. I just again do not quite understand. What is happening here? Why not?

Dr. MCGLYNN. Well, I think that there are a number of reasons. I think the main thing I try to keep people from doing is pointing fingers and saying, it is your fault, or your fault.

We have had an explosion in the possibilities of what can be done in health care. In my testimony I talk just simply about the number of articles that are published each year in specific clinical areas that would be hard for any practicing physician to keep track of, let alone figure out what it means for that doctor's own practice.

Each individual is quite unique. If you think about all the people in this room, each and every one of them has very different health care needs. So we have this rapid explosion of what we can do, we have this remarkably differentiated customer that is coming in, and we do not use any kind of technology that all of the rest of us use to do our jobs to try to put the two together in a sensible fashion. So I think that it is actually remarkable that we do as well as we do, given how poorly organized the health care delivery system is, to make sure that people get connected to the things that they need.

I think that we have a very reactive system. If a patient does not happen to mention that something is going on with them, the physician does not have—

The CHAIRMAN. So how do we deal with that?

Dr. MCGLYNN. Well, I think that we could get a lot more systematized. I think we can focus on things like chronic disease management where we have a pretty good idea of what we need to do to manage people's health and well-being, and we need to get sort of an agenda organized between physicians and patients about what should be done for those health care problems. There needs to be things like reminders, and prompts, and alerts, and decision support tools, all of which require some kind of underlying technology to help everybody make sure to efficiently get connected to the care they need.

I think we need to find ways to make people more responsible for their own health, too. I mean, I think this is not all on the medical care system. I think we have a culture in America where we think we can do whatever we like and the health care system is going to rescue us when we get sick.

The CHAIRMAN. So again, just pushing ourselves here, how do we make people more responsible?

Dr. MCGLYNN. Well, it is interesting. Last week I was at Johnson and Johnson, and yesterday was talking to some people from Anderson, IN who have both done a similar thing, which is to give employees reductions in health insurance premiums for hitting certain health objectives. Those are weight, blood pressure, no smoking, exercise, and I think there are five things.

The CHAIRMAN. Right. Yes. Right.

Dr. MCGLYNN. The J&J people have been doing this for more than a decade, and they have seen substantial reductions in their costs and substantial improvements in the health profile of their population. The Anderson, IN folks, they have people who can reduce their health insurance premiums by \$1,500 a year. That is real money. And they have been doing it for, I think, 2 or 3 years on about a half a million people, and they have seen big changes in terms of their employees' health. So it is interesting that these

two different groups, kind of independent of one another, have taken a similar approach, which is to connect some financial incentive to the behaviors that we would like to see people achieve.

We did some modeling, some colleagues of mine, about what would save the Medicare program money. The main thing that we found was reducing obesity. I mean, there were a lot of other things that are cost-effective, meaning they are good value for the money, but there were very few things that actually saved Medicare money. This is the one area. This is also what has been found in private companies. It looks like providing incentives could be helpful.

I think my colleagues have also done some research on just the environmental cues. There are a lot of other things that contribute, I think, to the current obesity epidemic that we need to take a look at that are, frankly, outside the health care system. They have to do with the way our cities are built, they have to do with a lot of different sort of cultural factors about how we live our lives. This is what I mean by paying as much attention to health as health services. We sort of put a lot, I think, off on the health care system.

The CHAIRMAN. All right. But say someone gave you *carte blanche* to address obesity.

Dr. MCGLYNN. Right.

The CHAIRMAN. What would you do?

Dr. MCGLYNN. Well, I think we would start by looking at reducing—

The CHAIRMAN. You are the person.

Dr. MCGLYNN. I am the person.

The CHAIRMAN. If whomever is President says, Dr. McGlynn, we want you to solve the obesity problem, and whatever you recommend, we are going to do.

Dr. MCGLYNN. All right. I think that it starts by providing people incentives in some way.

The CHAIRMAN. What would some be?

Dr. MCGLYNN. I do not know. Tax incentives. Financial rewards. Trading them something they value for something else. This is not my particular area of expertise.

The CHAIRMAN. Sure. It is not fair.

Dr. MCGLYNN. But I have people who study this, and I would be glad to share with you some of the ideas that they have come up with.

The CHAIRMAN. Could you?

Dr. MCGLYNN. Some are quite heavily regulatory in terms of—and I am sure the food companies would be in here protesting some of those ideas. But the easy availability of high-calorie foods and an environment that largely means that people do not get any natural exercise in their day-to-day life are two very big contributing factors.

We are also learning—there was a whole section in the *L.A. Times* yesterday about all of the things that we are learning about how the body is programmed to respond to these cues about eating more, that I think are quite interesting. So I think some of the basic science that is going on right now may contribute to finding some solutions that are not currently available to us, but I think it is an important problem.

The CHAIRMAN. Sure.

Well, I deeply appreciate the time that you have all taken to come here today. This has been very informative and very, very helpful. There is a series of hearings that we are having. The earlier one was just a basic kick-off with Secretary Shalala and Secretary Thompson and provided a lot of energy. This one is kind of the cost problems and some of the quality issues. We are having our Health Care Summit, an all-day summit at the Library of Congress on the 16th, where we will probe these issues more. The other hearings we are going to be having this year are more on solutions, the best we can do at this point.

I just urge all of you to keep doing what you are doing, just keep pushing and keep helping us. You are going to give us, basically, most of the answers, people like you who study this and know this subject very, very well. Then we will react to it and figure out what we think is best, but we need you very much to tell us what to do, not just today, but in the future. Thank you very much.

The hearing is adjourned.

[Whereupon, at 11:37 a.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

**UNITED STATES SENATE
COMMITTEE ON FINANCE
Max Baucus, Chairman**

**“Rising Costs, Low Quality in Health Care: The Necessity for Reform”
June 3, 2008**

Senator Bingaman’s Statement

I want to thank Chairman Baucus for holding this important hearing on cost and quality in our U.S. health system. I am very concerned about these issues and how they affect the health of every American. New Mexico is number 49 of 50 states in percentage of its population that is uninsured at 23%. It ranks 43rd of 50 states in per capita income. With limited resources, and pressing health needs, it’s critically important for states like New Mexico to focus on cost and quality. I thank our witnesses for coming to Washington, DC today, and for sharing your ideas with us.



**Testimony of
Felicia J. Fields
Group Vice President, Human Resource and Corporate Services
Ford Motor Company**

**Before the United States Senate
Committee on Finance**

Hearing on Rising Costs, Low Quality, the Necessity for Health Care Reform

June 3, 2008

Mr. Chairman and Members of the Committee:

Introduction

Good morning, Chairman Baucus, Ranking Member Grassley, and Members of the Committee. It is my pleasure to be here today to discuss Ford Motor Company's health care coverage – I am Felicia Fields, Group Vice President, Human Resource and Corporate Services for Ford Motor Company. In this position, I am responsible for overseeing the Human Resources activities for all of our business operations around the globe. This includes employee benefits and health care design.

First of all, I commend the chairman and the members of this Committee for calling this hearing to discuss the important issue of health care in the aim of working together for better quality and value. In my statement before you today, I'd like to discuss Ford's experience in providing health care benefits to our employees and retirees, initiatives we have launched or planned, and the challenges we face.

Ford Health Care Costs

In 2007, Ford provided health care coverage for about 535,000 employees, retirees and their dependents in the United States. Our health care expenses totaled \$2.2 billion, which breaks out to about \$1,000 for every vehicle manufactured in the U.S.

Major Changes to Retiree Health Coverage

Of that \$2.2 billion, over half, about \$1.2 billion, was attributable to post-retirement health care. Over the past few years, we have implemented a number of changes in the way we offer post-retirement health care coverage:

- **VEBA:** In November 2007, Ford workers represented by the UAW ratified a new contract. Included in the contract was a Memorandum of Understanding (MOU) to establish a new

independent *Voluntary Employee Benefit Association trust (VEBA)*. Starting January 1, 2010, (pending federal district court approval and SEC pre-clearance of the accounting treatment of the VEBA and the hourly retiree health care obligation), the trust will administer post-retirement health care benefits to all former UAW-represented employees and current employees who were active as of the effective date of the new contract.

Upon implementation of the final settlement agreement, Ford will contribute \$13.2 billion in assets to the VEBA. Its earnings will remain exclusively within the VEBA. This new, mutually-agreed to arrangement will permanently shift complete responsibility for providing retiree health care benefits for current and former UAW-represented employees (measured at \$20.2 billion on our December 31, 2007 balance sheet) from the Company to the VEBA.

- **Coverage for Salaried Retirees:** We have also taken steps to address costs of salaried retiree health care benefits.
 - For retirees under 65, we capped our contributions at 2006 levels.
 - Effective January 1, 2008, for retirees aged 65 and over or Medicare eligible due to age or disability, we credit health reimbursement arrangements (or HRAs) in the amount of \$1,800 per member per year. In order to ease retirees' transition into the competitive individual Medicare market, Ford provides retirees with an electronic enrollment and advocacy service that assists them in finding the coverage that best meets their needs and preferences, thus easing the paperwork burden. While planning this transition assistance program, we have received invaluable advice from State Health Insurance Program (SHIP) consumer assistance groups such as the Michigan Medicare/Medicaid Assistance Program (MMAP).
 - For new hires (those hired or rehired on or after June 1, 2001), in addition to providing coverage while they are an active employee, we credit HRAs with up to \$800/year for each year they work at Ford. Upon meeting the age and years-worked criteria for vesting, when these employees leave the Company, they will be able to draw upon their HRA for reimbursement of eligible medical expenses.

Continuing Challenges

While these measures are necessary to ensure our ability to continue offering health care benefits to our employees and retirees without compromising financial viability of the company, we are still concerned with the rate of U.S. health care cost increases which are projected to exceed overall inflation rate. The Centers for Medicare and Medicaid Services expects national health care spending to double between 2007 and 2017, increasing from \$2.25 trillion in 2007 to \$4.28 trillion by 2017.

Although there is no shortage of proposals on how to manage cost increases, a majority of the effective actions should be implemented only after careful deliberation and consensus development by all key stakeholders with strong leadership at the federal level.

To address the challenges at hand, I would like to share with you some of the steps we have taken at Ford, some independently, and some in collaboration with other stakeholders. I will then share some specific suggestions on areas where federal leadership would be most helpful.

Company Initiatives

Creating a Culture of Wellness Through Education and Providing Necessary Tools

Among the key drivers of health care costs are aging and declining health status. Therefore, we are creating a culture of health and wellness for our employees and their families as a central component of our health care strategy. As the first step, we started providing resources and tools to

improve their health status and help them make sound choices about health care services and coverage and help them understand the benefits of being a better health care consumer. We aim to work with our vendor partners on the creation of benefit options that engage people in improving their health status and making wise choices. We also aim to ensure that employees have the information they need to make the selections that are best for their individual situations. We concentrate on three main areas: 1) engaging the consumer in their health, 2) providing user-friendly tools to encourage wellness, and 3) creating partnerships to strengthen the health care delivery system and improve technology transfer. Our efforts include:

- An internal wellness campaign to encourage and motivate employees to take control of their health by:
 - Providing the skills that will help them understand their risks, and improve their health habits; and
 - Encouraging them to be better health care consumers by using health care quality information.

Currently, we are redesigning this campaign to substantially increase the outreach and expand the scope. Employees are encouraged to complete health risk assessments, prepare advance directives, and engage in a personal health plan with their primary care physician. We are also working to provide a more supportive at-work environment (e.g., more nutritious cafeteria selections, a hand-washing campaign to decrease cold and flu outbreaks, engaging Wellness Ambassadors in plants, etc.).
- An employee health improvement program and website, called "*Healthy Highway*," to prevent and manage illness, which includes:
 - Disease management,
 - Individualized health coaching programs,
 - Health appraisals, and
 - 24-hour phone access to nurse and on-site screening services.
- Online benefit comparison guide with educational information, which includes quality ratings of health plans, prescription drug information and links to important health care information websites.
- Managing prescription drug costs: prescription drug coverage of our self-insured health plans requires substitutions whenever chemically identical generic alternatives are available. Such requirement benefits both employees and the company since:
 - Employee co-pays are at least 50% lower for generic drugs, and
 - On average, cost per prescription for generic drugs is about one-fifth of cost per prescription for brand-name drugs.
- Community Initiative projects in Kansas City and Louisville with our UAW partners to improve the health of not just Ford workers but all members of the community by working to spread best practice guidelines, and to create partnerships to improve the quality and value of care.

Improving Infrastructure

We recognized one of the important tools our employees need to improve their health status and become a more informed health care consumer is the infrastructure to facilitate information gathering. We determined that the most effective approach for building such an infrastructure is through a regional collaboration with key stakeholders:

- In 2004, Ford -- jointly with GM, Chrysler, Blue Cross Blue Shield of Michigan and Medco Health Solution -- created the *Southeast Michigan e-Prescribing Initiative* (SEMI). The SEMI

initiative, which is one of the largest employer-driven e-Prescribing initiatives in the country, is focused on promoting the adoption and use of e-Prescribing, and validating the impact of e-Prescribing technology on improving patient safety and reducing prescription drug costs. Through this initiative, we are promoting e-Prescribing infrastructure service and offering a nominal financial incentive to any physician practicing in Southeast Michigan who signs up.

To date, 2,897 physicians have enrolled in SEMI, and they have written over 8 million electronic prescriptions. SEMI physicians changed prescriptions 39% of the time to less expensive generics, when a formulary alert was presented at the point of care. More than 1 million alerts were sent on moderate to severe drug-to-drug risks, resulting in 41% of those prescriptions being changed or canceled by the physician. This initiative has helped move Michigan into the top 5 of e-Prescribing states.

A recent survey of physicians in the program revealed that improved patient safety and quality of care topped the list of key benefits of the technology:

- 75 percent of prescribers believe strongly that e-Prescribing improves safety for their patients, and nearly 70 percent say it improves the quality of care.
- More than 80 percent of all prescriptions written by those surveyed are currently written electronically; four of 10 practices now only write e-Prescriptions.
- More than 70 percent saw a reduction in communications with pharmacies over prescription questions.
- More than half strongly agree that e-Prescribing saves clinicians' time and increases productivity.

These survey results clearly demonstrate e-Prescribing decreases errors, increases quality, and creates value.

- In 2006, we led the formation of *Southeast Michigan Health Information Exchange (SEMHE)*, also with GM and Chrysler to create the infrastructure needed for transmission of health care information among the health care providers and patients throughout the region. This initiative has since expanded to 46 participants, which include most major hospitals, insurance plans, several physician organizations and other key stakeholders in the region.

Last year, the initiative received \$1.4 million planning grant from the State of Michigan to assist formation of a formal entity and governance structure, drafting and approval of a business plan, and all other activities needed prior to implementation of the regional health information exchange. The effort is progressing to complete this planning phase by this fall but we face a significant challenge in raising start-up funding.

Our leadership in this area is well recognized throughout the State of Michigan, as evidenced by Governor Granholm's appointment of a Ford Manager to represent employers at the thirteen-member Michigan Health Information Technology Commission. This Commission is charged with formulating strategies to promote adoption of information technology by health care system in Michigan.

Involving Physicians

We also recognized that in many cases, our employees with chronic diseases need greater involvement by their primary care physicians to plan and implement programs for improving their health status. However, physicians are often overwhelmed by simply providing regular care. Therefore, we have agreed to take a leadership role in Michigan's participation in *the Improving Performance in Practice (IPIP) Initiative*, sponsored by the Michigan Primary Care Consortium through a grant from the American Board of Medical Specialties and the Robert Wood Johnson Foundation. The steering committee for the Michigan initiative, which is composed of all of the

allopathic and osteopathic primary care organizations in the state, is chaired by Ford Motor Company's Medical Director.

The initiative's key goals are:

- Provide primary care physicians the necessary tools to ensure patients receive recommended chronic disease and preventive services (such as peer-reviewed practice guidelines and reportable metrics).
- Provide physicians tools to improve their practice's efficiency. This way they can allocate more time for more serious health conditions. This involves using quality improvement health care professionals trained to review physician offices and recommend process improvement.

So far, we have accomplished:

- Adoption of one set of state guidelines for diabetes and asthma management,
- Development of one set of metrics for determining adherence to the guidelines, and
- Receipt of seed funds from a variety of sources and identifying automotive industry quality coaches for training. For this purpose, Ford is devoting a "Six Sigma master blackbelt engineer" for the next eighteen months.

We are scheduled to place the quality coaches in ten primary care offices in late June, followed by twenty more offices in September. One hundred more practices will be added to the initiative next year.

Communicating Expectation of Accountability by Insurance Plans and Providers

Finally, we continuously communicate our expectations to our major health care suppliers, through conferences and individual meetings. We meet with the senior leadership of virtually all of Ford's health plans and major providers (hospitals and physicians) to convey the importance of improving efficiency and safety.

Importantly, we have made substantial progress in incorporating the Four Cornerstone tenets outlined by President Bush and HHS Secretary Leavitt in our contracts with health plans and we will hold them accountable for performance and outcomes. These fundamental principles are key to quality and value and we commend the ongoing effort by the Department of Health and Human Services in establishing the framework and championing a true multi-stakeholder initiative.

Policy Recommendations

I hope this helps you better understand the challenges that employers face providing health care coverage and the roles that employers can play in addressing some of the challenges. As our overall business environment continues to be extremely challenging due to strong global competition, new fuel economy standards, and recent credit market constrictions, it is critical for us to continue seeking every innovative approach to manage health care costs in order to ensure our business remains viable.

Finally, I'd like to leave you with some policy suggestions on how Congress and the federal government could assist employers to continue offering health care benefits.

- **Focus on Affordability**

Much recent discussion on health care reform has justifiably centered on uninsured population. However, we believe too much of that discussion focuses on mechanisms to expand coverage such as financing, modifying insurance markets, and mandates.

We suggest a better approach is to improve health care coverage affordability by evaluating the key cost drivers of health care and how to address them. Simply subsidizing excessive health care spending does not offer a long-term solution to our health care problems. In fact, it may well exacerbate them. Instead, by first making health care coverage more affordable, the entire health care population -- uninsured and insured alike -- would benefit both immediately and over the long-term.

- **Address Prescription Drug Costs**

Over the last several years, generic substitution has allowed us to control the rate of increase of our prescription drug costs. However, one element of our prescription drug costs that continues to increase rapidly is biopharmaceuticals or biologics. For those suffering life-threatening and chronic illnesses, biologics provide great hope, but their price – often well over \$100,000 per patient per year – can put them out of reach.

Since there is currently no regulatory pathway to approve generic versions of these biologics, prices remain prohibitively expensive in perpetuity. While we support maintaining drug companies' ability to profit from new life-saving products, monopoly pricing has been balanced in other drugs. Therefore, we urge the Congress to enact a legislation to give the FDA authority to approve safe and effective biogenerics that balance profit with patient safety.

- **Remove Legislative and Regulatory Barriers on Wellness Programs**

Incentive-based wellness programs are currently limited to 20% of the cost of coverage. Raising this percentage to a higher level would allow greater incentives for people taking an interest in wellness behaviors. This is good for them, good for us, and good for the country.

Additionally, the current wellness regulations require that employers treat equally those who succeed, and those who try but fail to change a voluntary behavior (e.g., losing weight, quitting smoking, etc.). To prevent gaming of the system, we suggest modifying regulations regarding voluntary behaviors to enable wellness programs to offer differential rewards based on whether an outcome is achieved. This would allow employers to reward those who actually do the hard work to improve their health status and adopt better health practices. It is important to note that we would advocate this approach only for voluntary behaviors and habits – things that we as individuals can accomplish with dedication.

- **Enable Breakthroughs that Improve Patient Care**

Similarly, we recommend a strong leadership at the federal level for establishing one set of standards for health care quality and one set of best practice guidelines for improving the population's health status. The federal government, including the Center for Medicare and Medicaid Services, can provide a central leadership role by adopting constructive policies, which can then – and certainly will – be replicated in the private sector. Areas where the federal government could play this pivotal role include:

- Adoption of a comprehensive set of standards for meaningful comparisons of health plan, hospital, and physician cost, quality and satisfaction performance that are publicly available.
- Creation of a knowledge management and data base system on outcomes and effectiveness that can better guide the extent that proposed new technology and drugs improve treatment outcome. The Agency for Health Quality Research is charged with this critical work but much more needs to be done and additional resources need to be provided.
- Addressing the issue of end of life care, patient preferences, and creating more humane experiences in the last stages of life. Studies estimate 30% of Medicare spending goes for

care of patients in their last year of life. Often, patients' preferences are needlessly disregarded.

- Creation of a mandatory anonymous error reporting system to allow us to learn from our mistakes on a national basis. This approach has produced dramatic improvements in other areas and offers great promise for medicine as well.

- **Provide Funding to Assist Start up of Regional Health Information Exchange (HIE) Initiatives**

Many benefits stem from adoption of health information technology (HIT):

- Improved care delivery as treating physicians have access to a patient's complete medical information, not just information stored in their offices, and
- Elimination of duplicative tests and procedures.

These are only achievable if there is an infrastructure allowing electronic storage and exchange of such information.

This is why we are leading the initiative in Southeast Michigan to create such an infrastructure. But as I stated earlier, we face a significant challenge in raising start-up funding. We suggest federal assistance for such start-up funding. Funding through state grants would enable each state to evaluate the viability of each regional HIE initiatives before offering financial support. It would be each regional HIE initiative's responsibility to formulate a sustainable plan for on-going operation so our suggestion on support is strictly for the start-up funding.

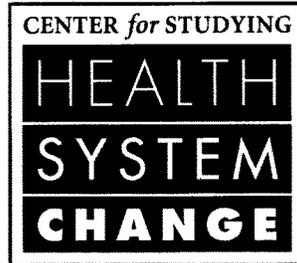
- **Preserve ERISA and Promote Uniformity**

As an employer that offers health care benefits in all fifty states, it is critical that we have the ability to offer and maintain uniform benefits throughout the United States. This flexibility to determine how to best meet the needs of our employees and retirees is crucial to our employees and to Ford. Congress understood this critical need when it enacted ERISA, which provides multi-state employers with a consistent approach to administration and design of nationwide health benefits. Therefore, this federal framework must be not only preserved, but strengthened where appropriate.

Closing

I'd like to thank you once again for the invitation to share our experiences with you. I commend you for examining this very critical issue. I am grateful for your interest in Ford's experience in health care benefit provision. Quality and value are integral to our core business and equally vital to health care. We offer our firm commitment of partnership to work with you on constructive solutions.

This completes my statement, Mr. Chairman and I'd be happy to respond to your questions.



Statement of Paul B. Ginsburg, Ph.D.
President
Center for Studying Health System Change (HSC)

**Before the United States Senate
Committee on Finance**

**Hearing on “Rising Costs, Low Quality in Health Care:
The Necessity for Reform”**

June 3, 2008

Chairman Baucus, Senator Grassley and members of the Committee, thank you for the invitation to testify about health care costs. My name is Paul B. Ginsburg, and I am an economist and president of the Center for Studying Health System Change (HSC). HSC is an independent, nonpartisan health policy research organization funded in part by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research, Inc.

HSC's main research tool is the Community Tracking Study, which consists of national surveys of households and physicians and intensive site visits to 12 nationally representative metropolitan communities. We also monitor secondary data and general health system trends. Our goal is to inform policymakers with objective and timely research on developments in health care markets and the impact on people. We do not make specific policy recommendations. Our various research and communication activities may be found on our Web site at www.hschange.org.

American health care—often lauded as the best in the world—is too expensive and growing more so every day. Too many Americans go without vital medical care because they are unable to afford health insurance.¹ At the same time, the overall quality of health care in the United States is uneven at best. How we finance health care and our pervasive unwillingness to confront the difficult trade-offs inherent in containing costs, improving quality and expanding coverage contribute to the seemingly intractable problem of stemming rising health care costs.

My testimony today will make three points:

- By any measure—per-capita spending and share of gross domestic product (GDP), for example—U.S. spending on health care is greater than other developed countries. In 2006, the United States spent \$2.1 trillion, or 16 percent of GDP, on health care, translating to \$7,026 per person annually.² But unlike other developed countries, which provide near-universal coverage, 47 million people in 2006, or 15.8 percent of the U.S. population, were uninsured.³
- The enormous amount of money spent on medical care in the United States does not appear to buy us outstanding health. Again, by almost any measure, ranging from infant mortality⁴ to preventable deaths,⁵ the United States does not measure up well against other developed nations.

¹ This testimony is in part based on previous work of the author. See Ginsburg, Paul B., and Len Nichols, "The Health Care Cost-Coverage Conundrum: The Care We Want vs. The Care We Can Afford," Center for Studying Health System Change, Washington, D.C. (2003).

² Caitlin, Aaron, et al., "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

³ U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the United States: 2006" (August 2007).

⁴ Organisation for Economic Co-operation and Development (OECD), *OECD Health Data: Statistics and Indicators for 30 Countries* (July 2007).

⁵ Nolte, Ellen, and C. Martin McKee, "Measuring The Health Of Nations: Updating an Earlier Analysis," *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

- Cost-containment and quality-improvement efforts are essential if Americans are to get better value for the tremendous amount of money spent on U.S. health care and to avoid an increasing proportion of our society lacking access to mainstream care.

Spending Beyond Our Means

After a significant respite in the mid-1990s during the zenith of tightly managed care, Americans are again struggling with health care costs rising substantially faster than incomes. According to data from the Kaiser Family Foundation-Health Research and Educational Trust Annual Employer Survey and the U.S. Department of Labor, premiums for employment-based private insurance increased 114 percent from 1999 to 2007, while average hourly earnings increased 27 percent, leaving a gap of 6.7 percentage points per year.

From 2007 to 2017, government economists expect U.S. health care spending to almost double from roughly \$2.2 trillion to \$4.3 trillion, while the share of GDP devoted to health care is expected to grow from 16.3 percent to 19.5 percent.⁶

Longer-range forecasts start with the premise that extrapolation of current trends will produce implausible results, such as more than the entire GDP going to health care, so they work from the other direction, considering how much health spending growth society will tolerate. This leads to conclusions that far more aggressive actions on the part of both the public and private sectors to control spending will be required than has been the experience to date. The Congressional Budget Office (CBO) recently published such a forecast, examining how rapidly health care spending could grow under the constraint that spending for goods and services other than health care does not decline in real terms from today's level. Under this scenario, health spending reaches 49 percent of GDP in 2082.⁷ The projection concludes that between 2018 and 2082, to meet this constraint, health spending could increase only 1 percentage point per year more rapidly than GDP on average (2.1 percentage points in 2018 declining to 0.4 percentage points by 2082), a much smaller gap than the historical experience.⁸

Even though other industrialized countries devote smaller percentages of GDP to health spending, their health care costs per capita also have grown faster than their GDPs. But recent analysis suggests that since the mid-1980s, other countries have had been more successful at limiting the gap between their health spending trends and GDP.⁹

⁶ Keehan, Sean, et al., Health Spending Projections Through 2017: The Baby-Boom Generation Is Coming to Medicare, "Health Affairs, Web exclusive (Feb. 26, 2008).

⁷ Congressional Budget Office, "The Long-Term Outlook for Health Care Spending," No. 3085 (November 2007).

⁸ Personal communication with CBO staff.

⁹ White, Chapin, "Health Care Spending Growth: How Different Is The United States From The Rest Of The OECD?" *Health Affairs*, Vol. 26, No. 1 (January/February 2007).

Interestingly, the magnitude of difference between U.S. health spending growth and income growth has not been constant. On a number of occasions in past decades, public or private initiatives have slowed the rate of cost growth substantially, only to be followed by periods of particularly rapid growth.¹⁰ These findings suggest that initiatives to slow cost growth were effective but could not be sustained. This was certainly the case with restrictive models of managed care, which created an intense backlash.

Why Health Care Costs Are High

A combination of factors contributes to high health care costs, including the way most health care is financed. Since much of the need for health care is unpredictable, insurance pools are necessary to provide the wherewithal to pay for expensive services needed by the relatively few who are seriously ill at any particular time. Unlike most other forms of insurance, such as life or fire, the benefits of health insurance are not predetermined or defined in terms of a set payment for a distinct event, such as death or your house burning down. Instead, health insurers' financial obligations are defined in terms of spending on treatments that physicians and patients decide to pursue—providing an environment where treatment decisions can be made with little regard for costs. This provides great comfort for those who are ill, but the downside is that when someone else pays—the health insurer—patients and their physicians have little incentive to economize and make sure the expenditure is commensurate with the clinical value of the service.

The impact of reduced patient out-of-pocket costs is probably magnified by uncertainty about the effectiveness of many medical tests and procedures. Little information on comparative effectiveness of medical goods and services is produced by the private market because of limited ability to charge the millions of users of the research. But limited public funding for effectiveness research is puzzling, given the clear interests of those—public and private—who pay the costs of health insurance—not to mention taxpayers. To date, providers and developers of medical technology have been more effective politically than the much broader array of interests who would benefit from increased comparative effectiveness research. But pressures on government to address health care costs are changing this dynamic.

Why Health Care Costs Are Rising Rapidly

Health care costs are not just high; they are rising rapidly as well. We know that much of the long-term trend toward greater per-capita spending is driven by technological change—new diagnostic tests and treatments and new applications of older technologies.¹¹ Much of this is highly valuable, but the benefits are diminished when the technology is applied beyond those patients most likely to benefit from it. But rapid technology diffusion would not be possible

¹⁰ Altman, Drew E., and Larry Levitt, "The Sad History of Health Care Cost Containment as Told in One Chart," *Health Affairs*, Web exclusive (Jan. 23, 2002).

¹¹ Congressional Budget Office, "Technological Change and the Growth of Health Care Spending," No. 2764, (January 2008).

without a financing system that pays most of the cost of all services and institutionalizes few mechanisms to screen new techniques and devices for clinical effectiveness prior to coverage. And a major downside to the status quo is that a significant proportion of Americans—the almost 16 percent without health insurance—have limited access to the wonders of modern medicine.

Following the collapse of tightly managed care, hospitals and physicians made the most of the reprieve from aggressive cost-containment tactics. Providers focused primarily on two strategies to bolster their financial position—pressing health plans for better payment rates and contract terms and expanding capacity to provide select services and technology that are particularly well compensated. Many medical groups opened ambulatory surgery and diagnostic centers and added capacity to deliver radiology, laboratory and imaging services in their practices.

The intense competition for niche specialty services—and avoidance of other less profitable services—is a strong sign that public and private payers are inadvertently overpaying for some services while underpaying for others. As HSC research has shown, marked disparities in the relative profitability of services under both Medicare and private plan payment policies appear to be a key force driving hospital and physician competition for certain specialty services.¹² Recently, Medicare has changed hospital and physician payment systems to better reflect relative costs of different services to reduce inadvertent incentives for providers to favor certain services at the expense of others. But market responses to these policy changes are not yet apparent, with some market observers indicating that the changes have not been substantial enough to alter provider behavior.¹³

Another factor behind rapidly rising costs is the likelihood that productivity increases in health care delivery have been small. Productivity in health care is extremely difficult to measure because product changes are important but difficult to adjust for. In much of the rest of the economy, price increases are held down by large increases in productivity over time. But productivity improvement is much less likely when each provider is paid on the basis of services it produces rather than on what is done by all providers to address a patient's medical condition. So providers have incentives to be efficient in their provision of each service but not to be concerned with the number of services or the cost of services of other providers involved in that patient's care.

Business Cycle Drives Employer Responses to Rising Costs

Employers' willingness to tackle cost control ebbs and flows with the business cycle. When health care costs are rising rapidly, profits are low and labor markets are loose, employers have

¹² Ginsburg, Paul B., and Joy Grossman, "When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care," *Health Affairs*, Web exclusive (Aug. 9, 2005).

¹³ Draper, Debra A., and Paul B. Ginsburg, "Health Care Cost and Access Challenges Persist: Initial Findings from HSC's 2007 Site Visits," Issue Brief No. 114, Center for Studying Health System Change, Washington, D.C., (October 2007).

taken strong actions to control costs, only to abandon their efforts when the cycle turns. As an example, in the early 1990s, employers responded to depressed profitability and extensive unemployment by incorporating restrictive models of managed care into their health benefit structures. In effect, they engaged private insurers to slow cost growth by imposing administrative controls on access to care and restricting provider choice to obtain larger discounts. But during the late-'90s' economic boom, when recruiting and retaining workers was perceived as a more significant challenge than containing health-benefit outlays, employers retreated in the face of worker complaints about restrictions on provider choice and access to care.

Following the 2001 recession, when premium trends spiked again, employers responded by buying down the benefit structure of their plans by increasing patient cost sharing through higher deductibles, coinsurance and copayments—a strategy that has mitigated somewhat in recent years. While employers don't appear to be interested in revisiting restrictive managed care models, they also are not optimistic that higher cost sharing alone is the long-term answer. Why employers opted for higher cost sharing rather than a return to restrictive managed care probably reflects the intensity of at least some employees' dislike of managed care restrictions, perhaps abetted by the lack of visibility of costs to them.

Once again, as the economy slows and costs and premiums continue to increase at higher rates than workers' earnings, employers are seeking solutions to rising costs. Employers now are looking to consumers to take more responsibility for medical costs, lifestyle choices and treatment decisions. While consumer-directed health plans have not gained widespread adoption, other developments—including a heightened emphasis on prevention and wellness, along with nascent provider cost and quality information—are advancing health care consumerism. However, concerns exist about whether these efforts will slow cost growth enough to keep care affordable or whether the growing problem of affordability will derail efforts to decrease the rising number of uninsured Americans and stymie meaningful health care reform.¹⁴

Government Responses to Rising Costs

State and federal governments deal with costs through two distinct roles—as managers of public insurance programs and as regulators of the health care system. Medicare and Medicaid have aggressively controlled spending when imperatives to cut budgets were greatest. The most heavily used tool has been to reduce provider payment rates. But rate reductions have been constrained by concerns about beneficiaries' access to physicians and concerns about hospitals and other providers' financial viability. After all, Medicare and Medicaid beneficiaries get their care from the same delivery system that others do, so there are limits to how much these programs can cut their outlays without addressing system-wide issues.

Benefit reductions have not been common, and governments have been less inclined to control utilization of services through administrative controls, partly due to statutory prohibitions against

¹⁴ Ibid.

“affecting the practice of medicine.” Medicaid programs have successfully outsourced some utilization management to managed care companies, but the Medicare program has faced intense opposition to mandating, or even favoring, tightly managed care.

Except for the 1970s, governments as regulators have not been very active in attempts to contain costs system wide. Hospital rate regulation, adopted by a number of states in the 1970s and unsuccessfully proposed at the federal level by President Jimmy Carter, was one exception. These programs had some success, but most were abandoned in the 1990s as the nation turned away from regulation in general, and because the combination of Medicare prospective payment and managed care contracting were perceived as adequate constraints on hospital costs.

Certificate-of-need (CON) legislation—which limited major capital expenditures by hospitals and some other facilities based on the belief that unneeded facilities increased costs, either by creation of excess capacity or by inducing additional use of services—was more widespread and continues to this day in many states. But most research shows that CON programs had little impact on capital spending in the aggregate, although they did have substantial impact on which institutions expanded facilities.¹⁵ This tool has been revitalized in some states as general hospitals have advocated its use to block construction of physician-owned specialty hospitals and outpatient facilities that are perceived as competitive threats.

Other Approaches

In contrast to the United States, OECD countries use a wider array of tools to limit resource use and expenditure growth. Until recently, patient cost sharing has not been used extensively in these countries. Direct regulation of prices, involving unabashed use of government’s sole-buyer purchasing power, and administrative limits on the acquisition and use of expensive technology are used in place of substantial patient cost sharing in these systems. Although a number of studies have focused on higher prices paid for services in the United States than in OECD countries, recent work by McKinsey has taken this further by documenting how this drives large differences in efficiency of delivery of services.¹⁶

Initiatives to collect and distribute more information on medical effectiveness, to reduce medical errors and improve quality, and to screen the development of new technologies all presume a rich lode of services being delivered today that will turn out to have little medical benefit to patients. There is compelling evidence from researchers analyzing Medicare data that suggests the higher-

¹⁵ Sloan, Frank A., “Controlling Health Expenditures: Lessons Learned from Certificate of Need Programs,” in *Cost, Quality, and Access in Health Care*, ed. F. Sloan, J. Blumstein, and J. Perrin, San Francisco, Calif., Jossey-Bass (1988).

¹⁶ Anderson, Gerard F., et al., “It’s The Prices, Stupid: Why The United States Is So Different From Other Countries,” *Health Affairs*, Vol. 22, No. 3 (May/June 2003); Anderson, Gerard F., et al., “Health Spending In The United States And The Rest Of The Industrialized World,” *Health Affairs*, Vol. 24, No. 4 (July/August 2005); and McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States,” (January 2007).

than-average spending—as much as 30 percent—in many areas of the country does not buy better outcomes; in fact, much of the spending variation comes from services where guidelines based on effectiveness research do not exist.¹⁷ But other research has pointed out that many quality problems in U.S. medicine are associated with underprovision of services that are known to be effective for specific types of patients.¹⁸ Thus, while more widespread application of evidence-based practice would surely improve the quality of care, it may add to, not subtract from, health care use and cost.

Implications of Rapidly Rising Health Care Costs

When spending rises for most goods and services, policymakers' attitude toward it is neutral because of a shared belief in consumer sovereignty. But health care is quite different because most health care is financed through health insurance. This reliance on third-party payment blunts consumer incentives to economize on the use of care and to signal by their behavior the value they place on services. And rising premiums cause problems for the employers, employees and governments that pay for health insurance. So, policymakers have good reason to be concerned about rising health care costs.

Unlike a housing purchase, for example, where a consumer can tailor the purchase to what they are willing to spend and can afford, consumers have much less ability to adjust their health spending to their ability to pay. For the most part, we have a single medical standard of what should be done for people who have various illnesses. This means that purchasing most types of health insurance buys into that standard. Those without the means to afford a typical insurance policy cannot simply go to a less expensive version in the way they would opt for a smaller or less well-located house. So if we want people with lower incomes to have access to care, they need to be subsidized, either through pools that employers establish (where the employer makes the same contribution regardless of the worker's earnings) or through government programs.

Rising health costs affect people's ability to afford health insurance. When insurance premiums rise faster than workers' wages, fewer people obtain employment-based health insurance. This happens through small employers deciding not to provide coverage to their employees and employees deciding not to take up employer coverage because the employee contribution is too high. If health care cost trends continue to exceed increases in wage rates by a large margin, this could result in substantial loss of employer-based health insurance.

While there is policy interest in shifting from a system based on employer-sponsored health insurance to individual coverage, caution is in order before jettisoning the employer system because today's individual insurance market is not an attractive alternative. The presence of underwriting in the individual insurance market based on medical history and age would make

¹⁷ Fisher, Elliott S., et al., "The Implications of Regional Variations in Medicare Spending," *Annals of Internal Medicine*, Vol. 138, No. 4 (Feb. 18, 2003).

¹⁸ McGlynn, Elizabeth A., et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26 (June 26, 2003).

insurance unaffordable for many who now obtain coverage through employment.¹⁹ The concept of regional health insurance exchanges to create pooling mechanisms that include both healthy and sick people is promising but largely untested. Rather than a wholesale abandonment of the employer-based system, it might be more prudent to test the concept with the millions of Americans who lack access to employer-based coverage than with the entire privately insured population.

Rising health care costs and stagnant incomes also are increasing the financial burden of health care for American families.²⁰ More than one in six Americans in 2004—or 17.7 percent of the nonelderly population—lived in families spending more than 10 percent of after-tax income on health care, including health insurance premium payments and direct spending on services, up from 15.9 percent in 2001. Despite the overall increase in financial burden, the share of total health spending paid for out of pocket actually decreased slightly from 34.8 percent in 2001 to 33.6 percent in 2004, meaning that much of the increased burden was a result of health spending growing more rapidly than income.

Finally, rising health care costs also pose a problem for the federal and state governments, which finance 40 percent of national health expenditures, mostly through Medicare and Medicaid.²¹ With public revenues staying at a relatively constant percentage of national income, growth in outlays for these programs in excess of growth in income that is taxed poses particular strains on public budgets. As the economy slows, states are facing these strains now in an acute manner, as Medicaid outlay growth exceeds the trend in state revenues by a large margin. The strain will become acute for the federal government as concerns about rising deficits increase and when the baby boom generation begins to become eligible for Medicare.

While I have touched on a number of the drivers of rapidly rising costs, I want to emphasize one core factor that is behind much of the cost problem. In the United States, our culture emphasizes that insured people should get all the medical care they want, regardless of cost. This works against attempts to discourage the development of treatments in which the benefits are uncertain or known to be small. Until the public becomes more aware of what is involved in truly containing costs, rising health care costs will continue to strain the resources of government purchasers, employers and consumers.

The Need for Leadership

The next few years are likely to be a period of particularly intense concern about costs. A combination of higher insurance premiums and increased patient cost sharing has already

¹⁹ Ginsburg, Paul B., "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, Vol. 27, No. 23 (May/June 2008).

²⁰ Bantlin, Jessica S, Peter Cunningham and Didem M. Bernard, "Financial Burden of Health Care, 2001-2004," *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

²¹ Caitlin, Aaron, et al., "National Health Spending In 2006: A Year of Change For Prescription Drugs," *Health Affairs*, Vol. 27, No. 1 (January/February 2008).

convinced the public there is a cost problem,²² though they appear to be focused more on who pays what share rather than on how much we all pay. Government budgets probably will be tight for some time, and policymakers will find growing outlays for Medicare and Medicaid increasingly threatening. Private insurers and employers will complain more loudly about provider reimbursement cuts by public programs being shifted onto them and further eroding the affordability of private coverage. More employers and employees are finding themselves priced out of the comprehensive health insurance market. Some will take cold comfort in plans with increasingly high deductibles, and others, faced with the choice of expensive comprehensive insurance for broad provider networks or being uninsured, will opt to take the risk and depend on the safety net in the event of serious illness. Hospitals already are alarmed by the increasing diversion of resources to providing uncompensated care to the uninsured and to bad debts owed by those who are insured.

Policymakers are pursuing ideas that promise to reduce costs, including federal support for an information technology infrastructure for hospitals and medical practices and an expanded role for disease management in Medicare and Medicaid. Many of these initiatives have merit because they have the potential to improve the quality of care, but skepticism is in order about the magnitude of cost reductions that might result.^{23 24} While there certainly will be instances where quality improvement will contain costs at the same time, it's questionable whether the net impact on costs will be commensurate with the magnitude of the cost problem.

Though some deny it, we ration care today. The uninsured get much less care than the insured and suffer worse health outcomes because of it,²⁵ and the insured with ample means get more care than do the lower-income insured, although without clear differences in outcomes. The challenge is to ration in a way that is more efficient and more equitable.

Once the clinical rationing imperative is widely acknowledged, a broader and complementary array of cost-containment tools can be brought to bear in the United States. These cannot and need not extend to the kinds of absolute limits on specific resources and consumer choices used by the centralized systems of most OECD countries. Rather, evidence-based practice guidelines and institutionalized technology assessment can help to inform benefit package design and differential cost-sharing requirements. In contrast to systems that decide for the patient what services are unavailable because of limited clinical value, a system more compatible with American values would continue to allow broad patient and provider choices, coupled with extensive information about likely clinical value and higher cost sharing when the values are small.

²² Kaiser Family Foundation, "Kaiser Health Tracking Poll: Election 2008," (April 2008).

²³ Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," No. 2976 (May 2008).

²⁴ Mattke, Soeren, Michael Seid and Sai Ma, "Evidence for the Effect of Disease Management: Is \$1 Billion a Year a Good Investment?" *American Journal of Managed Care*, Vol. 13, No. 12 (December 2007).

²⁵ Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, National Academy Press, Washington, D.C. (2002).

Acknowledging that relying on cost sharing alone will ultimately increase segmentation of insured risk pools by socioeconomic class over time, one should also be mindful of the dynamic that is driving increasing fractions of lower-wage workers to lose coverage over time.²⁶ Today, many lower-wage workers are essentially being denied the opportunity to opt for lower cost and more tightly managed care products, such as health maintenance organizations (HMOs) because higher-income people have objected to restrictions, especially on their choice of provider.

Some restrictive provider networks are capable of delivering high-quality care; indeed, systematic evaluations of the relative quality of HMOs and fee-for-service medicine have always concluded that average quality was about the same.²⁷ Results from HSC's Community Tracking Study surveys have shown consistently over time that the public is divided in its willingness to have more restricted provider choice in return for lower costs, with low-income people much more willing to make that trade-off.²⁸ Purchasing vehicles and subsidies can be created to permit low-income workers to exercise this choice, while providing time to develop the more sophisticated mechanisms needed to vary cost sharing based on the clinical value of services.

There is much we do not know about how to do effective clinical value rationing at the moment. Estimates of the fraction of physicians' care decisions that are supported by unambiguous clinical trial evidence range from 11 percent to 65 percent, depending on specialty and care setting.²⁹

Actions to address costs can be taken by both the private and public sectors, with each feeling distinct pressures to act and having different tools available to them. There is no single, silver bullet to control spending growth, but the range of possible steps is large. Indeed, the main problem with focusing on a single approach is the risk that it will not be as successful as promised and valuable time will be lost in pursuing other approaches.

One way to view many of the options is to classify them into demand-side and supply-side approaches. A key demand-side approach, which has been pursued broadly by the private sector—but not the public sector—is increased patient cost sharing at the point of service. Although consumer-directed health plans and their large deductibles and savings accounts have received the most attention, most people with employer-sponsored coverage are enrolled in preferred provider organizations (PPOs) (57%) and HMOs (21%).³⁰ So the changing benefit structures of PPOs and HMOs toward higher patient cost sharing is a more significant

²⁶ Holahan, John, and Allison Cook, "The U.S. Economy And Changes in Health Insurance Coverage, 2000-2006," *Health Affairs*, Web exclusive (Feb. 20, 2008).

²⁷ Miller, Robert H., and Harold L. Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001," *Health Affairs*, Vol. 21, No. 4 (July/August 2002).

²⁸ Tu, Ha T., "More Americans Willing to Limit Physician-Hospital Choice for Lower Medical Costs," Issue Brief No. 94, Center for Studying Health System Change, Washington, D.C. (March 2005).

²⁹ "What Proportion of Healthcare is Evidence Based? Resource Guide," www.shef.ac.uk/~scharr/ir/percent.html, accessed May 28, 2008.

³⁰ Kaiser Family Foundation-Health Research & Educational Trust, "Employer Health Benefits: 2007 Annual Survey" (2007).

development. Although these steps clearly lead to reduced spending, the question is how much of a reduction can be achieved without major sacrifices in other societal goals, such as access to care and protection from financial hardship.

Should policymakers want to push the demand-side approach further, the most powerful tool would be changes in the tax treatment of health insurance, a step that President Bush and Republican presidential candidate John McCain have advocated; Democratic presidential candidate Hillary Clinton also has a more modest proposal to change the tax treatment of health insurance. Government can also contribute to this approach by continuing to expand provider quality reporting to Medicare and making data and information from Medicare claims files available to the public.

Supply-side approaches include reforming provider-payment mechanisms and administrative controls on service use. Because private insurers and Medicaid programs now follow Medicare provider payment mechanisms extensively, this presents an opportunity for federal policymakers to influence the entire delivery system. There is ample evidence that Medicare payment structures for physicians do not reflect relative costs and are providing inadvertent incentives to specialize in more profitable services, such as imaging and minor procedures.³¹ Revising Medicare payment structures to better reflect relative costs could make an important contribution to controlling costs.

Building on revised Medicare payment structures, payment mechanisms that depart from fee for service have the potential to increase provider efficiency. This includes paying for major procedures on a per-episode basis that includes all providers involved in the episode of care and paying for the management of chronic disease, including care coordination, on a capitated basis. High-performance networks and newer forms of pay for performance are examples of initial steps in this direction. But with the fragmented payment system limiting the effectiveness of these approaches, Medicare leadership can potentially have a large impact.

Research on spending trends has highlighted the opportunity to contain costs—for at least the intermediate term—if wellness can be successfully promoted.³² Both employers and the public sector can support efforts of individuals to reduce high-risk behavior. But these wellness and prevention initiatives are at an early stage, without particular approaches demonstrating effectiveness. Many are intrigued with the notion of promoting wellness, but we are not yet at the point of having tools with proven effectiveness.

Reflecting on the U.S. experience with health care cost containment, what is striking is the consistency with which leaders in both the public and private sectors have avoided the idea that

³¹ Ginsburg, Paul B., and Robert A. Berenson, "Revising Medicare's Physician Fee Schedule—Much Activity, Little Change," *New England Journal of Medicine*, Vol. 356, No. 12 (March 22, 2007); and Medicare Payment Advisory Commission, "Report to the Congress, Promoting Greater Efficiency in Medicare," (June 2007).

³² Thorpe, Kenneth E., et al., "Trends: The Impact Of Obesity On Rising Medical Spending," *Health Affairs*, Web exclusive (Oct. 20, 2004).

real cost containment involves real sacrifice—patients going without services that may provide some benefit, or physicians, hospitals and insurers settling for smaller incomes or profits. After all, all medical care spending is somebody's income. Often what we hear from leaders is more wishes about directions that the health care system should take than concrete policy options to lead it to happen. More effective ways to cope with limited resources will depend on political, professional, corporate, labor and opinion leaders articulating the need to confront trade-offs among clinical effectiveness, costs and equity.

“Rising Costs, Low Quality in Health Care: The Necessity for Reform”

Testimony Submitted to

Senate Finance Committee

By

Arlene Holt Baker

Executive Vice President

American Federation of Labor and Congress of Industrial Organizations

June 3, 2008

Good morning, Chairman Baucus, Senator Grassley and distinguished members of the Committee. Thank you for the invitation to participate in this hearing and to offer our perspective, on behalf of working women and men, on the need for health reform. I would like to commend the committee for launching this series of hearings on health reform and laying the groundwork for a national debate on how best to secure affordable, high-quality health care for all Americans.

The AFL-CIO represents 10.5 million members, including 2 million members in Working America, our new community affiliate, and 56 national and international unions that have bargained for health benefits for more than fifty years. Our members are among the most fortunate: through bargaining, they have good benefits from their employers. Yet even the well-insured are struggling with health care costs hikes that are outpacing their wage increases and far too many working families just can't keep up.

Earlier this year, we launched an online survey that captured working families' concerns about health care. More than 26,000 people took the survey over just seven weeks. Most are insured and employed, most are college graduates, and more than half are union members. These are the people, it would seem, most likely to have positive experiences with America's health care system. Instead, their responses tell a sobering story about the breadth of the problems with health care in America.

Nearly all survey takers with insurance, 96 percent, say they are somewhat or very concerned about affording coverage in the next few years and almost two thirds who have employer provided coverage say their costs have gotten worse. More than half of survey takers say their health insurance does not cover all the care they need at a price they can afford and preventive care is uncovered or unaffordable for more than a third.

Almost 7,500 people posted their own stories of our health care system failures. One of those stories comes from Teresa in Vancouver, Washington. She said, "I have a job with a union contract. Every year, I get a raise that works out to be about \$12.00 per week. About the same time each year, I get a memo from my employer that my family's health insurance premium has increased by roughly the same amount. I have not seen a real increase to my take-home pay in 12 years at my company. Meanwhile, our family's bills for EVERYTHING else have risen, too."

Others weren't even lucky enough to hold onto their coverage. Dorene in Veneta, Oregon, wrote, "I worked for a manufacturer for over 15 years. My wages stayed the same for over 6 years as I found myself paying more and more for health care. Co-pays went up, deductible went up, and the last year I worked there, I was paying a portion of the premium. In late 2006 the company sent my production job to Mexico and China and I was laid off. I could not afford COBRA premiums. I am 2 years away from Medicare and unemployed and on the Faith Based health care system: I pray I don't get sick. Oh yeah, I'm a cancer survivor and I haven't done the yearly checkup in 3 years."

These survey results and stories put a human face on the statistics that are perhaps numbingly familiar yet all too telling: health premium increases are regularly outpacing wage hikes and inflation. Since 2001, premiums for family coverage increased 78 percent while wages went up 19 percent and inflation increased 17 percent. Annual premium costs for family coverage have almost doubled between 2000 and 2007. And as the number of uninsured grows, so too does the cost-shifting that occurs in our fragmented system: more than \$900 of the average family premium covers treatment for the uninsured.

And it's not just premiums that are climbing. Workers' out of pocket costs are going up as well, more than doubling between 2001 and 2007. Some of these increases are the result of passing along a share of annual cost hikes to workers. Other increases are more concerted efforts to increase workers' exposure to costs through high-deductible health plans in the name of "consumer-directed health care." Yet we know that cost sharing can discourage appropriate as well as inappropriate care, especially among the poor and the sick. And as costs go up, coverage becomes unaffordable for more workers, with the ranks of the uninsured increasingly reaching beyond low-wage workers into middle-income families.

Year in and year out, health care costs are the toughest issue in bargaining, and workers regularly forego bigger wage hikes to fend off greater health care costs, demonstrating the value workers place on the security of health benefits they can count on to cover the care they need. But these trends are unsustainable and the status quo is unacceptable.

Our employers are for the most part the good guys. Our unions work with them to make limited dollars stretch as far as possible to meet escalating health care costs. Yet they increasingly find themselves competing domestically and internationally with firms that don't bear the same cost pressures.

Globally, U.S. firms pay more as a percent of payroll and as an hourly cost than our major trading partners. Here at home, firms that provide good benefits to their workers and their families find themselves picking up costs for firms that either don't cover dependents or don't provide coverage at all. Even public employers that have typically provided good health benefits are struggling under growing cost pressures, especially as more states find their budgets hit by the economic downturn.

We regularly work with employers to tackle these problems. Value based purchasing and electronic prescribing are two policies that make sense and have the support of many in the business, labor and consumer worlds. We know we aren't getting consistently high quality for the money we spend. In fact, patients have a 50/50 chance of getting the right care at the right time and as many as 98,000 Americans die each year due to preventable medical errors. More than 1.5 million preventable adverse drug events occur annually in the U.S. About one third of all health care spending pays for poor quality. And disparities of care persist across our population based on race, ethnicity, language and gender. We can do better – and we can save money at a time when 47 million Americans are uninsured and tens of millions more worry about losing the coverage they have.

Measuring quality and publicly reporting the results have been shown to drive significant improvements in care. One such example is Pennsylvania's work on reporting hospital-acquired infections. With a broad cross section of public and private sector unions serving on the statewide council that oversees the reports, Pennsylvania's findings were dramatic. Research in Pennsylvania showed that individuals who acquire infections while in the hospital cost on average \$185,260 and remained in the hospital for an average of 20.6 days. Individuals who did not acquire such infections cost on average \$31,389 and stayed in the hospital an average of 4.5 days.

Going beyond reporting, we can realign the incentives in our payment system to ensure higher quality and more efficient care. But it is important that such a payment methodology reward both achievement of measures as well as improvement. We do not want a two-tiered system that leaves some providers – and their patients – behind.

It is crucial that we understand health reform as a process of transforming the way health care is structured and provided, not just a debate over who pays the bill. But reform must address cost and coverage as well. We need comprehensive reforms that will not only improve quality but lower costs and extend coverage for everyone. Last year, the AFL-CIO launched a campaign to mobilize our members to push for national reform that will guarantee affordable, high quality coverage for all Americans. As part of that campaign, we will educate our members on the false solutions that may find their way into a national debate and to inoculate them against the scare tactics that are sure to come from those who benefit most from the status quo. And we will measure various plans and proposals against our principles for reform.

Those principles build on group coverage and pooled risk rather than the flawed individual insurance market. Everyone should get health care as good as they have now or better, and everyone must share in the responsibility for financing that coverage – government, employers and individuals. Everyone should have a choice of health plans, including the right to keep their current coverage, or choose another private plan or public plan. And the government should act as a watchdog on costs, quality and fairness.

As we work toward lowering costs and covering everyone, we must be sure reforms do not undermine employer coverage, which is the backbone of our health care system and covers 160 million Americans. That is because employer-based coverage has significant advantages. It provides a natural pooling mechanism and has lower administrative costs when compared with coverage in the individual market: 10 percent of premiums for group coverage versus 25 to 40 percent for individual market coverage. And because there is no individual underwriting in employer plans, workers are not excluded from coverage due to age or health status and premiums are more in line with actual medical expenditures than they are in the individual market.

Furthermore, both employees and employers highly value employer-based coverage. Surveys show workers value health benefits more than any other non-wage benefit. Another survey asked workers in employer plans if they would prefer to continue receiving health benefits through their job or receive an increase in taxable income equal to the average premium instead. Three quarters said they would prefer to continue receiving employer sponsored health insurance.

Our principles for reform are consistent with those of many other stakeholders, but we recognize that there will be other approaches. Our members – and our employers – have an important role to play in the national debate to come and this committee will, of course, be at the center of that debate. We look forward to working with you to enact legislation that will guarantee affordable, high-quality health care for all Americans.

“ When things get bad enough the people will finally stand up and bring about change.

Insurance kept me from bankruptcy, but not from poverty.

How could this happen to my family when we had played by the rules?

What would you do if you had to choose between food or medicine?

For today a mother is helpless, a child suffers, and this is America.

Americans deserve health care for all.

I am...on the Faith Based health care system: I pray I don't get sick. ”

2008

HEALTH CARE FOR AMERICA SURVEY

MARCH 2008

AFL-CIO • WORKING AMERICA



**If fighting breast cancer weren't bad enough,
try beating it while losing your job to outsourcing.**

“ It was August of 2004 when my wife was diagnosed with breast cancer. The diagnosis was shattering, a double mastectomy was our best hope. My wife is a fighter and I'm really proud of her....Then worse news; in the spring of 2005 my employer started laying us off....I had worked there for over 15 years; how could I be losing my career... to an overseas vendor in Singapore? My wife is fighting for her life and I had to make unaffordable COBRA payments to keep our medical insurance....We nearly lost our home. I had to cut out nearly all of our kids' extra activities... even though we knew that those activities had helped keep them out of trouble....Our story has a happy ending—my wife survived!

My three sons and I know how lucky we are but we also know that we have to fight for health care reform—each and every one of us. My youngest son is 15 and he knows! You ask him what's important today and...he'll say good jobs, food on the table and affordable health insurance! ”

JEFF, Savage, Minn.

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Choose: Food or Medicine

“What would you do if you had to choose between food or medicine? Because of rising health care costs, that is a question that is frequently asked in my home. I work full time and have health care through my employer, but only a percentage is paid by them....I recently needed medication for an ailment, but did not get the medicine—I couldn't. What would I choose? I choose my children and what they need, whether it be food or medicine. I am the one who will go without before they suffer.”

MARIE, Madison, Wis.

SUMMARY OF FINDINGS

OVER A PERIOD OF JUST SEVEN WEEKS, from Jan. 14-March 3, a total of 26,419 people took the online 2008 Health Care for America Survey. Most are insured and employed. Most are college graduates. More than half are union members.

These are the people, it would seem, most likely to have positive experiences with America's health care system. Instead, their responses tell a sobering story about the breadth of the problems with health care in America. They say our system has fundamental problems that must be fixed.

And they're ready to vote about it.

The people who took the survey also submitted 7,489 heart-wrenching stories about the effects of this broken health care system on them and their families. You'll see some of their stories throughout this report.

The demand for change in today's health care system is based primarily on deep concerns about costs.

- One-third of respondents to the online survey, sponsored by the AFL-CIO and Working America, report skipping medical care because of cost, and a quarter had serious problems paying for the care they needed.
- Ninety-five percent say they are somewhat or very concerned about being able to afford health insurance in the coming years.
- Almost half overall (48 percent) and 60 percent of Latinos say they or a family member has stayed in a job to keep health care benefits when they would have preferred changing jobs.
- Ninety-five percent of respondents say America's health care system needs fundamental change or to be completely rebuilt.
- Seventy-nine percent say health care is a very important voting issue, and 97 percent say they plan to vote in the November elections.

The 2008 Health Care for America Survey gives voice to working families' concerns about health care in this critical election year, and the results will be shared with candidates for office across the country at every level.

A Too Familiar Story

“ I worked for a manufacturer for over 15 years. My wages stayed the same for over 6 years as I found myself paying more and more for health care. Co-pays went up, deductible went up, and the last year I worked there, I was paying a portion of the premium. In late 2006 the company sent my production job to Mexico and China and I was laid off. I could not afford COBRA premiums. I am 2 years away from Medicare and unemployed and on the Faith Based health care system: I pray I don't get sick. Oh yeah, I'm a cancer survivor and I haven't done the yearly checkup in 3 years. ”

DORENE, Veneta, Ore.

The failures of America's health care system, the survey reveals, are a significant factor in broader economic problems facing working families today.

- Eighty-three percent of respondents say their families have just enough to get by or are falling behind.
- And a shocking 84 percent predict the standard of living will be worse for the next generation.

Having insurance coverage is not insulating families from problems, concerns and dissatisfaction with today's health care system.

- Ninety-six percent of people with insurance say they are somewhat or very concerned about affording coverage in the next few years.
- Seventy-one percent of the insured worry about losing coverage because they may lose or change jobs.
- Almost two-thirds (61 percent) who have employer-provided coverage say their costs have gotten worse.
- Ninety-five percent of people with insurance are dissatisfied with health care costs, and 62 percent of them are dissatisfied with health care quality.
- Ninety-four percent of the insured say the health care system needs fundamental change or to be rebuilt.

But people who lack insurance—and those who have children younger than 18 who are not covered—report particularly troubling problems getting the care they need because of cost.

- In the past year, 76 percent of people who lack insurance themselves and 71 percent of people with uninsured children say someone in their family did not visit a doctor when sick because of cost.
- Sixty-seven percent of the uninsured and 66 percent of those whose children are uninsured report skipping medical treatment or follow-up care recommended by a doctor.
- Fifty-seven percent of the uninsured and 61 percent of people with uninsured children had to choose between paying for medical care or prescriptions and other essential needs (such as the rent or mortgage and utilities).

More than half of survey takers say their health insurance does not cover all the care they need at a price they can afford. Among them, people who buy their own insurance in the private market are more likely than those with employer-provided health care to report that critical needs are not covered or not affordable.

- Fifty-two percent of people who buy private coverage say prescription drugs are not covered or are unaffordable, compared with 44 percent who have employer-provided coverage.
- Forty-one percent who buy private insurance say preventive care and checkups are not covered or affordable, versus 36 percent overall.

Medicare is not a shield against unaffordable prescription drug prices.

- Fifty-three percent with Medicare, compared with 46 percent overall, say prescription drugs are not covered or affordable.

Concerns about today's health care system span all ages, races, education levels and affect the insured as well as the uninsured.

- A third of college graduates say they or a family member skipped recommended medical care because of cost.
- Half of people in insured families say their coverage does not cover all the care they need at a price they can afford.
- People of color, including 75 percent of African Americans and 76 percent of Latinos, are especially likely to voice dissatisfaction with health care quality.
- Large majorities in all age groups—from 74 percent among 18- to 29-year-olds to 80 percent among 50- to 64-year-olds—consider health care a very important voting issue for the 2008 elections.

The 2008 Health Care for America Survey gives voice to working families' concerns about health care in this critical election year, and the results will be shared with candidates for office across the country at every level. The survey exposes a health care system that costs too much, covers too little, leaves too many behind and is getting worse. The results deliver a mandate for health care reform to everyone who wants the support of working families in this year's elections.

Who is Really Getting Hurt?

“ My daughter was only 2 years old. Attending a hospital since birth because she has trouble breathing. She sometimes just stops....You feel helpless as her eyes grow wide like she has just seen a ghost. Finally it dawned on you...not again, she isn't breathing....Time seems to go by so slow but in a few moments she is spewing vomit and coughing. She is breathing again. When she was 3, I was offered a promotion. I knew I no longer qualified for Medicaid, so I did not fight it when they dropped us. I had no idea the terror I was to face. No one will cover my daughter....I go back to Medicaid....They tell me I would be better off to quit my job. I would lose our house and all I have worked for. Instead we pray for another healthy day and hope her lungs mature. For today a mother is helpless, a child suffers, and this is America. ”

JENNIFER,
Independence, Mo.

“ The 2008 Health Care in America Survey reveals tragic flaws in America’s health care system—flaws that provide more evidence that our country is headed in the wrong direction.

Our job in 2008 is to elect a president, Congress and leaders at every level who will work to Turn Around America. Health care costs are out of control. We have an economy that does not work for working families. Good jobs are disappearing. Our trade policies are disastrous. Workers are losing their freedom to form unions and bargain to improve their lives. Hard-working people are losing their homes, their home equity and their retirement security. Our schools and roads and bridges are crumbling underneath us.

The road to health care reform—and to an economy that works for all—runs through the 2008 elections.

We have to help candidates who support real reform become active champions for health care. And we have to expose and hold accountable candidates at all levels who oppose real reform and propose false solutions. ”

JOHN J. SWEENEY, AFL-CIO President

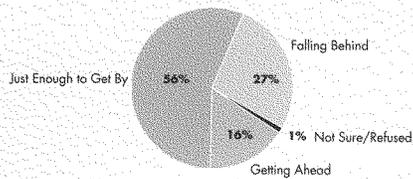
KITCHEN TABLE ECONOMICS

A QUICK LOOK AT THE DEMOGRAPHICS of who took the 2008 Health Care for America Survey makes it clear that these are people who *should* be experiencing the best of America's health care system and a secure place in our economy. They should be the foundation of the American Dream.

Seventy percent are employed, and 20 percent are retired. Seventy-seven percent are in insured families. Fifty-seven percent are union members (who, because they can bargain with employers, have better average wages and benefits than their nonunion counterparts) and 18 percent have a union member in the family or household. Fifty-one percent have completed college or postgraduate school, and another 29 percent have attended some college.

Nonetheless, most say they have just enough to get by or are falling behind economically. And a shocking 84 percent project the next generation will face a worse standard of living than we have today.

Working families are falling behind.
Which of the following best describes your family's financial situation?



No Real Raise

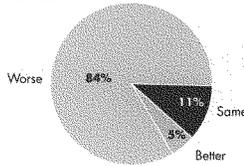
“ I have a job with a union contract. Every year, I get a raise that works out to be about \$12.00 per week. About the same time each year, I get a memo from my employer that my family's health insurance premium has increased by roughly the same amount. I have not seen a real increase to my take-home pay in 12 years at my company. Meanwhile, our family's bills for EVERYTHING else have risen, too. ”

TERESA, Vancouver, Wash.

Begging for Care
 I live in small
 Midwestern town.
 EVERY gas station here
 has a little can near
 the register asking for
 donations for husbands,
 wives, kids, who are sick
 and can't get treated,
 who are going under
 from the bills. For work
 injuries, cancer, heart
 problems, leukemia. No
 one should have to beg
 strangers for money
 to get health care.

LAUREL, Quincy, Ill.

Large majority lacks hope for the next generation.
 Do you think the standard of living for the next generation will be better than today, worse or about the same?



Nearly half of our respondents (46 percent) say they paid \$1,000 to \$5,000 out of pocket last year for health care (including premiums, deductibles and prescription costs); another 17 percent spent even more than \$5,000.

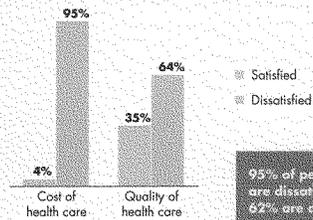
Out-of-pocket health care costs are big burdens for families.
 How much did you and your family spend out of pocket for health care in the past year?

Nothing	2%
\$1-\$100	4%
\$100-\$1,000	30%
\$1,000-\$5,000	46%
More than \$5,000	17%
Not sure/refused	1%

HEALTH CARE TODAY

DISSATISFACTION WITH THE COST OF HEALTH CARE today is overwhelming, according to our survey, and a majority also lack confidence in health care quality.

Nearly everyone is dissatisfied with health care costs—and almost two-thirds are not satisfied with quality.
Are you generally satisfied or dissatisfied with...



95% of people with insurance are dissatisfied with costs and 62% are dissatisfied with quality.

Less for More

“My son joined the National Guard and went to Iraq so his wife could have health insurance. A very heavy price to pay though luckily he survived his first deployment and we fervently hope he will survive future deployments as well.”

BARBARA
Winston-Salem, N.C.

Dig a little deeper and it's easy to see why: More than half (52 percent) say their health insurance does not cover all the care they need at a price they can afford, with prescription drugs topping the unaffordable list. An even larger proportion of Medicare beneficiaries (53 percent) say prescription drugs are not covered or not affordable—a telling statement about the failures of the Medicare Part D drug benefit, which blocks the government from negotiating with pharmaceutical companies to lower drug prices, is administered by private insurers and allows seniors to fall into a “donut hole” period when their drug costs are not covered. Preventive care—widely considered a cost-saving approach to health care—is uncovered or unaffordable for more than one-third (36 percent).

People who buy their own insurance in the private market are more likely than those with employer-provided coverage to say important care isn't covered or affordable—a caution to proponents of pushing people into private insurance.

Lost a Brother Last October

“ He didn’t have health care. His job didn’t provide health care. He was hurt on the job. His employer didn’t care enough to get him medical treatment. His injury progressively got worse. He didn’t have the money to get it taken care of.... After 2 years of pain and agony, he passed away. He was already in hell. Now I know he’s in heaven.... Love you brother. God rest your soul.”

ROBERT, Sunrise, Fla.

Health coverage is not meeting the need.

Among people who say their insurance doesn’t cover all the care they need at a price they can afford, what is not covered or not affordable?

	All	Employer-Provided Insurance	Medicare	Provides Own Insurance
Prescription drugs	46%	44%	53%	52%
Specialists	43%	43%	38%	44%
Tests	40%	39%	37%	44%
Preventive care and checkups	36%	33%	37%	41%

These cost obstacles are blocking people from getting at least some of the care they need—especially people who do not have insurance and who have children younger than 18 who lack insurance. One-quarter to one-third of respondents overall say their family has skipped needed care or medicines, had trouble paying bills or run up debt because of costs.

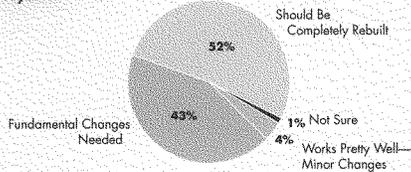
Cost keeps people from getting the care they need.

In the past year, did you or a family member experience any of the following:

	Overall	Uninsured	Have Children Under 18 Who Lack Insurance
Skipped medical test, treatment or follow-up recommended by doctor because of cost	33%	67%	66%
Did not visit doctor when sick because of cost	31%	76%	71%
Did not fill a prescription or skipped doses because of cost	29%	51%	56%
Had to choose between paying for medical care or prescriptions and other essential needs (rent/mortgage, utilities)	24%	57%	61%
Had serious problems paying or were unable to pay medical bills	23%	48%	56%
Ran up credit card or other debt you’re still paying off due to medical costs	22%	34%	39%

All in all, 95 percent of respondents to the survey say America’s health care system needs fundamental change or to be completely rebuilt. Seventy-nine percent say health care is a very important voting issue, and 97 percent say they plan to vote in the November elections.

Today's health care system is broken.
Overall, what do you think about today's health care system?



One fact that comes through loud and clear in these survey results is that problems paying for health care are not limited to the uninsured. Even among the insured, 94 percent say today's health care system needs fundamental change or to be completely rebuilt—and 95 percent are dissatisfied with the cost of health care. Ninety-six percent are somewhat or very concerned about affording health insurance in the next few years, and 71 percent of the insured are concerned about losing health coverage because of losing or changing jobs.

Stories submitted as part of the survey illustrate that people are struggling to pay rising premiums, deductibles and the costs of care that insurers refuse to cover. Others suffer because insurers refuse to cover people with pre-existing conditions.

Altogether, more than three-quarters (77 percent) of our respondents say they and their families have health care coverage, but 16 percent say some members in the household do not. In these households, 23 percent lack health care themselves, and more than half (53 percent) say an adult child is uninsured.

Who's not insured?
Among households in which someone lacks insurance, who does not have coverage?

Self	23%
Spouse/partner	18%
Children younger than 18	8%
Children ages 18-24	25%
Children 24 and older	34%
Other relatives [parent, sister, brother etc.]	24%
Not sure/refused	2%

Should I Call the Ambulance or Not????

“ A friend upstairs who has NO insurance fell backward in his apartment when I went to check on him...and had a seizure. I found myself debating... whether to call an ambulance for him or not because I knew I would be making his situation worse in that he would receive the bill for the ambulance as well as a bill for the hospital stay....I should never have to debate calling for help for myself or others.”

EDWIN, Los Angeles, Calif.

My Mother's Mastectomy

“ My mother had breast cancer, from which she eventually died. When it was determined that she need to have a radical mastectomy, it was done as an OUTPATIENT procedure, because that was all her medical insurance would pay for. She was sent home with an IV.”

ELLEN, Mt. Juliet, Tenn.

Employers provide most insurance—by far.

Do you or your family have health care coverage? If yes:

Coverage provided through employer (yours, spouse's, partner's or parents')	78%
Medicare	20%
Coverage purchased by you or someone in your family	15%
Other	9%
Not sure/refused	3%

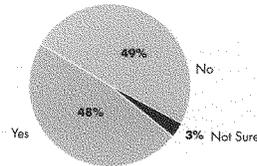
But almost two-thirds (61 percent) of respondents with employer-provided coverage say their costs have gotten worse in the past couple of years. (Twenty percent say costs stayed the same, and 2 percent report they improved.)

Health coverage has become a major factor in virtually all union contract bargaining, with increasing employee cost-sharing consuming wage increases and other improvements for which unions are fighting. Union members are acutely aware of these effects: 67 percent of members and 66 percent of people in union households say their costs for employer-provided coverage have gotten worse.

For union and nonunion workers alike, the value of health coverage is tying people to jobs they might otherwise want to leave. Nearly half the respondents in our survey (48 percent) and 60 percent of Latinos say they or a family member has stayed in a job just to hold on to health care benefits.

Almost half stayed in jobs for health care.

Have you or has a family member stayed in a job to maintain health benefits when you would have preferred changing jobs?



60% of Latinos or their family members stayed in jobs for health care.

HEALTH CARE IN THE FUTURE

“**HEALTH CARE REFORM** should control costs and ensure everyone gets health care at least as good as what they have now,” according to 83 percent of respondents. “It should let people choose their own doctor and establish government as a watchdog on quality and costs.”

Conversely, only 13 percent agree with a statement summarizing a “free market” approach to health care: “Health care should be based on the current private insurance market. If we let the market do its job, companies will compete for customers and

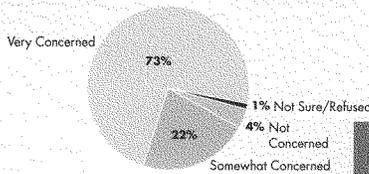
Simple Wishes of a Physician

“As a physician, I have simple wishes for our health care system. I would like to be able to care for all comers on equal footing, regardless of their socioeconomic status. I should not have to decide on a ‘second best’ option, because a patient does not have health insurance, or because their insurer is unreasonable.... All my career I have fought for a fairer system. We cannot continue with such a two-tiered system. Health, not just health care, is a human right. Everybody deserves high quality, affordable health care.”

LISA, Seattle, Wash.

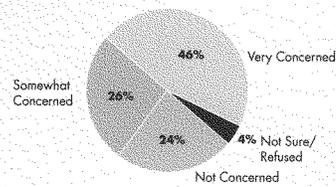
Affording insurance is a real worry for the near future...

Looking ahead over the next few years, are you concerned about affording health insurance?



95% of insured people are concerned, too.

...So is losing coverage along with a job. Are you concerned about losing health coverage because you may lose your job or change jobs?



71% of insured people are concerned.

Scared to Retire!

“I’m a 64-year-old single grandmother raising my two grandchildren. Now we’re all covered under my employer. When I retire my employee health coverage will end because I will qualify for Medicare, but my grandkids will have no coverage. It appears that I will make just too much money with my pension and Social Security for them to qualify for [state aid], but I don’t know that I can keep my house and buy private insurance for them, too. Both kids have disabilities that require daily medication and ongoing therapy. I’m tired—very tired, and I’d love to retire, but I’m too scared. I don’t think we’d make it if I do.”

PATSY, Milwaukee, Wis.

that will control costs and quality. People who don’t have health coverage now should get tax incentives to help them pay for insurance.”

In conflict with their vision for what the health care system ought to be, looking ahead toward health care in the future is a frightening prospect for many who see costs rising out of reach for life-saving treatment and medicines. Ninety-five percent of the people who took the 2008 Health Care for America Survey—and an equal portion of respondents with insurance—are concerned about affording health insurance over the next few years. Nearly three-quarters (72 percent overall and 71 percent among the insured) are concerned about losing health coverage because of losing or changing jobs, including almost half (46 percent overall and 43 percent of the insured) who are very concerned. Forty- to 49-year-olds make up the age group most likely to have this worry, with 81 percent very or somewhat concerned about losing coverage along with a job.

When painting a picture of the health care system they would want to see for the future, respondents see many solutions that will help people like them. They are especially supportive of covering preventive care and establishing a watchdog on drug and insurance companies to reduce costs.

We need preventive care coverage and a watchdog on costs.

Choose whether you think each of the following is a good idea or a bogus solution:

	Good idea	Not a good idea	Not sure
Cover preventive care at little or no cost	93%	5%	2%
Establish a watchdog on drug companies to reduce costs	90%	7%	3%
Set rules and establish a watchdog on insurance companies to reduce costs	87%	9%	4%
Offer choice of health insurance plans at least as generous as members of Congress receive	85%	12%	3%
Use technology to increase efficiency and reduce paperwork	85%	10%	5%
Require employers to provide health care coverage or contribute to its cost	76%	19%	5%

When it comes to the future for our children...

People who responded to the survey are deeply concerned about the future for their children. In addition to worries about health care, they cite the economy, the environment, rising college costs, eroding retirement security and the massive imbalance of wealth and corporate power in America.

But the sense that America's people and our unions are poised to bring about significant change gives the survey respondents hope for the next generation—as does the intelligence, resourcefulness and decency of their children.

...What concerns you most?

"The fact we've bankrupted future generations....The system we have now is brutal and it runs roughshod over our most vulnerable citizens: children, the poor, and the elderly."

"Losing the middle class."

"Will our children really be able to live the American Dream?"

"My concerns are greater than my hopes. I see my children struggling to make ends meet every month. I see that struggle becoming even harder when the grandchildren get sick because there is no insurance to cover the health cost. Even the cost of a doctor's visit and medicine cannot be met without a bill going unpaid or less food on the table. A great education is not worth much if you can't find a job that will let you pay your bills, put food on the table and furnish you with an affordable health insurance."

"That it will take a generation or more to undo the damage that seeing health as a commodity has caused."

...What makes you most hopeful?

"My willingness to fight for that better future."

"History. When things get bad enough, the people will finally stand up and bring about change. The role of the union will be to direct that change."

"Electing a president that will watch out for the middle class, which this current status administration has not."

"People in America always seem to be able to overcome adversity when they work together. Hopefully, we will have better leaders that will be able to recognize what a dynamic country we live in and the strength of the people."

What's wrong with this picture? And what's wrong with this country?

“ I’ve done everything right. I studied hard, graduated university with honors, went to work, delayed marriage and childbirth, had only two children, stayed happily married to a PhD’d husband. What happened? My husband’s...new job provides no coverage, nor does mine. Our kids skate & bike; we ride in cars daily. It’s risky.... I’m studying first-aid and stocking up on sutures and balsa wood for folks to bite down on if need be. It’s the 1830s all over again. ”

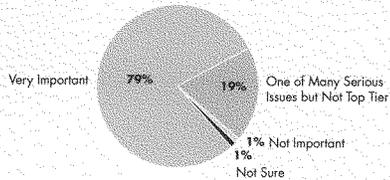
SILVERSTEIN, Santa Clarita, Calif.

TURN AROUND AMERICA: HEALTH CARE

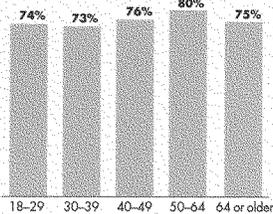
THE RESULTS OF THE 2008 HEALTH CARE FOR AMERICA SURVEY would be depressing were it not for the commitment of working families to become active on health care to help Turn Around America.

Health care is a very important voting issue...for ALL ages.

How important is health care to you as a voting issue in the 2008 elections?



People who say health care is a very important voting issue, by age:



I Couldn't Believe What America Did to Our Elderly!

“ I work in a pharmacy for an HMO. When 2007 came around for our Medicare patients, I just couldn't believe what they had to pay for their meds out of their pockets. This one patient had to take out a loan from her house in order to pay for her medications and she was in tears....Our politicians need to come out to the real world and stand in line at the hospitals and see what Americans have to go through just to get health care. **”**

EVELYN, Riverbank, Calif.

Let's Hope

“ My family is experiencing a financial meltdown because of the lack of affordable insurance. We simply had to give up our insurance because the monies that were needed for our health coverage are excessive.... Let's hope the upcoming presidential and local elections put people in office who truly care about this extremely critical issue. ”

CATHEY, Lockport, N.Y.

Ninety-seven percent of respondents say they are registered to vote, and the same proportion say they plan to vote in November. Across all age groups, large majorities (79 percent overall) consider health care a very important voting issue in the upcoming election.

In addition to voting, survey respondents are willing to take a range of actions to improve health care.

People are ready to act.

What steps would you be willing to take to improve health care?

Sign a petition	90%
Send an e-mail to a friend or elected official	72%
Talk to family/friends about the issue	71%
Write to or visit an elected official	61%
Attend a rally/demonstration	45%
Write a letter to the editor	39%
Actively volunteer for a political party or candidate	31%

By and large, they are at least somewhat informed about the presidential candidates' health care proposals, with 89 percent saying they have heard some or a lot, while only 10 percent say they have heard nothing. Familiarity with candidates' health care proposals is shared by all age groups, including 89 percent of 18- to 29-year-olds.

What advice would you like to give to elected officials and candidates about America's health care system?

When asked what advice they would like to give to elected officials and candidates about America's health care system, people spoke out strongly for health care that covers everyone and for letting doctors rather than insurance companies make the decisions. They want health care as good as what their elected leaders receive—and for officials to experience or at least understand the system in which the rest of us are living.

"Let's catch up with the rest of the world and adopt a universal health care plan and insure everyone. Let's make health care a human right like it should be."

"Try living for a year as a regular person under the present system."

"I want the same as you have. Because I am paying for you and your family."

"Our present health care system is a disgrace. It is a criminal enterprise. You cannot have a for-profit health care system.... Don't tell us you don't have the funds for universal health care. If you can spend a trillion dollars on an unproductive and illegal war, you can provide us with universal health care."

"Americans deserve health care for all. Our elected officials have some of the best health care available, while their constituents suffer. We are in a health care crisis, and the citizens of other countries far surpass us in the quality of care they get."

TAKE ACTION!

Sign up now to be part of the fight to Turn Around America and to win health care we all can count on. Use the form on page 22 or sign up online at www.aflcio.org/healthcare.

ABOUT THE 2008 HEALTH CARE FOR AMERICA SURVEY

SOARING HEALTH CARE COSTS are a major factor in the economic upheaval facing today's working families. Costs are rising much faster than our wages or inflation, pushing working families into housing problems and bankruptcy, undercutting bargaining and making it impossible for our employers to compete with overseas companies and domestic competitors with low standards.

Largely because of rising costs, 47 million people in this wealthy and powerful country—including 8.7 million children—have no health coverage at all.

In this election year, the AFL-CIO and community affiliate Working America wanted to give voice to working families' concerns about health care—a voice we could share with candidates running for office at every level in every part of the country.

From Jan. 14 through March 3, 2008, a total of 26,419 people participated in the survey. (See the survey at www.aflcio.org/healthcaresurveyform.) They submitted 7,489 heart-wrenching stories about their experiences in America's broken health care system.

The survey was featured on the AFL-CIO website, and Working America, affiliate unions and state and local labor councils linked to the survey as well. Through the Working Families e-Activist Network, the AFL-CIO and 30 partner organizations sent e-mails urging activists to take the survey and encourage their friends and family to take it, too.

Altogether, more than 35 organizations promoted the survey through links and e-mails. These include eight national unions: (AFGE, AFSCME, AFT, BCTGM, IBEW, UAN, UMW)

Working America, community affiliate of the AFL-CIO, combines the strength of union men and women and that of workers without the benefit of a workplace union. The result is a force of 10.5 million working people who share common challenges and goals to fight in communities, states and nationally for what really matters—good jobs, affordable health care, world-class education, secure retirements, real homeland security and more.

To join Working America, visit

www.workingamerica.org.

Peter D. Hart Research Associates tabulated and analyzed the response data for the 2008 Health Care for America Survey.

and USW); nine state labor federations (Ariz., Calif., Iowa, Ill., Minn., N.H., N.J., S.D. and Vt.); nine area and local labor councils; the constituency groups Pride at Work and the Coalition of Labor Union Women; and allied organizations including the Alliance for Retired Americans, American Rights at Work, Campaign for America's Future, Jobs with Justice, Union Privilege, USAction and the Universal Health Care Action Network.

Of the people who took the survey, 57 percent are union members, and 18 percent live in households with a union member. Seventy-seven percent are in insured families—including 83 percent of union members, who are able to bargain for employer-based coverage. Seventy percent are employed, and 20 percent are retired. The largest age group of respondents (49 percent) is 50 to 64 years old. Eighty-six percent are white, and 51 percent have completed college or post-graduate studies.

Here's a look at them:

Employment

Currently employed	70%
Retired	20%
Not currently employed and not retirement age	9%
Not sure/refused	1%

Age

18-29 years	5%
30-39 years	12%
40-49 years	21%
50-64 years	49%
65 or older	12%
Not sure/refused	1%

Education

Schooling level completed	
First-11th grade	1%
High school graduate	11%
Non-college post-high school (technical school, etc.)	9%
Some college	29%
College graduate	27%
Post-graduate school	24%

Race/Ethnicity

White/Caucasian, non-Hispanic	86%
African American, non-Hispanic	5%
Hispanic/Latino	4%
Asian Pacific American/East Asian	1%
Native American	1%
Biracial/Multiracial	2%
Not sure/refused	1%

Household

Check all that describe you	
Student	7%
Have children younger than 18 living with me	22%
Married	57%
Domestic partner	8%
LGBT	4%
Union member	57%
Someone in my family or household is a union member	18%
Not sure/refused	9%

Count Me In—For HEALTH CARE We Can Count On!

We've bargained hard for our health benefits. But lately we've been forced to sacrifice well-deserved wage increases in exchange for health care. And it's getting worse.

It's time to cap skyrocketing costs, protect our health care, fix a broken health care system and provide secure, high-quality health care for everyone in America.

Join the national fight to protect health care for those who have it—and to provide secure health care for those who don't!

**Find out more and sign up online at:
www.aflcio.org/healthcare
or complete and mail in the form below**

COUNT ME IN—FOR HEALTH CARE WE CAN COUNT ON!

- I will take action to protect our health benefits, fix America's broken system and provide health care for all who need it. I will:
 - Talk to my co-workers, family and friends about health care.
 - Support my union in bargaining for good health benefits.
 - Urge candidates and elected officials to support secure, high-quality health care for all.
 - E-mail friends and contacts about health care.

<small>FIRST NAME</small>	<small>MI.</small>	<small>LAST NAME</small>
<small>EMAIL ADDRESS (IMPORTANT: We'll contact you with information, alerts and tools you can use to win health care reform.)</small>		
<small>HOME ADDRESS</small>		
<small>CITY</small>	<small>STATE</small>	<small>ZIP</small>
<small>BEST PHONE NUMBER TO REACH YOU</small>		
<input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Cell		
<small>NATIONAL UNION</small>		<small>LOCAL</small>
<small>EMPLOYER</small>		

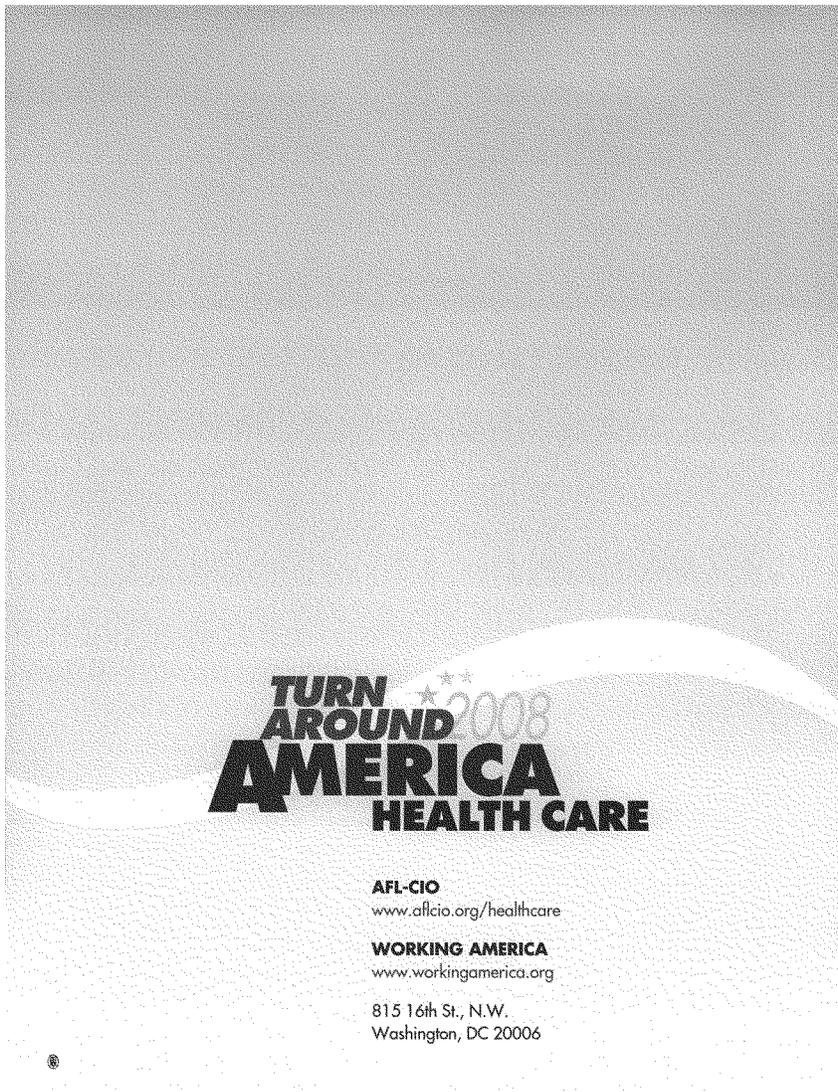
- Are you a local union officer? Yes No Are you a steward? Yes No
- I am not a union member and want to join Working America, the AFL-CIO community affiliate.

Sign up online at www.aflcio.org/healthcare or complete this card, place it in a stamped envelope and mail to: AFL-CIO Health Care, 815 16th St., N.W., Washington, D.C. 20006. Please include your e-mail address—the fastest and most cost-effective way for us to reach you.

Brother Falls

“ He was a force to be reckoned with, lifelong union man, community activist, father, brother and grandfather. After a life of putting other people first, his health began to deteriorate. One fateful day last year he went in for his daily dialysis. Little did he know that this life-giving process could put him at death’s door. To say that his family went through a nightmare for three days while he wasted away in a small local community hospital is putting it mildly. They told his family that it was his time to go and that they should prepare themselves to “let him leave.” Instead, they accepted the help from the very people that he himself had helped so many times before. After what amounted to a small short-lived major revolt in the small hospital’s waiting area, he was finally frantically transferred (via helicopter) to another facility where he magically came back to life....It was not his time to go and...it is in fact our time to fight.”

NANCY, Los Angeles, Calif.



**TURN
AROUND** ^{***}2008
AMERICA
HEALTH CARE

AFL-CIO
www.aflcio.org/healthcare

WORKING AMERICA
www.workingamerica.org

815 16th St., N.W.
Washington, DC 20006

American Federation of Labor and Congress of Industrial Organizations



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July 14, 2008

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Baucus:

Thank you for the opportunity to provide testimony before the Finance Committee at the June 3rd hearing on "Rising Costs, Low Quality: The Necessity for Reform." I was pleased to be able to offer our views on behalf of the AFL-CIO.

Please find attached my responses to the written questions from members of the Committee. I would be happy to provide any additional information the Committee may request.

The AFL-CIO commends the Committee for launching this series of hearings on health reform and laying the groundwork for a national debate on how best to secure affordable, high-quality health care for all Americans.

Thank you, again, for the opportunity to appear before the Committee.

Sincerely,

Arlene Holt Baker
Executive Vice President

Attachment
AHLB/kcm

Question from Senator Bingaman on health reform and private sector inefficiencies: How would you suggest that Congress address these very significant market failures as it contemplates broad health reform?

We agree the market has failed to efficiently or effectively deliver high quality, affordable health care to all Americans. Insurance companies are businesses that perform best when they collect more in premiums than they pay in claims. As a result, individuals who actually need health care are frequently charged more or turned away for coverage. In addition, consumers and purchasers lack information on quality and effectiveness that can inform their health care choices. And in the absence of this information, our payment system will continue to reward volume rather than quality of care.

Congress can and should address these failures and inefficiencies as part of its health reform efforts. To begin, government has a critical role to play in establishing a more fair and cost-effective health care system. Insurers must abide by rules that guarantee access to affordable coverage regardless of the factors insurers regularly use to price their plans, including age, gender, and health status.

Government can also use the purchasing power of Medicare to require greater information on quality of care and to transform our reimbursement system to one that rewards quality. We have joined with our employers and health plans to leverage higher value health care through our purchasing. Yet these efforts can have only a limited effect in our fragmented system, creating silos of improvement. Medicare can use the purchasing power of 44 million Americans to drive these improvements further and more effectively.

There are many other policies Congress can enact to make the market work better. Among those is a substantially increased investment in research on the comparative effectiveness of different treatment options in order to realize cost savings without compromising care. Another set of policy options would improve competition in the prescription drug market by lowering barriers to approval of generics and authorizing approval of biogenerics.

If, as most believe, broad health reform will build on the strengths in our current system while addressing its shortcomings, government will have a critical role in correcting the market failures at the heart of many of those shortcomings.

Question from Senator Bingaman on Special Needs Populations: How can we ensure that the health care needs of all populations are met through health reform?

Clearly a necessary first step in ensuring that the health care needs of all populations are met will be to cover everyone. But the quality of coverage – and whether or not it guarantees access to needed care – is equally important. Getting everyone covered will mean very little if we have not thought through what that will mean for all populations getting care. We will, of course, have to eliminate perhaps the most commonly recognized barrier to care: affordability. Even modest cost sharing can be a barrier to care for some. Another widely recognized barrier is language. Health reform must improve access for individuals with limited English proficiency. But we will have to push our thinking further to consider all

factors affecting access to care. For example, if a low-wage worker must forgo pay or even risk her job to keep a doctor appointment during work hours, she is not likely to get the care she needs. Health reform must aim to provide everyone the coverage they need – and access to the providers they need – if we want a health system that keeps people healthy and provides care when they’re sick.

Question from Senator Bingaman on Improvements in Employer-sponsored Health Insurance: Would you favor reforms that brought more transparency, consistency, and accountability to health outcomes for employer-sponsored health insurance offerings?

As noted above, we fully support efforts to bring greater transparency, consistency and accountability to health outcomes. Whether in bargaining or in our advocacy work, we have partnered with our employers and health plans to promote that approach. One recent example of that is the “Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs,” which has been endorsed by leading physician groups, health plans, labor and consumers. The Patient Charter is a national agreement to guide, in a meaningful and fair manner, how health plans measure doctors’ performance and report the information to consumers. However, these private purchasers can have only limited effect on quality and cost in our fragmented system. A better, more comprehensive approach is to use the purchasing power of Medicare to drive improvements in this way.

Question from Senator Rockefeller on Retiree Health: What do you think should be done to help early retirees secure affordable health care coverage? I’d like to know your thoughts on the Medicare buy-in concept as well as any other potential solutions that you believe Congress should consider.

Retirees, in many ways, represent some of the key challenges we’ll face in health reform. If retirees are not yet eligible for Medicare and don’t have coverage from their former employer, they have no affordable options for coverage in the individual market because of age and pre-existing conditions. We need to make sure coverage is available and affordable for all, regardless of age and health status. And we should support those employers that carry the cost of covering retirees because those plans are the best and most affordable option for retirees.

Proposals that help alleviate costs for employers are the most effective approach to shoring up employer-sponsored retiree health benefits. An example of this has been the Retiree Drug Subsidy in Medicare, which helps reduce costs for employers that maintain prescription drug coverage for their retirees while minimizing costs for the federal government. Reinsurance has been proposed to more broadly spread the costs of the highest cost individuals. And the Medicare Buy-In bill, as introduced by Senator Rockefeller, would help both employers who continue their retiree health benefits, as well as early retirees who are uninsured, by providing a stable, affordable source of coverage.

Elizabeth A. McGlynn, Ph.D.¹
The RAND Corporation

*The Case for Keeping Quality on the Health Reform Agenda*²

Before the Committee on Finance
United States Senate

June 3, 2008

Chairman Baucus, Ranking Member Grassley, and members of the Committee on Finance, I am honored to have the opportunity to testify before you today about the problems with health care quality. On a personal note, I am delighted to appear before my Colorado College classmate, Senator Salazar. Go Tigers!

I applaud the Committee for including quality as a topic for consideration in the debate about health care reform. All too often people assume that if we take care of the problems with cost and access, the quality problem will solve itself. The most important message I can leave you with today is this: if we find solutions to the problems of uninsurance and underinsurance and we control rising health care costs we will not have solved the quality problem. It is a separate problem. It requires separate solutions.

My testimony today covers three main areas. First, I will review with you some of the evidence about the problems with quality. I define quality as occurring when the right care is delivered to the right person at the right time, every time. Second, I will discuss some of the reasons these problems with quality exist. Third, I will highlight promising directions for solutions to these problems.

The Quality Problem

It is commonly said that the United States has the best health care system in the world. Although on many levels that is true, this assertion ignores the substantial gap that exists between what we know works and what is provided in the U.S. health care system. In 2003, my colleagues and I published in the *New England Journal of Medicine*, the first national, comprehensive study on quality of care for adults. We examined 439 indicators of quality for 30 clinical areas. We found that,

¹ The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

² This testimony is available for free download at <http://www.rand.org/pubs/testimonies/CT306/>.

on average, American adults received just 55% of recommended care for the leading causes of death and disability. To make that more concrete, participants in our study needed an average of 16 health care services – like mammograms to screen for breast cancer, flu shots, and medications to control blood pressure and blood sugar – over a two year period and they received about 8 of those services. We spend nearly \$2 trillion annually on health care and we get it right about half the time. That may be the best in the world, but I think you would agree that we can and should do better.

We found problems across the board with preventive care (like flu shots), care for acute health problems (like colds), and care for chronic conditions (like diabetes). Adults received 55% of needed preventive care services, 54% of recommended care for acute health problems, and 56% of the care that doctors agree is necessary for people with chronic conditions.

Looking at the continuum of care, we found adults received 52% of needed screening services (like pap smears to screen for cervical cancer), 56% of services to accurately diagnose illnesses (like testing the lung function of people with asthma), 58% of needed treatments (like prescribing the right antibiotic for pneumonia), and 59% of needed follow-up care (like monitoring whether treatment for diabetes is effective in controlling blood sugar).

We evaluated how well the health care system delivered care for 30 common health care problems and found wide variation ranging from 79% of needed care for people with cataracts to 11% of needed care for persons identified by their doctors as having an alcohol dependence problem. In between those two extremes we found that 76% of needed care for breast cancer was delivered, but just 54% of needed care for asthma, 45% of needed care for diabetes, and 39% of needed care for pneumonia was delivered.

Colleagues of mine at RAND have published the findings of similar comprehensive studies of the quality of care delivered to vulnerable elders – people over the age of 75 who are at increased risk of significant declines in their health and functioning. Their results were similar to ours for problems common to all adults. But, for problems unique to the vulnerable elderly – like dementia, falls that can lead to hip fractures, and urinary incontinence – they found that these patients received just one-third of recommended care.

Last year, my colleagues and I published in the *New England Journal of Medicine*, results from a national study of the quality of care delivered to children. We found that, on average, children were receiving just 47% of recommended care overall. We were perhaps most surprised to find that children were receiving just 41% of the preventive services that they needed. Children with chronic illnesses received about 53% of needed services. The best performance was in care for acute

health problems (colds, urinary tract infections) where we found that 68% of needed care was delivered.

At the time, people said to us – “well, there may be problems across the country, but the care in my local area is much better than that.” We had collected enough information to allow us to construct quality scores for 12 metropolitan areas around the country. We found remarkably little variation in quality, ranging from 51% of recommended care delivered in Little Rock in Senator Lincoln’s home state to 59% of recommended care delivered in Seattle in Senator Cantwell’s home state. When we published these findings, the *Seattle Post Intelligencer* headline read “Seattle Best of A Bad Lot” – I thought they got it about right. I’m sure Senator Kerry would be disappointed to find that Boston, a well-known medical mecca, was second to Seattle at 57%. Performance in other communities located in states represented on this committee included: 56% in Syracuse and 55% in Lansing and Phoenix.

The communities we studied were very different in terms of median income, the proportion of the population living below the poverty level, the proportion of the population lacking insurance, the number of hospital beds and physicians per 1000 population, and the penetration of managed care. These factors had no relationship to the quality of care delivered in the community. The relatively small differences we found in these very disparate communities have led most people who have looked at our study to conclude that their own community probably performs similarly.

The next comment we heard was – “well, quality may be a problem nationally and even in my community, but my care is excellent.” In 2006, we published in the *New England Journal of Medicine* what we had found about who was at risk for receiving poor quality care. We found that everyone is at risk. We found no substantial advantages for population subgroups defined by gender, age, race, income, and insurance. We know these factors may make a difference in determining who gets in the door of the medical care system, but once in it appears that those factors convey little advantage.

The consequences of these failures to deliver needed care are significant. We found that 40% of persons with diabetes in our study had not had their blood sugar measured in the past two years. Such measurements are essential for tracking whether treatment regimens are effective – and for guiding changes to those regimens to prevent avoidable consequences. Among those who did have their blood sugar measured, nearly one-quarter had levels that were too high. Using models developed by the Diabetes Control and Complications Trial, we estimated that these quality gaps are associated with 2600 cases annually of preventable blindness and 29,000 cases annually of preventable kidney failure.

We found that 58% of persons with hypertension in our study did not have their blood pressure adequately controlled. We estimated that this quality failure contributes to 68,000 preventable deaths annually from stroke, heart attacks, and other causes.

Among persons in our study who had a heart attack, 39% failed to receive aspirin and 55% failed to receive beta blockers. These failures are associated with 37,000 preventable deaths annually – many occurring in the 30 days following the heart attack. This is one area where we have seen substantial improvements thanks largely to routine monitoring and reporting of performance by the Centers for Medicare and Medicaid Services, the National Committee for Quality Assurance, and the Joint Commission.

Among those in our study over the age of 65, more than one-third had not received a pneumococcal vaccine, which is effective in preventing the most common type of pneumonia. This level of performance is associated with 10,000 preventable deaths annually. On a side note, while we were doing this study much attention was given in the media to SARS – a disease we had no clear tools for prevention or treatment and which killed 813 people worldwide. Pneumonia – a disease we know how to prevent and treat and which affects many more people receives little public attention.

Finally, we found that 62% of study participants who were age 50 and older had not been screened for colon cancer using one of four methods that are known to be effective in early detection of this disease. This level of failure to screen for colon cancer and commence treatment is associated with 9600 preventable deaths annually.

Our colleagues studying the vulnerable elderly found that there was a significant association between the proportion of recommended care received and the likelihood that an individual would survive for the next three years. Poor quality causes premature death and disability.

In summary, there are significant gaps in the quality of care delivered nationally. Those gaps can be found in your community. Those gaps are likely to be experienced by you and the people most important to you. While we were conducting this study my father was hospitalized with congestive heart failure for the third time in about 18 months. In looking at his medical records (which he would only ask for after he was discharged from the hospital for fear of upsetting his doctor), we found that he was not on the right medications and he was on subtherapeutic doses of the medications he was receiving. My father was insured, educated and had been a hospital administrator for more than 30 years. And even he was failing to get the care he needed.

Why Is Quality So Poor?

There is no single answer to the question – why is quality of care so poor? And it is tempting to point fingers in an effort to make the problem someone else's fault. But we are all part of the problem and we can all be part of the solution.

A starting point, and a key factor in motivating my colleagues and I to study this problem, is the lack of awareness about the quality gap among the public, health professionals, and policy makers. We are making strides in this regard but a lot of work remains to be done. The reason I believe we need to continue to raise public awareness is that if you do not believe you have a problem, you have no motivation to invest in finding and implementing solutions. For individuals, the lack of awareness can be dangerous – people may not take sufficient responsibility for making sure that they get the care they need. For health professionals, the lack of awareness may lead them to fail to demand access to the tools that can help close the gap. For policy makers, the lack of awareness can lead to failing to look for solutions and ignoring the policy options that could help stimulate improvement.

Another factor is the sheer explosion in knowledge about what is possible. In the last 5 years, for example, there were 4,424 articles registered on Medline reporting the results of clinical trials related to hypertension (and 22 review articles). For diabetes, 5,319 articles were published along with 10 review articles. For coronary artery bypass graft surgery, 1,453 articles were published and 5 review articles. Just reading the articles relevant to the diseases a physician is treating in his or her own practice would take more time than most practicing physicians have. But reading an article does not help one figure out (except rarely) whether one's practice should change as a result of the study. Review articles are designed to help provide summaries across large numbers of articles, but even those may not offer insights into how practice should change. Advances in science, while critically important and something we point to as an advantage of the American health care system, may be difficult to incorporate effectively into practice. One study found, for example, that it takes about 17 years on average for a new therapy to enter into mainstream practice. Our own study focused on the basics of good medical care. We did not look at how well medical care is delivered at the cutting edges, just at bread and butter medicine. And we found substantial failure on the basics. As knowledge accelerates, the gap is likely to widen.

Third, the U.S. health care system is a technological anomaly. We have made incredible advances in the availability of diagnostic machines, chemicals to treat or cure illnesses, microsurgical techniques to repair the ravages of disease or injury. Yet most doctors and hospitals rely on barely legible, handwritten notes to track what is done to a patient and how the patient responds to treatment.

Doctors are also expected to maintain in their individual memories the appropriate approaches to diagnosing and treating a wide variety of diseases as they are manifest in human beings of radically different designs (age, race, height, weight, other health problems). By contrast, airline pilots are only allowed to fly one type of airplane and rely on extensive checklists and computer monitoring to ensure its safe operation. Nonetheless, we are surprised when physicians, using systems from the 19th century, and subject to the limitations of being human, fall substantially short of perfection.

Fourth, the health care delivery system itself is organized to deliver care reactively more than proactively. The delivery system reflects a time when the majority of health care problems were acute illnesses requiring the patient to show up at the doctor's office or hospital with symptoms. The health care system responded with what limited tools were at its disposal. As science has advanced and acute illnesses have given way to chronic diseases, the organization of care has not really changed. Patients initiate most of the health care visits with little prompting from their physicians. Patients often show up with multiple problems but no advance warning of what services they might require. The process is like running a meeting without an agenda (and often without notes about what happened at the last meeting). Visit lengths are short (17 minutes on average) and the patient and doctor may have very different objectives for the visit. When you add the individuality and complexity of most patients to the range of options for intervening, I think it is remarkable that the health care system gets it right as often as it does.

Finally, our methods of paying for health services are not aligned with the objectives of delivering high quality. We pay for piecework. We pay more money for more services whether or not they are needed. We may effectively pay less if a doctor keeps a patient healthy. We pay more for interventions than we do for thinking and talking to a patient. More recently there have been efforts to reward physicians who deliver better quality on select measures of performance. There is rarely enough money devoted to these strategies to offset the otherwise dysfunctional payment system. I do not think that the payment system caused the problem with quality, but I do believe that it presents a barrier to improving quality.

So What Can Be Done?

Although the focus of this hearing is on the problems of rising costs and low quality, I would like to offer some thoughts about solutions.

My colleagues and I conducted a study comparing quality of care in the Veterans Health Administration with that in the U.S. We were interested in studying the VHA experience because

they have implemented many of the ideas that people have suggested might improve quality. They have one of the most mature electronic medical records systems in the country. The system includes reminders and protocols to help physicians deliver care consistent with standards. They routinely measure and report on the quality of care delivered in their facilities. Regional administrators have performance incentives as part of their compensation package.

We found that veterans receiving care in the VHA received recommended care about two-thirds of the time – significantly higher than the U.S. average. We found that the greatest difference was in those clinical areas where the VHA routinely measures and reports on quality, includes financial incentives for managers, and has decision support tools imbedded to facilitate clinical care. In those clinical areas where no measurement, incentives, or decision support was available, quality was still significantly better than the U.S. average, but the difference was relatively small. I think of this difference as the improvement you get in moving from paper records to electronic records.

I use this study to make a point: no single solution will close the quality gap. Rather we must engage in a sustained and multi-faceted approach to the problem. The VHA did not arrive at its superior performance overnight and we should not expect anything different from the rest of the health care system.

The starting point for improving quality is accelerating the adoption of interoperable, interconnected health information technology. We need this technology in every hospital, every doctor's office, every nursing home, every home health care provider, every school clinic. We need those systems to be able to talk to one another. We need health professionals to be trained to use the tools that can be imbedded in these technologies. And we need patients to have access to their own information. It is hard to imagine how any of the other solutions are possible or as effective in the absence of a modern information system. Such information systems will help physicians and patients more effectively partner to ensure optimal health. For this to happen, we need to invest not only in hardware and software, but also in "peopleware." If you look at the VHA and other systems that have successfully adopted information technology, they have also had large teams of people helping health professionals make the transition.

As a byproduct, widespread adoption of information systems will facilitate quality measurement, which in turn will enhance transparency efforts. Today, largely because of limits on the data systems in use, consumers have available relatively little information about the performance of different parts of the health care system. Reducing the burden of data collection (which will require enhanced and new functionality in health information systems) will increase the number of areas that can be measured and publicly reported on. It will mean that you and your family can get information that is relevant to your health concerns.

We need to look at reforming the payment system to remove disincentives to improving quality. This likely will require fundamental overhaul, but there are clear examples of systems that have improved substantially even in the face of the current payment system. So, while it is not a rate limiting factor, it is likely that changes in payment policies will lead to accelerated quality improvement activities.

I would like to close with a final observation. The hearing today pairs the problem of rising health care costs with the problem of low quality. There is considerable support for the idea that improved quality will lower health care costs. While there are certainly examples of better quality being cheaper (where the quality problem is use of services that are not medically necessary), there are other areas where we would expect improved quality to increase costs (where the quality problem is the failure to deliver care that is known to be effective). The history of quality improvement for more than five decades shows greatest interest in improving quality to achieve cost reduction objectives. I hope this Committee has the courage to support efforts to improve quality whether or not it saves money. I hope you will be committed to improving quality because it is the right thing to do. It is possible that we as a nation will spend as much money as we are spending today – but we can substantially improve the value of that expenditure if we focus on making real the claim that America has the best health care system in the world. We can and we must deliver on that promise. Thank you.

Elizabeth McGlynn
Answers to Additional Questions from Senate Finance Committee
June 3, 2008

Questions From Senator Bingaman

Question: How would you suggest that Congress address these very significant market failures as it contemplates broad healthcare reform?

Answer: I will leave to the economist on the panel, Dr. Ginsburg, to comment on the degree to which we can ever reasonably expect the health care market to function as a free market. However, among the sources of market failure, asymmetry of information is one area that Congress has and can continue to motivate improvement. Medicare has made a great beginning in this area through the public release of information about the quality performance of different hospitals and nursing homes. This information is readily accessible on the Internet. The hospital information, however, currently covers only about one-quarter of the conditions treated in hospitals so Congress could provide support for expanding the number of available quality measures. More recently there has also been a focus on price transparency. The efforts to date have not been successful for a number of reasons including differences in the way information is presented. Congress could recommend that CMS develop a standard way for hospitals and doctors to report the price that will be paid by a Medicare beneficiary for common reasons for admission and visit. Pairing information on price with information on quality will provide a substantial improvement in market function. The final step on information is to invest in understanding how best to communicate this information to end users (in this case, Medicare beneficiaries). Just collecting the information is not enough. Finding ways to make it easy for people to shop for the highest value health care services will be critical to improving market functioning.

Question: What are your thoughts on aligning payment with quality outcomes? How can we help make this happen at the federal level?

Answer: In thinking about potential approaches to payment reform, I think it is useful to consider the different types of health care problems faced by patients and the different types of patients served by the Medicare program. A single approach is unlikely to work across the diversity of problems and people.

For preventive care and the routine, time limited acute problems like colds, one possible approach is a global budget – an amount paid annually to take care of all of an individual's routine needs. These should be reasonably predictable for each person based on age and gender. A question that might be explored is who controls the payment – the doctor or the patient – and whether it is paid prospectively or retrospectively.

For the management of chronic disease, a similar approach (global budget) may be warranted but the mechanisms for arriving at the right amount for each patient are considerably more complex as they depend on the severity of disease, the number and type of comorbid conditions, and the general health and functional status of the patient. The global budget should be based on the resources necessary to deliver evidence-based care for a condition. An interesting pilot project using a methodology like this is currently underway called the Prometheus Payment system (see <http://www.prometheuspayment.org/> for more information). Prometheus pairs payment reform with required reporting on quality performance.

For unexpected serious illness, fee-for-service payment likely remains the most appropriate method to ensure that appropriate care is delivered and that the patient has a choice about where to go for care. Even within fee-for-service, however, one could add bonus payments for better outcomes.

Finally, the path Medicare is beginning to take of not paying for mistakes will be interesting to evaluate. Conceptually the program makes a lot of sense – Medicare will not pay for mistakes that should not happen. CMS has selected a few areas that are likely to be easier to implement at the outset, but this approach is new enough that it should be carefully evaluated to identify both whether it had the intended effect and whether any unintended consequences were observed.

There remain significant challenges to using outcomes as a basis for payment because of the difficulty in many cases of attributing many outcomes to a specific health care provider within the short time frame required to pay bills. For most chronic diseases, the outcomes of interest take many years to be observed. Further, the focus on outcomes ignores the reality that factors outside of the health care system are often more important in determining outcomes than what can be done by the health care system. For example, we know that people who have attained higher levels of education have better chronic disease outcomes even when they have access to the same level of health care. So investing in education might well have benefits for health outcomes.

Questions From Senator Rockefeller

Question: Can you talk a little bit about the reasons for the low quality of care delivered to children in this country?

Answer: As you noted, we found that U.S. children receive 47% of recommended care for the leading reasons children see the doctor. We found the best quality associated with care for acute medical problems (68% of recommended care), followed by care for chronic conditions (53% of recommended care) and then preventive care (41% of recommended care).

I believe that one of the contributing factors to the current level of performance is the lack of routine information on performance. Before we published this study, most people assumed that care for children was excellent in the U.S. and, if you think things are working well, you rarely look to see how things could be better. So an important lesson is the need to routinely monitor how well we are delivering needed care to children. Earlier versions of the SCHIP reauthorization legislation included resources to increase the number of quality measures that could be used to evaluate care for children. We absolutely must do this.

We have also learned that just measuring performance and keeping it private may be much less likely to stimulate improvement. So, increased measurement must be coupled with public reports on performance. We have seen repeated examples of where this has motivated improvements and innovations in care delivery.

The next culprit is an antiquated delivery system that is increasingly dysfunctional in the face of complex service requirements. Scientific discoveries have vastly expanded the number of areas in which health services are effective, including the provision of preventive care. However, there is very little proactive identification of health care needs or tracking whether those needs are being met. Care is usually delivered by a physician seeing one patient at a time – there may be opportunities to use group visits, email, medical assistants, nurses and other methods for delivering care. Physicians could use checklists to ensure care is consistent with the standards of excellence. Having such checklists frees physicians to use their knowledge, training, and judgment for more challenging medical problems.

The way that physicians are trained offers another explanation for the differences we observed between acute, chronic and preventive care. Pediatricians, like most physicians, are trained dominantly in acute care settings (hospitals) and spend relatively little time during training on preventive care and management of chronic disease. They tend to acquire less experience in these areas during training and are unlikely to have exemplary role models because this care does not typically occur in a hospital-based setting. Thus, a longer run strategy is taking a look at changes in training that would better prepare physicians for the majority of the types of care they will be asked to deliver.

All of these strategies could be facilitated with widespread adoption of health information technology. Most of us would find it impossible to do our jobs today without using computers to find and help organize information. I rely on reminder systems at both work and home to ensure that I am keeping up to date on various obligations. We should expect no less from the health care system.

You also asked whether we found differences in the quality of care delivered to children with private insurance versus those in public programs. We did not have adequate statistical power to detect differences between these two groups of children. Most of the children in our study (82% vs. 70% for the U.S. overall) had private insurance so our results are dominated by those with private coverage. We also had a lower proportion of

nonwhite children in our study than the U.S. average, so again our results may overestimate quality for children overall.

Question: Aren't we just making the quality problem worse by failing to first push for the adoption of uniform federal health information technology system – much like what the VA has done?

Answer: I agree that widespread adoption of interoperable health information technology is fundamental to achieving significant improvements in health care quality. It is hard for me to imagine how we can make substantial progress without a major role for health information technology. I don't know that we need a single vendor but we do need products that can deliver the needed functionality or communicate with the products of other vendors. It is not unusual, for example, to have information technologies inside the same hospital that cannot communicate with each other. Ultimately fewer vendors might be useful but this may happen naturally with market forces over time. Having several vendors competing may also be advantageous from the perspective of stimulating innovation.

The U.K. provides an interesting alternative idea about ways to accelerate adoption. When their new pay-for-performance system was put in place, they announced that to qualify for the bonus payments, primary care trusts would have to have electronic medical records that could routinely report on the full set of performance metrics that would be used for payment. Almost overnight, primary care practices in the U.K. went from a rate of adoption similar to what we have in this country to a rate well over 90%. There was no top-down order, just an incentive to adopt a technology that had a particular functionality. By specifying what functionality was critical, the NHS took away uncertainty about which products to buy (a concern that a lot of U.S. physicians have). There may be other incentives that could be used to accelerate adoption.

An alternative experiment underway in Massachusetts focused on “wiring up” three communities with a subsidy provided by Blue Cross Blue Shield of Massachusetts. The Commonwealth of Massachusetts is currently looking at ways this approach might be expanded statewide. There are interesting lessons to be learned from what was done there.

On a cautionary note, there is good evidence that unintended consequences can occur with automation so efforts to speed adoption should be tempered with checks to ensure that the systems are operating as expected and are not introducing different problems into the system.

OPENING STATEMENT OF SENATOR KEN SALAZAR**Senate Committee on Finance Hearing****June 3, 2008****Rising Costs, Low Quality in Health Care: The Necessity for Reform**

Thank you, Chairman Baucus and Ranking Member Grassley, for convening today's hearing to continue the Committee's health care reform discussion. I appreciate your leadership in developing a detailed dialogue on one of the most challenging, and potentially promising, issues facing our nation today.

As I mentioned at our last hearing, there is little doubt in my mind that America's health care system is broken. We are headed towards a crisis, and Americans are finding it more and more difficult to obtain affordable, high-quality care as each day passes. This path is unacceptable, and I share a strong commitment with my colleagues on the Finance Committee to take the steps necessary to point us in a new direction.

Recently, I was reminded of a comment that sums up my viewpoint on the challenge ahead quite nicely: "We should now resolve that the health of this Nation is a national concern, that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation." Interestingly enough, this statement was offered by President Truman in 1945, when America embarked on the first of many efforts to improve our health care system. While those efforts have resulted in positive changes, it is clear that this is an issue that has been building over time and has, in my opinion, reached its breaking point. We must act swiftly to re-chart our course.

Today's hearing focuses on two elements that are fundamental to our discussion of health system reform: how much we are spending, and the quality of care we are receiving for those dollars. As we will hear from the hearing witnesses, America's high-cost care is simply not producing high-quality services and outcomes. We can do better for our people, and it is important that we reintroduce the concept of "value" into our health care market as an essential component to reform.

There is no question that our country is willing to invest in health care—with an annual expenditure of over \$2 trillion, we are spending more per capita than our counterparts through the world. In fact, the U.S. currently spends 50 percent more per capita on health care than other industrialized countries, a figure that is on the rise. But what results are we reaping as a result of this investment? Based upon the statistics with which we have become all too familiar, these dollars are not translating into readily-accessible, high-quality care.

America's high spending level might not be such a cause for concern if we knew that our citizens had unfettered access to care that produced outstanding clinical outcomes, but that simply is not the case. Rather, I hear from people in my home state of Colorado everyday who cannot afford to seek treatment for their basic health care needs. According to the Department of Health and

Human Services, nearly 40 million people (19 percent of the U.S. population) did not receive “needed services” in 2005 because they could not pay for them. Clearly, our spending levels are attributable to higher costs of service rather than just higher utilization of services.

Additionally, many researchers—including some testifying here today—tell us that our health care system falls behind in quality when compared to our peers. Study after study demonstrates that the clinical outcomes seen in the U.S. are not as successful as those seen in other developed countries, despite the fact that we spend more on care and use advanced technology more frequently.

For instance, a recent study conducted by the Commonwealth Fund comparing the U.S. to its international counterparts on a number of health care outcomes found that the U.S. experienced significantly poorer outcomes and higher mortality rates than most of its peers. In fact, the U.S. ranked 15th out of the 19 countries examined. Considering that America spends over \$2 trillion on health care each year—nearly 16 percent of our GDP—compared to 10 percent GDP spending in many other developed countries, it is clear that the current system is not producing the results our citizens deserve.

So where is our money going, and why aren’t we seeing more “bang for our buck?” That is the question I hope we can answer, in part, today so that we can move forward on a course to improve the “value” consumers experience in our health care system. Thank you to all of the witnesses for joining us today. I look forward to hearing your thoughts on this very important issue.

COMMUNICATION

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June 16, 2008

STATEMENT FOR THE RECORD COMMITTEE HEARING ON POOR QUALITY OF HEALTH CARE IN THE UNITED STATES BY SAMUEL B. WALLACE IV MEDICAL RESEARCHER

Dear Chairman Bacaus Ranking Member Senator Grassley

On Friday June 13, I completed a short 3 page paper titled: "THE NECESSITY TO FORMULATE AND IMPLEMENT IMMEDIATELY A SOUND ENERGY AND HEALTH CARE POLICY" And at 4:00 A.M. this morning I learned on C-span radio that your Finance Committee was scheduled to hold hearings on the Economic Implications of the Poor Quality of Health Care in the United States. Because I am a successful but vastly underpaid Medical Researcher, who could probably contribute more to a real understanding of Why American Health Care is of such poor quality despite the huge amounts of money paid for Public and Private Health Care who has lived in Washington, D.C. doing Medical Research who understands why Congressional Efforts to find an answer to this problem which may now cost the American Tax payer over a trillion dollars annually, I thought it would be counterproductive to attend a Hearing where the same type of interests representing the status quo of the very interests that have provided such poor health care with their elaborate and irrelevant silly excuses for such poor quality care that always ended with promises of how American Health Care would be improved by additional generous funding by the American Congress.

However, since I am a patriotic American citizen and an Honorably Discharged Veteran of the Korean Conflict who disagrees with those who think we have a God given responsibility to impose a neo-colonial rule on certain parts of world where there are large reserves of oil, but no obligation to correct a corrupt government in Burma that refused the United States permission to deliver huge quantities of food and medicines to its populous in Rangoon that were overwhelmed by hurricanes and floods as almost happen to the victim of floods and Katrina in Mississippi and Louisiana I thought because I had at least some understanding of how our poor quality health care was related to American "scientific" approaches to medicine that I might at least contribute a statement for the record where I would futher document the cause for the failure of American Medicine. Despite, ironically its great but limited advances in some areas such as Genetic Research, and Organ Transplants.

Rather than a lengthy analysis of the causes of the failures of American Medicines such as those listed by the brilliant, Mary T. Griffin Vol. 17 American Medicine and Law P.363, 1991: Titled: AIDS DRUGS AND THE NEED FOR MEDICAL REFORM" who alleged truthfully that almost the entire Pharmaceutical Industry was both in per se violation of the Antitrust Laws, and in violation of our nation's qui tam laws which forbid fraud against the United States Government and the American Taxpayers.

I shall concentrate on showing how the lives of two U.S. Senators who both are suffering from different forms of Brain Cancer have had their lives placed in jeprody who would have a better chance of survival if better conventional medical techniques were applied to their cases. But before doing so, I will try to show why Congressional Hearings on Health Care Reform fail.

WHY CONGRESSIONAL HEARINGS ON HEALTH CARE REFORM GENERALLY FAIL

I have noticed that over the course of many decades that when Congressional Committees hold hearings about Health Care Reform they invariably call on the same types of witnesses who are essentially paid lobbyist who represent the Interests of the Pharmaceutical Companies, the Health Care Insurers., the hospitals, or the HMOS and government Health Institutes. And invariably the Senate Committee receives the same specious answers.

Several decades ago, there was a FACA Conference on Health where every complex issue on Health Care was examined in great detail except the application of good low cost safe and effective curative medicines.

And many years before that in the early 1960's, a great U.S. Senator did concentrate on incorporating the low cost safe and effective *ANTIBIOTICS* into our Health Care System who even required that those medicines be tested for both safety *and effectiveness* by the U.S. Government. As a result of his efforts which were true medical reform. Health Care Providers were required to treat and cure their patients with low cost safe and effective Antibiotic Medicines. And so reasonable were Health Care costs that the entire American economy benefitted so much that the President of the United States JFK was able to lower taxes and at the same time increase revenues.

What Senator Kefauver had proved is that you can not have Health Care Reform without having safe and effective low cost medicines. And in Japan where they still rely on low cost safe and effective medicines as in Canada and Puerto Rico both the quality and costs of Health Care is much more reasonable to this day.

Thus, the high cost of Health Care in the United States is primarily due to the absence of the proper use of Safe and Effective Antibiotic Medicines promoted by Senator Kefauver Reform of FDA Act 1962 which emphasized those medicines and even required their testing by the government for effectiveness which were passed into law and signed by President Kennedy.

Today because our Public and Private System rely on the so-called "block buster drugs" which do not cure but only relieve some of the symptoms it may well cost the entire Public System 1 to 2 Trillion Dollars Annually and the same amount for the private Health Care System and of course this gigantic waste spills over into Social Security's Medicare and Medicaid Costs. John McCain knows that and knows Consultants in Public Interests groups that were formerly his employees in the U.S. Senate.

For example, I indicated to Senator Coburn when I just learned today from the Wednesday Journal *POLITICO* in an article by Samuel Lowenberg that he wisely chose with seven conservative Senators to place a hold on legislation reauthorizing the new 50 Billion Dollar HIV/AIDS Bill designed to offer AZT and the weak none Curative Protease Inhibitors to a larger minority of Sub-Saharan Africans who are suffering from the AIDS Epidemic which on its face appears to be a noble and praise-worthy cause. On the basis that the AZT treatment lowers "the viral load to the point where those patients may not infect others." And even though only 10 percent of the 33 million people infected with AIDS are now being treated.

In 1983, Dr. Hamao Umezawa discussed at the Vienna Conference on Infectious Diseases four Antibiotic *strong protease inhibitors* that cured HIV Leukemia as well as inexpensive methods for discovering new antibiotics produced by humans which were more specific cures for Cancer and Leukemia and which could be manufactured at greatly reduced costs of production.

Evidence that his research was and is successful is indicated by the World CIA Fact Book which indicates that the rate of Infection for HIV/AIDS is less than .1 of 1%. In Japan. The lowest rate of infection for any developed country. Which is a fairly good proof that HIV/AIDS is being cured in Japan where they specialize, still, in Antibiotic Research.

THERE IS SUFFICIENT EVIDENCE THAT SUGGESTS THAT BOTH SENATORS KENNEDY AND SENATOR ARLEN SPECTOR WERE VICTIMS OF POOR MEDICAL PRACTICE BY THEIR DOCTORS, WHICH CAN BE PROVED FROM CONVENTIONAL SCIENCE ITSELF-PARTICULARLY FROM INNATE PRIMARY ANTIBIOTIC THERAPY THAT UTILIZES THE NEURO-BRAIN GLIA CELLS TO EXCRETE NEURO-EPINEPHRINE AND PEPTIDE DEFENSIN ANTIBIOTICS TO WHICH SYNTHETIC EPINEPHRENE COMBINED WITH FACTORY MADE ANTIBIOTICS WHICH IMMEDIATELY BEGINS THE CURATIVE PROCESS.

Both Senators Kennedy and Senator Arlen Specter are victims of medical failures based on poor medical practices because there is sufficient evidence to indicate that both Senators did not receive the best treatment that conventional medicine can provide through Innate Primary Antibiotic None Specific Therapy.

The primary reason that therapy for Neuro-Brain Diseases and Brain Tumor and Tumor Cells fails is because the Glia Neuro-Brain Macrophage Cells which secrete Neuro-epinephrine and Peptide (Defensin) Antibiotics fails to take advantage of their ability to activate complement through the none specific C-3 Complement pathway which in turn sensitizes the same Macrophage and Neutrophils etc. and causes those Cells to become chemically attracted to the Tumor or Tumor Cell Infection. Through the process known to conventional medical science as "chemotaxis" whereupon they deliver the neuro-secretion and Antibiotics immediately to the area of Brain where the Tumor Infection is located provided the Innate Immune System receives sufficient quantity of Antibiotics and Synthetic epinephrine to supplement the quantity already in the glia neuro-brain cells.

There are several indications that Innate Antibiotic Therapy occurs after sufficient quantity of supplemented synthetic epinephrine combined with the ordinary peptide Antibiotics such as Penicillion, Amoxicillin or Tetracycline such as:

- 1. The immediate reduction of neutropenic fevers which ordinarily takes from 3 to 8 hours without the Antibiotic Therapy which Guyton indicates in his Medical Physiology Text.**
- 2. Immediate before and after Immuno-assays which measure the increase of Glia Macrophage and B and T and T-4 cells and Antibodies is further evidence that the curative process has begun.**
- 3. Reduction in the size of the Tumor and a diminishing in quantity of Brain Tumor Cells in the Blood Systems and Brain Tissue is further evidence that the infective process has been reversed or has begun to be reversed.**
- 4. Lack or diminishing of pain or nausea in the area of the tumor infection as well as increased ability to concentrate ability to use motor skills is further evidence that the curative process has begun.**

THE QUESTION THAT MAY WELL BE ASKED BY THOSE CURIOUS ABOUT THESE RESULTS IS HOW ARE THE ANTIBIOTICS DELIVERED TO THE SITE OF THE BRAIN TUMOR INFECTION WHEN THERE IS THE BLOOD BRAIN BARRIER TO OVERCOME WHICH CAN NOT BE OVERCOME BY VENUOUS INJECTIONS OR ORAL APPLICATION OF THE ANTIBIOTICS AND SYNTHETIC EPINEPHRINE.

The answer to that question is found in conventional medical science because when its principles are properly applied there is no blood brain barrier and therefore the desired safe and effective Antibiotic and Synthetic epinephrine can reach the infected area of the Brain very rapidly.

That answer is found in the traditional science of Grey's Anatomy and Arthur Guyton's Physiology where amazingly we see the other Blood Circulatory System which delivers Oxygen, blood carried nutrients, neuro-epinephrine secretions, and human body made Peptide Antibiotics or "Defensins" similar to the ordinary Penicillin, Tetracycline and Amoxicillin Antibiotics to the highly compartmentalized Brain where this Arterial "Cerebral" blood systems has access to each and every part of the otherwise compartmentalized Brain and to all the other parts of the human body. Then Arterial Bloodm system supports and sustains the Brain, and all the other parts of human body and its tissue, organs and glands by delivering oxygen, nutrients, immune hormones, immune cells and human body made Antibiotics called "Defensins" by Dr. Selsted to the Brain ande all other parts of human body.

That is a truth long known to medical and nursing students which has been obscured or overlooked even though accepted by conventional medical science and amazingly *occasionally even used to treat the sick: Arterial Blood carrying nutrients, oxygen, immune cells, including Antibodies and human body made Peptide Defensin Antibiotics flows directly from the left ventricle of the heart directly to the brain via the two carotid arteries of the neck.*

To illustrate this important scientific truth I shall quote two well known conventional medical authorities: the late Professor of Biology David Atkins who was the author of the famous predikin diet and the renowned Medical Physiologist Arthur Guyton:

(This illustrated Treatise on Brain Blood Flow by the late Dr. David Atkins with my comments is Relevant to Treating and Curing Brain Tumors similar to Senator Kennedy's with none invasive innate Antibiotic Curative Therapy. Signed: Samuel B. Wallace IV: Google.com [penicillin diversum] 107th Congress.)

(ARTERIAL) CEREBRAL CIRCULATION is a most remarkable exercise in supply and demand with a top-down strategy. With a cell metabolism utterly dependent on aerobic metabolism and having the highest metabolic rate of any organ in the body--by far--excellent circulatory flow is a necessity. In addition, the brain (and in some species, the spinal cord) is a major endocrine gland and endocrine target organ. These aspects are complicated by the brain's chemical isolation from the rest of the body via the blood brain barrier (of the venular blood system, there is no Blood brain Barrier for the Arterial System where Arterial Blood flows directly from the left ventricle of heart to the brain.) (Parenthesis added by me.)

C: CEREBRAL CIRCULATION **(ARTERIAL) "CEREBRAL BLOOD FLOW"**

(Parenthesis Added for Clarity)

by David L. Atkins, Prof. of Biology Department of Biological Sciences =| George Washington U. Washington, DC (excerpted and reformatted for clarity.)

"The (Arterial Brain Blood) Supply... breaks down into a fairly simple matter of plumbing, except--"toward the end of the Arteries" "are the Capillaries who do the real work of the circulatory system." 1/

(See also: Medical Physiology 1996 Edition, Ch. 16., 1996, Dr. Arthur Guyton, M.D. 1/ WRONG: As Alberts et al proved in his famous medical text "The Molecular Biology of The Cell." P. 962, 1996 in that edition only: "The real work is done by the endothelial blood vessels that deliver oxygen, nutrients, antibiotics and other immune cells from the heart to the (Arterial) blood circulatory system(s) of the Brain: (which is the main Arterial Circulatory System of the heart and the remainder of the human body.)

This of course is what Doctor Guyton and Professor David Atkins call "the (Arterial)Cerebral Circulatory System of Brain" which is in reality composed of Arteries that also carry composed blood laden with what Dr. Hamao Umezawa in 1972 and called by Dr. Selsted University of Cal at Irvine:

"Defensins" or "Peptide Antibiotics" similar to Penicillin and Tetracycline which have "antiviral" and "tumoricidal properties". This Arterial Blood rich in components capable of resisting and curing cancer, leukemia and eliminating malignant tumors carries that blood at extremely high pressure at accelerated rates of blood flow that far surpass venous blood flow.

While both Dr. Guyton and Professor Atkins some times attribute the "real work of the cerebral" or arterial blood system to the capillaries located at the ends of the arteries "smallest arterial branches, the arterioles threading their way among tissue cells spraying nutrient/O₂-laden blood serum into the tissue spaces where they exchange immune cells and (human body made antibiotics...)

Their "real work designation over emphasizes the work of the capillaries while ignoring the more substantive work of the Arterial blood system as they prove in other parts of their texts:

Thus, Dr. Guyton in Chapter 61 of his Text on Physiology: CEREBRAL BLOOD FLOW, THE CEREBRO-SPINAL FLUID AND THE BRAIN METABOLISM: Proves that he is discussing the Arterial Blood Flow in the first paragraph of that chapter:

"Thus far, we have discussed the function of the brain as if it were independent of its (arterial) blood flow, its metabolism and its fluids. However ..abnormalities of any of these can profoundly affect brain function."

For instance, the total cessation of blood flow to the brain causes unconsciousness within 5 to 10 seconds due to lack of oxygen delivered to brain cells and shuts down most of their metabolism (and) abnormalities of the (chemical composition) or in its fluid pressure, which can have equally adverse effects on brain."

And of course measurements of normal Blood Pressure show the Systolic(arterial) pressure to be almost twice that of the diastolic (venular) Blood Pressure.. Likewise, Professor David Atkins in his (Arterial)"Cerebral Blood Flow" even more accurately describes the rate of Blood Flow of the arteries:

"You already know that arteries carry blood under high pressure away from the heart. This higher pressure demands a thicker wall...Because blood is under high pressure, there is a high flow rate and the vessel lumen can be smaller than in the low pressure, low volume venous oxygen-depleted, nutrients, immune cell and human body made Antibiotic depleted venous blood."

My own Innate Antibiotic Research in Brazil with ordinary respiratory illnesses, encephalitis of the brain and an infection of a leg artery after rigor mortis had set in proves that both scientist exaggerated the power of the capillaries and underestimated the ability of the Arterial Blood supply system and the Bone Marrow Immune System to act independent of the rather weak and defused capillary system found at the end of the arterial blood supply. Just as modern practitioners underestimate the power of the lung immune system to resist and cure respiratory diseases.

I personally incurred encephalitis of the brain in 1973 in Belem do Para, Brazil. I entered the Pharmacy Belem which was opposite a cemetery and on the Highway from Belem to Brazilia. I asked a nurse practitioner at the Pharmacy if she would inject an antibiotic into my right frontal lobe which she did curing my Encephalitis of the brain immediately. A few years ago an article in the New York Times by Nicolas Wade, indicated that immune cells from the Bone Marrow are genetically structured to proceed to areas of disease or injury to the tissue to which the bone is connected.

Therefore, in the three different types of Innate Antibiotic Therapy: one involving the Alveolar macrophage, the other Glia macrophage in the cranium bone marrow and the Dendritic Macrophage of the leg bone, where the appropriate Antibiotic Medicine was administered to an appropriate part of the human anatomy the curative process began as soon as the proper Innate Antibiotic therapy was applied. And in each case cures occurred more rapidly than ordinary using ten percent of normal dosage of antibiotics.

SENATOR KENNEDY'S CASE AND THAT OF SERVICEMEN RETURNING WITH TRAUMATIC BRAIN INJURIES ILLUSTRATES HOW PRIMITIVE CONTEMPORARY BRAIN THERAPY IS AS WELL AS HOW EFFECTIVE INNATE ANTIBIOTIC THERAPY COULD BE WHEN PROPERLY APPLIED TO BRAIN DISEASE OR INJURY.

SENATOR KENNEDY'S DOCTORS HAVE ERRED TWICE: 1. WHEN THEY FAILED ANTIBIOTICS TO THE AREA OF HIS BIOPSY AND 2. AFTER HIS BRAIN TUMOR SURGERY.

The key to successful antibiotic brain tumor therapy can be found by determining the nature of brain immune cells including their ability to produce human body brain antibiotics called "Defensins" as well as neuro-brain cells' immune hormones, such as noroepinephrine which is similar to epinephrine. The key to finding an Antibiotic Cure for Brain Tumors can be found in sound exponents of medical science such as that of the late Dr. Hamao Umezawa of Health Tokyo, Japan, Dr. Bonadonna, Instituto, Tumori, Milan Italy, Professor Bruce Alberts et al authors of :

MOLECULAR BIOLOGY OF THE CELL, Second edition only 1989, Garland Publishers, N.Y and London, Dr. Arthur Guyton, Professor and author of Medical Physiology, and the late Professor of Biology and Anatomy MOLECULAR BIOLOGY OF THE CELL, second edition only 1989, Garland Publishers, NY and London, Dr. Arthur Guyton, Professor and author of Medical Physiology, and the late Professor of Biology and Anatomy David Atkins (The Arterial) *Cerebral Blood Flow* (of Cerebral (Arterial) Circulation of the Brain which Arterial Blood System flows from the heart to the Brain without a Blood Brain Barrier).

Therefore, in Summary it can be said that the general topic of Innate Primary Antibiotic Therapy whereby Macrophage and Neutrophil carry oxygen and human body made Peptide Antibiotics and activate complement through the non-specific C-3 complement pathway which are then complement synthesized and are chemically attracted through the process known to conventional medical science to the area of infection and or tissue damage and begin at once the curative process immediately is for the most part known to conventional medical science.

However, my Research in Brazil 1968 to 1974 proved it could be applied to Brain Infections and Brain Damage by techniques I helped to pioneer that overcame the Blood Brain Barrier by treating Brain Infections including Brain Tumor and Brain Tumor Cells through the Arterial Systems that go from the left ventricle of the heart Directly to the Brain.

This approach using Innate Antibiotic Therapy will lead to high Cure Rates for all forms of Cancer and Leukemia including Brain Tumor Cancer and HIV I, II and III Leukemia as well as other Neuro-Brain Diseases considered "incurable" because of the obstacle of the "blood-brain barrier" which does not exist when Innate Primary Arterial Antibiotic Therapy is applied. And it is in conformity with good conventional medical practices.

SUGGESTIONS FOR NEW LEGISLATION TO IMPROVE QUALITY OF HEALTH CARE

I suggest that were the Congress to fund the use of the low cost safe and effective Antibiotics in the proposed treatment of AIDS Infection in developing countries world wide that the proposed 50 Billion dollars proposed for Sub-Saharan Africa would provide cures for not only that region but for all the countries of the developing countries in Asia and perhaps South America as well.

But such a program would require testing of the new proposed Antibiotic Protocols including ones that I discovered that would provide comprehensive Antibiotic curative treatments for those who were infected at extremely low costs per patients treated and cured.

AIDS Prevention programs would be eliminated because they provide no benefit to those actually infected with AIDS as past history with the exception of needle exchange programs has shown

I also suggest that Congress consider a moratorium on all forms of medical research while a comprehensive program of investigating the Antibiotics as cures for most diseases in light of the failure of the Block Buster Drugs to cure the sick with very serious and dangerous side effects

And the safety and effectiveness of long known natural remedies such as ground ginger to cure high blood pressure and high cholesterol levels, and a single fresh grapefruit squeezed for its juice in a quart of water and taken morning and evening as an effective way to reduce the desire to smoke and drink alcohol. Particularly in light of recent antismoking drug scandal at the V.A. Hospitals.

Drugs showing severe side effects should be retested by the FDA. And all pharmaceutical self evaluation of drugs should be stopped.

Pilot tests of a few months for safe and effective Antibiotics against various diseases should be sufficient for FDA approval unless serious side effects occurred during the Pilot Tests.

Lastly, the United States Congress should make available to plaintiff's pursuing Qui Tam cases against the Pharmaceutical Industry free legal counsel and legal representation in programs similar to those for Disabled Persons because it appears to me that the Pharmaceutical Companies in order to protect their interests have managed to buy out or employ both all Defense and Plaintiff Lawyers including so called Public Interest Lawyers at least in Washington, D.C.