



The Waiting Room

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From the Filmmaker

Dear Viewer,

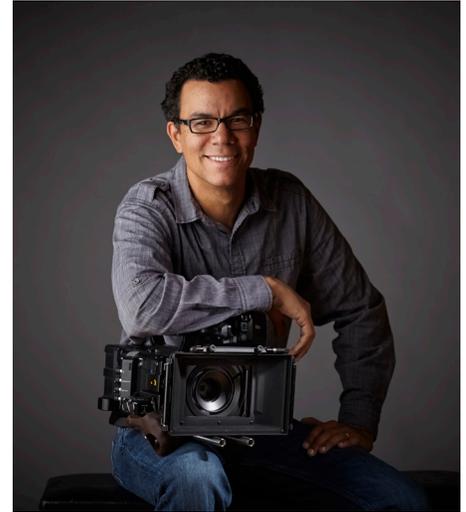
A few years ago, as the contentious vote for health care reform got louder, it occurred to me that the people who were not participating in the debate were the very people we were fighting over: those stuck in waiting rooms at underfunded public hospitals all over the country. How would the patients in the waiting room at Highland Hospital respond to President George W. Bush's statement, echoed by many others, that we already have universal health care in this country because, by law, nobody can be turned away from an emergency room for lack of ability to pay?

The Waiting Room developed from stories that my wife, a speech pathologist at HighlandHospital, told me about the struggles and resilience of her patient population. By following the caregivers and patients as they passed through the waiting room, we felt we could shed some light on the challenges of delivering primary health care in an environment designed for emergency medicine.

What we found was that the uninsured and underinsured were more likely to be hospitalized for avoidable conditions because there is virtually no continuity of care and no regular doctor to get a detailed medical history or conduct a follow-up visit to make sure the prescribed treatment is working. And because the wait times are so long – both in the emergency department and to see a doctor in the clinics – simple conditions like high blood pressure and diabetes can escalate to severe life-threatening emergencies like strokes and kidney failure. These true emergencies end up back in the emergency department but at a much higher personal and financial cost.

The Waiting Room is a story and a symbol of our national community and how our common vulnerability to illness binds us together as humans.

-- Peter Nicks



Peter Nicks, Director/Producer



The Film

The Waiting Room is a feature-length immersive documentary film that uses unprecedented access to go behind the doors of Oakland's Highland Hospital, a safety-net hospital fighting for survival. Using a blend of cinema verité and characters' voice-overs, the film offers a raw, intimate, and often uplifting look at how patients, staff, and caregivers cope with disease, bureaucracy, frustration, hope, and hard choices during one typically hectic day.

Filed prior to the enactment of the Affordable Care Act (ACA), this compelling picture of a day in an urban emergency room (ER) captures in vivid detail what it means for millions of Americans to live without health insurance or proper access to primary care doctors. Stretched to the breaking point, Highland is the primary care facility for two hundred and fifty thousand patients of diverse nationalities, races, religions, ages, and economic circumstances. Two hundred and fifty patients -- many of them uninsured -- crowd its ER waiting room every day.

The film weaves together stories from the hundreds of dramas being played out daily at Highland: a frightened child with a dangerous case of strep throat; a young man with a testicular tumor in desperate need of surgery; individuals suffering from chronic conditions such as heart disease and diabetes, accompanied by stressed-out caregivers; and people struggling with alcohol and drug abuse who have no one. Young victims of gun violence take their turn alongside artists and uninsured small-business owners. Steelworkers, cab drivers, and international asylum seekers crowd the halls.

We also meet the overwhelmed hospital staff who cope with understaffing, insufficient beds, and a never-ending stream of trauma patients who jump to the head of the line of those sitting in the waiting room. As one doctor says, Highland is "the institution of last resort for so many people."

The Waiting Room lays bare the struggle and determination of both a community and an institution functioning with limited resources and no road map for navigating a health care

landscape marked by historic economic and political dysfunction. It challenges viewers to think about how policy debates might change if we looked at them through the eyes of those most affected: the uninsured and the people who care for them. And it provides a springboard for discussions about how to recover, not only from physical maladies, but also from systemic failure.

The Waiting Room premieres on PBS's *Independent Lens* on October 21, 2013.

Using this Guide and the Film



Community Cinema is a rare public forum: a space for people to gather who are connected by a love of stories, and a belief in their power to change the world. This discussion guide is designed as a tool to facilitate dialogue, and deepen understanding of the complex issues in the film *The Waiting Room*. It is also an invitation to not only sit back and enjoy the show – but to step up and take action. This guide is not meant to be a comprehensive primer on a given topic. Rather, it provides important context, and raises thought provoking questions to encourage viewers to think more deeply. We provide suggestions for areas to explore in panel discussions, in the classroom, in communities, and online. We also provide valuable resources, and connections to organizations on the ground that are fighting to make a difference.

For information about the program, visit: www.communitycinema.org

The Waiting Room can be used in a wide range of circumstances to spark discussions about health care in the United States. You might use the film to:

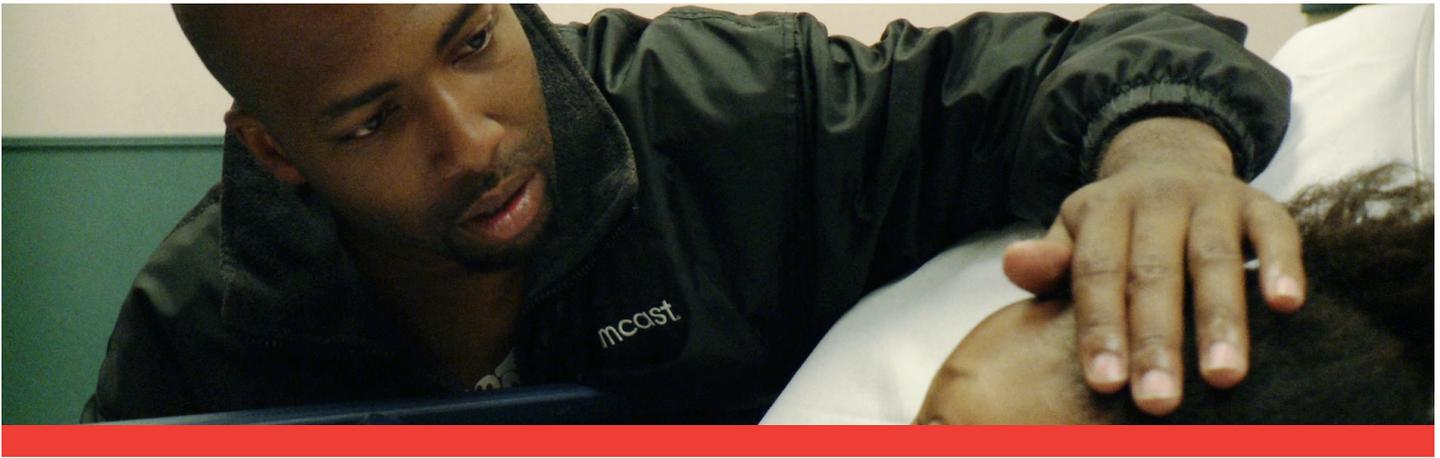
- educate individuals about the poor state of the health care system;
- convene a community task force on creating health care alternatives to the ER;
- train health care workers to handle on-the-job stress;
- recruit people to become patient advocates and/or community activists to press for a better health care system;
- moderate a conference session, town hall meeting, or panel discussion on health equity;
- kick off a health-related campaign with members of a nonprofit, civic, or religious group;
- approach policy makers to identify and fix what is broken in our health care system;
- draw attention to health equity issues in your community and increase media coverage of them;
- host a viewing party followed by an ongoing online discussion about what is and isn't working in your community's health care system;
- create a screening event at your local public television station with information available about care options in your community and/or how to find health insurance that meets one's needs.

Event or project partners might include any individual or group interested in:

The Affordable Care Act
Economics
Health care policy or reform
Health care workers
Health equity
Health insurance
Hospitals

Human rights
Medicine
Poverty
Public policy
Social justice
Socioeconomic class
Sociology





Background Information

Who Pays for U.S. Health Care?: A Brief History

Before 1900

Until the turn of the 20th century, unless one was in active military service, individuals in the United States paid for (and often provided) their own health care.

In the mid-1800s, growing industrial urban areas might have included public or charity-run hospitals, and “spas” might have been available to provide care for the wealthy, but typically, healing took place at home. Employers played no role in providing health care (unless you count owners caring for slaves). In fact, if someone was injured or ill, they were likely to be fired and replaced.

This system worked, in part, because health care options were limited; there wasn't much expense because there wasn't much available to purchase. Surgery was primitive and there were few medications available. Louis Pasteur didn't even make the link between germs and disease until 1880 and antibiotics wouldn't become widely available for another sixty years!

1900-1929

In the early years of the 20th century, Progressive reformers and Labor leaders saw that many European nations were beginning to institute compulsory national health insurance. They began to press for the United States to do the same. In 1906, the American Association for Labor Legislation organized the first national conference on what they labeled *social insurance*. The effort was defeated in the face of opposition by some labor leaders who feared that government-provided social services might weaken unions (which also provided such services), some physicians and pharmacists who feared that government intervention

would limit their fees or undermine their businesses, and the commercial insurance industry.

There were, however, some life insurance companies that began to offer related products. Newly emerging transportation systems, like passenger rail, offered accident insurance to their passengers. And some insurance companies offered *sickness* insurance -- what might be termed *disability* insurance now. These policies addressed the concerns of workers who stood to lose more from being unable to work than from covering actual medical expenses.

In general, commercial companies were unwilling to write health insurance policies. They lacked methods to accurately calculate the risks or the costs of ever-changing treatments, which made it impossible to know what to charge for premiums. The companies also argued that there was a great potential for fraud by people who would apply for policies claiming to be healthy when they were not, or who would increase risky behaviors once they were insured.

However, by the 1920s, Americans were witnessing the growth of hospitals. Continuing innovation in science and technology meant the development of procedures that could not be conducted at home, and as the population shifted from rural to urban, people no longer had space in their homes to care for the ill or injured. The resulting reliance on hospitals came with increased costs. And the growth of health care costs created a demand for health insurance.

1930s

The Great Depression created a challenge for the commercial insurance industry. Ironically, that challenge came from hospitals. With many patients unable to pay their bills, hospitals looked for a way to achieve financial stability. They found their solution in prepaid hospital plans.

The first such plan -- a precursor to Blue Cross -- was started in 1929 by a group of Dallas teachers who contracted with Baylor Hospital to provide 21 days of hospitalization for a fixed six-dollar payment. Other prepaid plans soon followed.

The plans provided hospitals with steady income and consumers with the reassurance that they would receive hospital care should the need arise. To avoid competition that might have led to lower revenues, hospitals cooperated and allowed consumers to

tution. By the start of the 1940s, hospitals -- not insurance companies -- were underwriting Blue Cross policies, and Blue Shield policies were added to cover fees charged by physicians.

On Capitol Hill, there continued to be calls for compulsory universal health care. In particular, there were versions of the legislation creating the Social Security Administration in 1935 that included health care coverage, but these continued to be opposed by the American Medical Association (AMA) and, as before, the health provisions were defeated.

1940-1960

The shift to the employer-provided health insurance system that is in place today occurred during World War II. The war economy led to caps on wage increases. Without the ability to offer higher pay, companies began to offer health benefits as a way to compete for workers.

Three main factors led this employer-provided health insurance to become entrenched: First, in most circumstances -- unlike in the case of wages -- neither employees nor employers were responsible for paying income or payroll taxes on health benefits. Second, commercial insurance companies had seen the success of Blue Cross and Blue Shield and were eager to begin offering policies. And third, it was a time period of low unemployment, so an employer-based system effectively provided health insurance to most of the population.

Despite the widespread adoption of employer-provided health insurance that covered both workers and their families, there continued to be calls for universal health care. The United States helped craft United Nations (UN) treaties that guaranteed every citizen the right to adequate medical care, but President Harry S. Truman's proposals and the 1945 Wagner-Murray-Dingell bill to create a single, nationalized system of health insurance were labeled "communist" or "socialized medicine" and, once again, were defeated.

1960s

Commercial health insurance was now thriving, with over seven hundred companies selling policies. But the system began to show cracks as people who were not employed by large companies (like domestic workers and senior citizens) could not find or afford insurance.

President Lyndon B. Johnson's War on Poverty, combined with a Democratic majority in Congress, created a climate open to federal solutions to this problem. In 1965, to address the lack of coverage available to the elderly, Congress created Medicare. Part A automatically enrolled citizens at age 65 in a major medical (hospitalization) policy. Part B provided supplemental insurance that subsidized costs for nonhospital medical services. The expenses for this coverage would come from payroll and income taxes, trust fund interest, and enrollee premiums.

Under Medicare, the federal government established reimbursement rates for various medical services. However, to ensure that physicians would not refuse to treat Medicare patients, the initial legislation allowed doctors to bill patients directly at whatever rate they wanted. Patients could seek reimbursement from Medicare, but only for the Medicare-approved rate. So patients were responsible for covering out-of-pocket any difference between what their physicians charged and what the government would reimburse. That would change in 1983, when Congress enacted a fee-for-service payment system that reimbursed doctors directly at set fees.

Medicaid was also established in 1965. Intended to guarantee health care for the indigent, program eligibility was determined according to a means test. The program was jointly funded and administered by a state-federal partnership. This meant that while the federal government established coverage minimums, actual benefits and eligibility differed in every state.

1970s

As health care costs continued to rise, President Richard Nixon once again attempted to pass a national health insurance plan, but his proposal was opposed by labor unions, who preferred a single-payer system to the president's system relying on private insurance provided through employers, and the plan failed. Nixon did succeed in turning attention to health maintenance organizations (HMOs) by passing legislation (the 1973 Health Maintenance Organization Act) that certified and provided assistance to these group programs.

1980s

The 1980s were marked by corporate takeovers and consolidation of health services. National and regional corporations became owners of hospitals (as opposed to local public and private entities, which had been the case previously). Scientific advancements in treatment and increasing specialization continued to drive up costs. Those increases were met by caps on payments, with fee-for-service and payment-by-diagnosis reimbursement rates set by private insurers and HMOs as well as by the federal government.

1990s

Health care costs continued to rise well beyond the rate of inflation. In response, managed care programs expanded, as did eligibility and benefits for Medicaid and Medicare. Premiums and deductibles for health insurance policies also rose.

In 1997, Congress created the State Children's Health Insurance Program (SCHIP), which provided matching funds to states that were willing to cover health insurance costs for children in families who earned too much to qualify for Medicaid, but too little to afford health insurance on the open market. The goal was to ensure universal health care for every American child, but implementation varied greatly from state to state.

A study published in Health Affairs (<http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.short>) found that nearly half of all individual bankruptcies were health related, and most filings were by middle-class workers who had health insurance at the onset of their medical difficulties. To address the problem, President Bill Clinton attempted to create a comprehensive national health care system, but as had been the case for previous administrations, his proposal failed to pass Congress. By the end of the decade, nearly one-sixth of the U.S. population -- approximately 44 million Americans -- had no health insurance coverage of any kind.

2000-2010

Health care costs continued to rise, leading some employers to back away from providing health insurance to employees and retirees. In contract negotiations, employees' share of premium payments and co-pay fees often increased, making insurance unaffordable even for people who were employed full-time.

Some legislators saw the cost increases as a threat to the solvency of the Medicare trust fund and began to propose "rescues," even as the George W. Bush administration added prescription drug coverage (Part D) to the program, significantly increasing its cost.

In 2008, banking and mortgage loan crises drove the U.S. economy into recession. Millions of Americans lost their jobs and the health insurance tied to those jobs. Millions more found themselves employed in part-time positions that didn't qualify for health insurance. With no other alternatives, more and more of the uninsured sought treatment at ERs for non-trauma-related problems. This not only clogged trauma centers, it raised health

costs for those who had to absorb the fees for very expensive ER visits, including hospital patients, taxpayers (via county, state, and federal taxes), and insurers (who passed along the cost to policy holders in the form of higher premiums).

In 2009, President Barack Obama began to address health care reform, and on March 23, 2010, signed the Patient Protection and Affordable Care Act (commonly known as the Affordable Care Act or ACA) into law. The ACA was written to put into place health care reforms that strive to expand coverage, improve access to health care, and make health care more affordable; major reforms to the health care system will officially begin on January 1, 2014.

Sources:

- » <http://www.pbs.org/healthcarecrisis/history.htm>
- » <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>
- » <http://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/History/>
- » http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html
- » http://www.pnhp.org/facts/a_brief_history_universal_health_care_efforts_in_the_us.php
- » <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>
- » <http://www.whitehouse.gov/healthreform/healthcare-overview>

After viewing the film, imagine what the 2010-2020 paragraph of this section will say. What do you want it to say?

Snapshot: Increases in Health Care Spending		
	1960	2010
1. U.S. population	180.7 million	308 million
2. U.S. health care expenditures	\$27.5 million	\$2.5 billion
3. Health care expenditures as percentage of gross domestic product (GDP)	approx. 5%	above 15%
4. Consumer price index for medical services adjusted for inflation	\$19.50	\$411.20
5. U.S. per capita spending on health care	\$147	\$8,402
6. Percentage of health expenditures covered by private insurance	21.1%	32.7%
7. Number of Americans receiving Medicaid	0 - Medicaid was established in 1965	more than 50 million

Sources:

1. U.S. Census. <http://www.census.gov/popest/data/historical/index.html>.
2. Centers for Medicare & Medicaid Services. "Historical." <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.
3. <http://www.pbs.org/healthcarecrisis/history.htm>; <http://chartingtheeconomy.com/?p=526> (both retrieved July 6, 2012).
4. <http://www.statista.com/statistics/187228/consumer-price-index-for-medical-care-services-in-the-us-since-1960/> (based on U.S. Labor Dept. Bureau of Statistics numbers).
5. Kaiser Family Foundation. Health Care Costs: A Primer. 2012, p.10. <http://www.kff.org/insurance/upload/7670-03.pdf>.
6. Ibid., p.18.
7. Centers for Medicare & Medicaid Services. <http://cms.gov>.

Current Health Care Models

Single-Payer – Governmental Model

Perhaps best illustrated by the United Kingdom, but also used in Spain, New Zealand, and much of Scandinavia, in this model, health care is provided and financed by the government through tax payments. The government owns most hospitals and clinics and some doctors are salaried government employees, though there are still private doctors and hospitals that are eligible for government payments. In addition to government-provided health care, residents have the option of purchasing private insurance. This secondary, private market is available for those who can afford it, funded as part of an employer-funded health care plan or paid directly by the customer.

For government-funded public health care, financial transactions take place between care providers and the government; no patient ever gets a doctor bill and no one ever goes bankrupt from medical expenses. Because the government is the sole payer, it controls what doctors can do and what they can charge. Some governments do not pay a fee for service, so there is no incentive to perform unnecessary tests or procedures; instead they determine a fixed fund for care and offer financial incentives for keeping patients well.

National Health Insurance (Single-Payer – Nongovernmental Model)

Used by Canada, Taiwan, and South Korea, this model uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims, and no profit, these national health insurance programs tend to be cheaper and much simpler administratively than systems relying on for-profit insurance providers.

Like the government-run single-payer system, the government insurance agency is the sole payer and therefore has considerable market power to negotiate for lower prices. National health insurance plans also control costs by limiting the medical services they will pay for or by making patients wait to be treated.

Universal Insurance

Sometimes described with words like “compulsory” or “mandated,” this system requires everyone to enroll in a not-for-profit insurance fund (often referred to as a *sickness fund*). Employers and employees, through payroll deductions, usually finance these funds jointly, with government subsidies for those who are indigent or unable to work. Multiple funds compete to enroll members by adding various perks and supplements (sometimes for an additional charge) to a required basic package of services. The idea is that competition for subscribers improves service and keeps costs down (though tight government regulation is also used to

control costs). The number of funds in nations that use this system varies widely. For example, Germany has about 240; Israel has 4.

In this system, doctors and hospitals tend to be private and are paid by the funds. In many places, individuals also pay small co-pays for certain services. This model is used in Germany, France, Belgium, the Netherlands, Japan, Switzerland, Israel, and some Latin American countries.

The Out-of-Pocket Model

In poor or politically unstable nations, there is no system of health insurance. In these countries, those who can afford it pay for care out-of-pocket. The poor stay sick, seek help from local healers as they are able (perhaps bartering for treatments), receive care from a charity-run medical program, or die.

The United States

The United States currently employs elements of every major model, depending on an individual's status:

- Military veterans receive care in a single-payer, government-run system (the Department of Veterans Affairs).
- The elderly and some chronically ill and disabled people are automatically enrolled in Medicare, which is similar to a national health insurance system.
- Government assistance is provided to qualifying low-income people. Medicaid provides free or low-cost health care to qualifying families and individuals (pregnant women, the elderly, and people with disabilities) based on income and family size. SCHIP provides health insurance to children whose family income is too high to qualify for Medicaid, yet too low to afford private insurance.
- Those who receive health insurance through their employers are part of a system that is similar to universal compulsory insurance.
- Those who are uninsured are essentially operating in an out-of-pocket model.

The ACA expands the number of people covered in the various insurance categories. It puts a twist on the universal insurance model by mandating that people purchase insurance, but rather than restricting insurers to being not-for-profit, the law creates exchanges through which those who are not employed can purchase insurance from private companies. The ACA decreases the number of uninsured, but it does not unify the system nor does it guarantee coverage for all.

Sources:

- » <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html>
- » <https://www.healthcare.gov/>

What does the film reveal about the strengths or weaknesses of the current health care models? Which model or combination of models do you think would most effectively provide Americans with access to medical care?

- minorities are much more likely to be uninsured than whites. About one-third of Hispanics and nearly one-quarter of black Americans are uninsured, compared to 14 percent of non-Hispanic whites;
- the majority of the uninsured (81 percent) are native or naturalized U.S. citizens.

Source:

» The Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer*. Washington, D.C.: Kaiser Family Foundation, 2012. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7451-08.pdf>.

Who Is in the Waiting Room?: Demographics of the Uninsured

Prior to passage of the ACA, there were three main groups of Americans who had health insurance:

1. People 65 years and older (covered by Medicare)
2. People who obtain health insurance through their employer or membership in a professional group (this accounts for 56 percent of all Americans)
3. People living in poverty (through Medicaid, SCHIP, or other state-subsidized programs)

While covering most Americans, this system left approximately 49.1 million people in the United States -- 18.5 percent of those under age 65 -- without health coverage. Of this group:

- more than three-quarters of the uninsured are in working families: roughly 61 percent are from families with one or more full-time workers and 16 percent are from families with part-time workers;
- nine in ten of the uninsured are in low- or moderate-income families. Individuals below the poverty line make up 41 percent of the uninsured (the poverty level for a family of four was \$22,050 in 2010);
- adults make up a disproportionate share of the uninsured because they are less likely than children to be eligible for Medicaid;
- young adults (ages 19 to 25) comprise a disproportionately large share of the uninsured. Half of uninsured young adults are from families with at least one full-time worker, but their low incomes make affording coverage difficult. The average income of uninsured young adults in 2010 was less than \$12,000;
- more than half (60 percent) of nonelderly uninsured adults have no education beyond high school, making them less able to get higher-skilled jobs that are more likely to provide health coverage;

How do each of the people in the film exemplify or contradict the typical characteristics of the uninsured?

Is Health Care a Universal Human Right?

The United States helped author and then became a signatory to two different UN declarations that defined access to medical care as a basic human right:

The Universal Declaration of Human Rights

Adopted by the UN General Assembly on December 10, 1948, the Universal Declaration of Human Rights was developed in response to the experiences and atrocities of the Second World War. Article 3 of the document states that “everyone has the right to life, liberty and security of person.” Health care is specifically addressed in Article 25:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

UN International Covenant on Economic, Social and Cultural Rights

This was adopted on December 16, 1966, and Article 12 reads:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) the improvement of all aspects of environmental and industrial hygiene;
 - (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

A Moral Right

Further reinforcing the notion that health care is a right are basic precepts taught in modern medical schools that doctors should “do no harm,” exercise all the knowledge and skill they have to return patients to health, and treat every patient to the best of their ability no matter the patient’s character or standing. In a compassionate society, we expect physicians to accept that they have a moral obligation to help alleviate suffering rather than turn away from it.

Sources:

- » <http://www.un.org/en/documents/udhr/index.shtml>
- » http://treaties.un.org/Pages/ViewDetails.aspx?mtdsg_no=IV-3&chapter=4&lang=en

As you watch the film, use the Articles from the UN declarations as a checklist to determine how well the United States is meeting its obligations as a signatory.

How the ACA Proposes to Address Health Care Policy

In 2010, Congress passed the Patient Protection and Affordable Care Act, often abbreviated as “ACA” or “Obamacare.” The ACA is a complex law and it is beyond the scope of this guide to cover every detail. Instead, this section zeroes in on a few central issues. The two columns under each issue describe the ACA and the single-payer approach favored by progressives.

As you consider each of the alternative visions of health care reform, choose a person in *The Waiting Room* and think about how their situation would be affected by the ACA, and the single-payer system. Assess the different approaches and think about who makes final decisions about health care, how costs are distributed (i.e., Who pays?), and who benefits financially.

The Problem:

Millions of Americans Have No Insurance.

There are many reasons that people are uninsured. Some simply choose not to purchase. Others would like to have coverage, but have been denied because they have a preexisting condition or have maxed out their policy's lifetime cap for payouts. The majority of uninsured people cannot afford premiums. They live below the poverty line, choose not to purchase health insurance, are unemployed (and cannot afford the exorbitant premiums charged to individual purchasers), or are employed but are not eligible for their employer's insurance or cannot afford the premium required to participate in their employer's coverage.

As we see in *The Waiting Room*, having no insurance or having public insurance where access to primary care can be a major challenge, can lead to delays in seeking treatment and skipping doses of medication necessary for managing chronic but treatable conditions. The resulting damage to health can make people less productive as employees or can make them unable to work altogether, causing taxpayers and employers to shoulder the costs of unemployment and disability payments. Yet when health conditions deteriorate, some seek treatment at the ER as a last resort for primary care and join the trauma patients who do not carry insurance because they were healthy and mistakenly believed they could cover their own out-of-pocket costs. The expenses from their unpaid bills are then absorbed by everyone else through higher insurance premiums or increased tax funding for public hospitals (which leaves less public funding available for other needs).

Proposed Solutions:

The ACA

Mandates every individual to purchase health insurance or pay a penalty for not doing so. The penalty will be waived for those who qualify.

People who are not covered by Medicare, Medicaid, or an employer or group policy must purchase private insurance. They can do so on the Health Insurance Marketplace, a government-run exchange. Costs of this insurance may be subsidized through the Advance Premium Tax Credit, where savings will depend on one's income and family size.

Tax incentives for small business are designed to guarantee affordability and access.

Young adults are now eligible to stay on their parents' health insurance plans as they enter the workforce, until they turn 26.

The original law included a provision expanding the number of people eligible for Medicaid. However, it was found by the Supreme Court to be unconstitutional, leaving the possibility that several million Americans will remain without insurance even after the law takes full effect in 2014. The Obama administration estimates that once the law is fully implemented, about 95 percent of Americans under age 65 will have insurance.

Single-Payer Alternative

Mandates that everyone pay into a single, government-run fund that pays private-sector providers to deliver services.

The Problem:

For Individuals with Preexisting Conditions, It Is Nearly Impossible to Obtain Insurance.

Traditionally, insurance companies have excluded people with preexisting conditions as a way to counter possible fraud (e.g., someone purchasing coverage only after they have been diagnosed with an illness or injury) and to avoid being saddled with a pool of insured people who need expensive care. Group policies that enroll a wide range of individuals (e.g., covering all the workers in a company or all the students and staff at a university) generally mitigate the latter concern.

However, a large number of people who are not intending to defraud insurance companies and who are willing to pay reasonable premiums are, nonetheless, denied coverage. So, for example, their employer's insurer could deny a person new to their job insurance because they had childhood leukemia, even though they have been in remission for thirty years.

Denial of coverage for preexisting conditions puts a drag on the economy because people are forced to keep their current job in order to keep existing coverage. That can mean that they lose out on promotions, that spouses remain unemployed because the family can't move to another city, and that employers lose the opportunity to hire the best person for the job.

Proposed Solutions:

The ACA

Prior to 2014, the Pre-Existing Condition Insurance Plan (PCIP) was temporarily set up to provide insurance to people with health conditions who have been uninsured for six months, helping those with cancer or other serious conditions to get the treatment they need.

In 2014, PCIP ends, but insurers must continue to provide coverage to individuals with preexisting conditions and cannot charge higher rates based on gender or health status.

For insurers, instituting a mandate that everyone purchase insurance broadens the risk pool.

Single-Payer Alternative

Because everyone is covered, the category of "preexisting condition" ceases to be relevant.

The Problem:

There Are Many Ways That Individuals Who Pay Their Premiums Can Lose Coverage.

For-profit insurance companies need to provide a return to investors. This can lead to policies that deny coverage to people who have paid insurance premiums. These include:

- the imposition of lifetime caps for payment, so if someone incurs charges that are more than their lifetime cap, not only do they have to pay out-of-pocket, but they will be dropped by their insurance company. In such circumstances, the chances of finding another company that would provide coverage are minimal;
- a person who changes jobs being subject to a waiting period before being eligible for coverage at the new workplace. If medical services are needed during the waiting period, that person is obligated to cover the cost;
- an insurance company simply refusing to cover physician-recommended treatments by claiming the recommendation doesn't conform to the company's accepted treatment protocols. Companies have also denied coverage by claiming that individuals failed to fully disclose their health status during the application process, even if the omission was minor and inadvertent.

In addition to raising questions about fairness and financial loss caused by having paid premiums that provide no benefit, denial of coverage creates a class of people who are uninsured.

Proposed Solutions:

The ACA

Bans lifetime caps and makes those who had already hit a lifetime limit eligible for unlimited coverage.

Consumers have the ability to appeal to an independent third party when insurance companies refuse to cover services or care.

Starting October 1, 2013, the Health Insurance Marketplace will be a resource consumers can use to compare all the plans in their area and find the coverage that best fits their budget and health care needs.

In 2014, all Americans will have access to health insurance no matter their circumstances -- whether they change jobs, lose their job, decide to start a business, or retire early.

Single-Payer Alternative

Health care is guaranteed. There is no way for a citizen to lose coverage.

The Problem:

Health Care Costs Continue to Rise Much Faster Than the Rate of Inflation.

There are significant disagreements about why health care costs have escalated dramatically since the mid-1900s. Some blame government programs while others lay responsibility at the feet of corporations in pursuit of profits, or the growth of expensive pharmaceuticals, medical devices, and surgical procedures.

No matter what the reason, extremely high costs place an enormous burden on local, state, and federal governments; on employers; and on individuals. Funds set aside for health care can prevent governments from spending on other necessities, keep employers from expanding their businesses, and dampen consumer spending. So, while health care employs many people and thereby contributes to the economy, when costs are too high, it serves as a drag on the nation's economy.

Proposed Solutions:

The ACA

Insurance exchanges through the Health Insurance Marketplace will create competition that keeps costs down.

The Advance Premium Tax Credit will provide subsidies for health coverage purchased through the Health Insurance Marketplace and for those who qualify based on income and family size.

Medicaid is expanded to families of four with yearly incomes of up to \$29,000 and individuals with yearly incomes of up to \$14,000.

Insurance companies are required to publicly justify rate hikes and provide rebates if they don't spend at least 80 percent of premiums on care instead of on overhead, marketing, and profits.

All new insurance plans are required to cover certain preventive services without charging a co-pay or deductible.

Preventive and coordinated care, and elimination of waste and abuses will produce cost savings.

Single-Payer Alternative

The system makes care affordable for everyone by: eliminating costs associated with for-profit private insurance (e.g., big CEO salaries, advertising, confusing paperwork from hundreds of different companies); bargaining for discounts on pharmaceuticals, medical devices, and services; eliminating both delays in seeking needed care and using an ER for primary care; consolidating all health programs into a single system, thereby eliminating the need for separate Medicaid, Medicare, and Department of Veterans Affairs health programs.

Though some single-payer plans would still have employers paying into the system, the fees would be predictable and thus remove the uncertainty that many companies now face.

Sources:

- » <http://www.barackobama.com/health-care/> (retrieved July 6, 2012)
- » <http://www.pnhp.org/facts/single-payer-resources>
- » <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html>
- » <https://www.healthcare.gov/>
- » <http://www.healthcare-now.org/whats-single-payer>



Discussion Tools

Discussion Prompts

Identifying and Understanding the Challenges

- What did you learn from the film about the challenges of delivering primary health care in an environment designed for emergency medicine?
- Consider these phone conversations:
 - *Certified Nursing Assistant (CNA) Cynthia Johnson explains that the caller can't make an appointment at an ER.*
 - *Veronica Couvson explains that in an emergency department doctors can't write prescriptions without actually seeing the caller as a patient, even for some one who had previously been in the ER. Because doctors rotate daily, the caller would have to come in again.*

Why might callers have misperceptions about the role of the ER in their community? What are the possible sources of their ideas?

- Dr. Douglas White says, *"Unfortunately we see a lot of patients coming in with very treatable conditions who don't have access to a regular doctor. I know that I can make someone better in the short-term. But the ER is not the place to manage someone's overall health. It's going to require a heck of a lot more follow-up that I can't provide."* In your view, who should provide the follow-up that ER doctors can't?
- One of the doctors describes a familiar patient: *"So, this is our gentleman that came in, found down, apparently he doesn't take his medicines that would help him stay out of the hospital. Um, he comes in, I mean I'm just looking back; he's come in a dozen times this year. August, July, June, June, May, May, May, March, March, February, February, February, February, February."* Patients leave the ER with medication, but when it runs out and they can't afford more, they return. How does everyone in the community pay for this cycle? What else would you do to create a more efficient, effective system?
- A female patient anticipates an all-day wait: *"I'm just sayin'. You have a long wait. You have to bring your blanket, your dinner, your lunch and all that."* A man with a bullet in his leg becomes increasingly frustrated because even with pain, nausea, and increasing numbness he can't be seen for hours because there are no beds available. Dr. White provides one explanation: *"Not everyone has a place to go and there are often times where I don't want to send a patient out into the cold with bad lung problems and no access to get medicines that night. I can't just send them to the street. Uh, so there's no...there's no movement on that bed and nobody in the waiting room can use that bed until that patient has a place to go. If I was a patient in the waiting room, knowing that there was somebody who was completely stable and didn't need to be admitted but there's nowhere else to go and I was stuck waiting for that bed, uh I think I would be pretty darn frustrated."* What else causes long waits? What is the cost of those long waits? Who pays that cost? What would need to happen, both in and outside of the hospital to reduce wait time?
- CNA Johnson escorts an elderly, somewhat disoriented patient to the bus stop, and viewers are left to wonder whether or not the woman gets on the bus and makes it home safely. In another part of the hospital, social worker Ricka White-Soso struggles to find someone to take a chronic substance abuser so they can release him and free up a bed. In your view, what should the hospital do if she can't find anyone? What should happen to patients who are finished with treatment but who don't have any place to go, or patients who don't need hospital treatment, but need some supervision and don't have anyone to provide that supervision?

- Davelo Lujan finds out from the financial counselor that the best help he can qualify for would be a 60 percent discount on his bill. Eric Morgan finds out he can get help with Highland's bill, but not with the charges he incurred at Kaiser. Both men are in Highland's ER because they can't afford health insurance or the care they need. So how do discounts and partial payments help? If you could redesign the system, what would you do to ensure that men like Morgan and Lujan aren't forced into bankruptcy because of necessary medical expenses?
- How would you characterize the people in the waiting room? What adjectives would you use to describe them? To what degree are they responsible for the situations they are in and to what degree have their choices been made for them? Which aspects of their situations are purely individual and which are structural?

Close-Up on the Hospital and Staff

- Use what you see in the film to compare Highland Hospital's ER to the ERs of your local public and private hospitals. What are the similarities and differences? What do you think accounts for the differences that you observe?
- List the stressors for staff members in Highland Hospital's ER. Which of these stressors are preventable and which are simply part of the job (e.g., the death of the 15-year-old trauma patient)? What would you do to mitigate or help staff cope with the stressors?
- Dr. White recalls that many people like him chose emergency medicine *"because of the TV show [ER], or the media portrayal of the ER as an intense, high-adrenaline, nonstop action world."* How does what you have seen in popular media compare to what you see in this film? How do media portrayals of doctors, nurses, and hospitals compare to your own personal experiences?
- Think about CNA Johnson's interaction with the man who hadn't taken his diabetes meds because they had run out, the father worried about his young daughter with a fever and swollen throat, and the man who had been using abusive language. If you were evaluating her work, how would you rate her performance? What, specifically, does she do that is effective?
- Based on the roles of the health care workers you see in the film, how would you design their pay scale? Who should be paid the most? Why? What criteria would be the most important in determining pay and why? Amount of time spent with patients? Education level? Contribution to the efficiency of the hospital? Something else?

Going Public

- Dr. White ponders Carl Connelly's case: *"That'll do it. So he got the million-dollar work-up for a rough night out. He's basically been denied by his pastor Boswell ... I've admitted him for increased work of breathing, but it's more about, it's actually more of a social condition.... We never know the right answer on this one. There are times I have to admit people to the hospital, keep them overnight, just as much for their social conditions as for their medical ones. It's not ideal, but we're a public hospital. We're the safety net in society. We're an institution of last resort for so many people."* What are the systemic costs of making public hospitals the default "institution of last resort"? In your view, does it make sense for public hospitals to function as society's "safety net"? Why or why not? If hospital beds are reserved for medical conditions, whose job should it be to deal with the social conditions that Dr. White references?
- Glenn Terry says that he has been told to come to Highland for dialysis -- an essential but not an emergency procedure. Why would another hospital have instructed him to come to Highland? From what you see in the film, how would you describe the impact of this deflection of responsibility from one institution to another on Mr. Terry's health?
- In the film, a recently unemployed woman has trouble providing ID. She explains that she would have gone to another hospital, but because she lost her job she is "trying to get a Highland card." What role does shame or embarrassment play in the interactions between public hospitals and people who are seeking help?

Broadening the Discussion

- In your view, is health care a right? Why or why not? In what ways would our health care systems change if they were based on the notion that every person has a right to basic medical care?
- Barbara Johnson, an elderly diabetes and dialysis patient, asks CNA Johnson for something to eat. Johnson provides her with a sandwich. Under what circumstances is food part of medical care? If food is a medical necessity, should its cost be covered by health insurance? Why or why not?
- We see a woman on the phone trying to get a ride home: *"So could you meet me or you don't want to sound like it. Because I got a gang of Vicodin, I got ... I got bus tickets, I've got a ten-dollar card for Safeway to buy food if you want that for like three packs."* What is or should be the role of transportation in the health care system? How do people in your community get to and from the medical services they need? Are those transportation methods efficient? Who absorbs the cost?

- In the beginning of the film there is an issue with a patient who doesn't speak English. Fortunately, she has a man with her who translates. Why would the nurse want to hear from the patient herself and not from the man accompanying her? Who should supply translation for someone who doesn't arrive with an English speaker? Should they be able to bill Medicaid, Medicare, or an insurance provider for the services of a translator? Why or why not?
- We see a woman and her family praying to relieve their loved one's pain. In your view, what is the role of faith in healing? What role should religion play in the overall design of an effective health care system? In which situations and structures can faith traditions be most helpful and where might they create obstacles?
- Dr. White describes regular ER visitors like Carl Connelly: *"After a certain point we know them. We know them by first name, they know us by first name."* He knows Connelly has substance abuse issues, but still has to do a full work up on him. Why? What are the ethical and legal issues that prevent the ER from turning away patients like Connelly or from putting them last in line through a triage process?

Individual Stories

- If you could ask anyone in the film one question, who would you ask and what would you want to know? Why is that question interesting or important to you?
- Consider the stories of Demia Bruce and Davelo Lujan. Bruce, the worried father who brings in his daughter with a throat infection, says, *"This is the first time I've gone almost a year without a job. I'm used to having those benefits. You know, that's how important a job is: to be able to have somebody look at her as soon as possible. And it just seems, it just seems like a let down. You have to just depend on somebody to help you out when you're not having the means to do it yourself the right way. You know? Just, it's okay -- I'm glad that there's a way to provide the help out, but I wish there would've been another way for me to do this."* Lujan is the self-employed carpet layer whose wages have been cut; so despite being employed for 30 years, he is broke. What do their experiences suggest about the benefits and drawbacks of having health insurance tied to employment?
- Staff members urge Bruce to be calm so that his concerns don't upset his daughter. They don't learn until much later that he and his ex-wife lost a 2-year-old son in a hospital after they brought him in with a seizure. How might this piece of information have changed their interactions with Bruce? Is it reasonable to expect staff in a busy ER to take full family histories? What is lost if the system can't carve out that time, both for patients and for staff?
- Lujan needs pain relief so he can work, because if he doesn't work he can't afford the treatment he needs for the bone spurs in his back. Dr. Amandeep Singh tells Lujan that the ER can't do anything for him because his medical condition is chronic, so he'll have to talk to his regular doctor about getting help. But Lujan doesn't have a regular doctor, which is why he came to the ER. Ricardo Manalastas shows up with the effects of a stroke after being sent home from a clinic without his blood pressure medication because he didn't have insurance. The doctor would like to admit him, but Manalastas can still walk (which is a good sign in terms of potential recovery), so protocol labels him a general medicine patient. With that status, he can't be admitted and the general medicine department is so backed up that they can't see him for months. How does the system create catch-22s that prevent these men from getting the care they desperately need? What could be changed to avoid creating such catch-22s?
- Eric Morgan delayed seeking treatment and "self-medicated" because he didn't have insurance, and because, as a young adult, he didn't have any reason to suspect that it was an emergency. When he decides he needs care, he has trouble getting an appointment with a doctor. He eventually gets in to a private hospital where tests reveal he needs immediate surgery for testicular cancer. But they cancel his scheduled surgery when they discover he is not a Kaiser policy holder. He shows up at Highland after raising funds from friends and family to cover the cost of depositing sperm at a sperm bank so that he will have a way to have children even if cancer treatment renders him sterile. What do you learn from Morgan's story about the impact of health insurance (or the lack thereof) on the medical decision-making process? Who is empowered to make decisions and at what points in Morgan's diagnosis and treatment? Should the people paying for care get to make decisions about what a person is or isn't allowed to do, or should individuals be able to make such decisions autonomously? What if they opt for expensive procedures for non-life-threatening conditions (e.g., preserving one's ability to bear children) but expect others to foot the bill?
- How will the ACA change the situations of these people?
 - Eric Morgan – the man seeking surgery for testicular cancer who comes in with his girlfriend, Daniela Cyganik
 - Ricardo Manalastas – the 44-year-old who exhibits signs of having had a stroke
 - Davelo Lujan – the carpet layer with a back injury
 - Déjà Bruce – the child with strep throat, and her mother, Nicole Douglas, and father, Demia Bruce

Supporting Health Care Workers

Background

According to the U.S. Department of Labor and the Occupational Safety and Health Administration (OSHA):

- More workers are injured in the health care and social assistance industry than in any other job category.
- In 2010, the health care and social assistance industry reported 653,900 cases of injury and illness -- that is 152,000 more cases than the next closest industry: manufacturing.
- In 2010, health care and social assistance workers were the victims of approximately 11,370 assaults, a greater than 13 percent increase over the previous year.
- Hospital work routinely requires coping with some of the most stressful situations found in any workplace, including overwork, understaffing, tight schedules, paperwork, intricate or malfunctioning equipment, complex hierarchies of authority and skills, dependent and demanding patients, and patient deaths.
- Hospital workers report that the consequences of working under stress include difficulties in communicating with very ill patients, in maintaining pleasant relations with coworkers, and in judging the seriousness of a potential emergency.

Discussion

As you watch *The Waiting Room*, think about each of the staff members on screen (nurses, doctors, social workers, and administrative staff):

- How does their day compare to your own experiences?
- Who are the best professional role models and why?
- What strategies do they use to reduce patient stress?
- What strategies do they use to reduce their own stress?



Stress-Reduction Checklist

This checklist is developed from OSHA's recommendations for stress reduction. As you watch *The Waiting Room*, use the list to identify which strategies are in use [Yes / No / No information Available]. Discuss which are currently used or which you would like to see in your own workplace. [Yes, in use / No, not used / Unsure / Want to see in my workplace]. To wrap up your discussion, identify any "Wants" which there is consensus and brainstorm action steps the group could take to put the ideas into practice.

<i>The Waiting Room</i>				My Workplace			
Y	N	N/A		Y	N	U	W
			Provide an organized and efficient work environment.				
			Provide adequate staffing / establish reasonable work loads.				
			Provide reasonable shift schedules to allow adequate time for sleep each day.				
			Recognize and take action on legitimate complaints regarding overbearing supervisors.				
			Establish regular staff meetings and discussions to communicate feelings, gain support, and share innovative ideas.				
			Provide on-the-job education about stress-reduction techniques.				
			Provide readily available counseling from a nonjudgmental source.				
			Provide flextime and/or flexible scheduling to accommodate workers' personal needs.				
			Provide breaks long enough to take advantage of stress-reduction techniques like exercise, walks outside, or yoga.				
			Provide adequate work space.				
			Ensure that work tasks and expectations are in line with workers' capabilities and resources.				
			Design jobs to provide meaning, stimulation, and opportunities for workers to use their skills.				
			Clearly define workers' roles and responsibilities.				
			Give workers opportunities to participate in decisions and actions affecting their jobs.				
			Provide frequent in-service educational sessions and other opportunities to improve skills and confidence.				

Sources:

- » <https://www.osha.gov/SLTC/etools/hospital/hazards/stress/stress.html>
- » <https://www.osha.gov/SLTC/healthcarefacilities/index.html>
- » <https://www.osha.gov/SLTC/healthcarefacilities/violence.html>
(all retrieved July 13, 2012)

Survey Tool: What Do You Know?

The survey below is designed to be used in two different ways:

1. You can take the survey yourself as a way to assess your own knowledge and think about how your personal situation compares to national averages
or
2. You can use the questions to conduct in-person surveys or create an online survey (using a tool like SurveyMonkey) to collect data from your organization or community. Use the survey results to focus education efforts on the areas where there are the most misconceptions or to engage people in conversations about the issues.

1. On average, which of the following is the best predictor of one's health?

- a) Whether or not one smokes
- b) What one eats
- c) Whether or not one is wealthy
- d) Whether or not one has health insurance
- e) How often one exercises

2. In 2010, the total dollar amount that the United States spent on health care was:

- a) \$856 million
- b) \$2.6 billion
- c) \$56.8 billion
- d) \$2.6 trillion

3. In 2008, how many visits were made to hospital ERs in the United States?

- a) 83.8 million
- b) 103.8 million
- c) 123.8 million
- d) 153.8 million
- e) 173.8 million

4. How many Americans reported that in the past 12 months, they or someone in their household did not fill a prescription because they could not afford it?

- a) 1 in 100
- b) 1 in 75
- c) 1 in 50
- d) 1 in 25
- e) 1 in 4

5. How does American life expectancy compare to that of other countries? The United States is:

- a) Number 1
- b) In the top 5
- c) In the top 10
- d) In the top 25
- e) In the top 50

6. Which of the following groups is the most likely to have reported at least one ER visit in the last year?

- a) People without insurance between the ages of 45 and 64
- b) People with private insurance between the ages of 45 and 64
- c) People without insurance between the ages of 18 and 44
- d) People with private insurance between the ages of 18 and 44
- e) Children under age 18 not covered by insurance
- f) Children under age 18 covered by private insurance

7. In 1960, the share of U.S. economic activity (GDP) spent on health care was about 5 percent. In 2010 the share was:

- a) 1.9 percent
- b) 7.9 percent
- c) 17.9 percent
- d) 27.9 percent
- e) 37.9 percent

8. In 2011, annual worker contributions for employer-sponsored health insurance for a family averaged:

- a) \$2,129
- b) \$4,129
- c) \$6,129
- d) \$8,129

9. Spending on prescription drugs accounts for what percentage of total health spending?

- a) 2 percent
- b) 10 percent
- c) 30 percent
- d) 45 percent

10. In 2012, what percentage of Americans said they experienced serious financial problems due to family medical bills?

- a) 1 percent
- b) 7 percent
- c) 17 percent
- d) 25 percent
- e) 33 percent

Answer Key

1. On average, which of the following is the best predictor of one's health?

c) Whether or not one is wealthy

In the United States, the single strongest predictor of health is one's position on the class pyramid. Those at the top have the most power and resources and on average live longer and healthier lives. Those on the bottom are exposed to many health threats over which they have little or no control -- insecure and low-paying jobs, mounting debt, poor child care, poor-quality housing, less access to healthy food, unreliable transportation, and noisy and violent living conditions -- that increase their risk of chronic disease and early death. Even among smokers, poor smokers face a higher mortality risk than rich smokers. Those of us in the middle are still worse off than those at the top.

2. In 2010, the total dollar amount that the United States spent on health care was:

d) \$2.6 trillion

In 2010, Americans spent an average of \$8,402 per person on health care. However, just 2 percent of the population accounts for 50 percent of the spending.

3. In 2008, how many visits were made to hospital ERs in the United States?

c) 123.8 million

In 2008, U.S. ERs recorded a total of 123.8 million visits. Of those visits, 13 percent resulted in admission to the hospital and 1.7 percent resulted in transfer to another hospital.

4. How many Americans reported that in the past 12 months, they or someone in their household did not fill a prescription because they could not afford it?

e) 1 in 4

In addition, 33 percent (1 in 3) reported relying on home remedies and over-the-counter drugs rather than visiting a doctor, and 28 percent said they postponed getting health care they needed.

5. How does American life expectancy compare to that of other countries? The United States is:

e) In the top 50

American life expectancy is 77.9 years. We are tied with South Korea and Denmark for 29th place, despite spending 2 ½ times more on health care than the average spent by other industrialized countries and despite claims that we have the best health care in the world. Japan has the highest life expectancy at 82.3 years.

6. Which of the following groups is the most likely to have reported at least one ER visit in the last year?

c) People without insurance between the ages of 18 and 44

Among adults aged 18 to 44 the uninsured were more likely than those with private insurance to have at least one ER visit. In the other age groups, people without insurance were no more likely than those with private insurance to report an ER visit.

7. In 1960, the share of U.S. economic activity (GDP) spent on health care was about 5 percent. In 2010 the share was:

c) 17.9 percent

The amount that Americans spend on health care as a percentage of U.S. GDP has increased steadily since World War II. This means fewer funds available to meet other needs.

8. In 2011, annual worker contributions for employer-sponsored health insurance for a family averaged:

b) \$4,129

At the same time, the contribution from employers to a family-coverage health insurance policy was \$15,073, bringing the total cost of coverage to more than \$19,000 per family per year. For individual coverage the cost averaged \$77 per month.

9. Spending on prescription drugs accounts for what percentage of total health spending?

b) 10 percent

Though spending on medications accounts for only one-tenth of health care spending, the amount has grown rapidly over the last decade (up 114 percent from 2000 to 2010). By contrast, in 2010, 31.4 percent of all health expenditures were for hospital care, and 19.9 percent for physician and clinical services.

10. In 2012, what percentage of Americans said they experienced serious financial problems due to family medical bills?

c) 17 percent

Of these individuals who experienced serious financial problems due to family medical bills, approximately 11 percent said they had used up all or most of their savings, 11 percent had been contacted by a collection agency, and 7 percent reported being unable to pay for basic necessities like food, heat, or housing. The United States is the only industrialized nation where people routinely go bankrupt because of medical bills.

Sources:

- » Centers for Disease Control and Prevention. "FastStats: Emergency Department Visits." <http://www.cdc.gov/nchs/fastats/ervisits.htm>.
- » Kaiser Family Foundation. Health Care Costs: A Primer. 2012. <http://www.kff.org/insurance/upload/7670-03.pdf>.
- » Unnatural Causes. "Health Equity Quiz." http://unnaturalcauses.org/interactivities_01-1.php.

Resources

Where to Find Assistance

If You Need Low-Cost Medical Care

- » <http://findahealthcenter.hrsa.gov/> -- This section of the Health Resources and Services Administration (part of the U.S. Department of Health and Human Services) website will help you locate a federally funded health center that provides medical and dental services on a sliding-scale fee based on ability to pay.
- » <http://www.medicaid.gov/> -- Medicaid is administered by individual states, so each state's rules and programs are different. This website includes state-specific links for information about getting Medicaid or SCHIP (for children) coverage.

If You Are Looking for Insurance or Information on the Affordable Care Act (ACA)

- » <http://www.Healthcare.gov> -- The Health Insurance Marketplace website includes interactive sections on finding and understanding your insurance options, and how the ACA could affect you.

If You Are a Senior Citizen or Approaching Retirement

- <http://www.Medicare.gov> -- The official government website for Medicare includes comprehensive information about Medicare, including a "Getting Started with Medicare" section that walks you through the necessary steps to enroll.
- » <http://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-starter-guide.html?intcmp=HP-link1-spot1C> -- This section of the AARP website provides an online "Medicare Starter Kit" -- including a "Doughnut Hole Calculator" -- in both English and Spanish.

For additional information on where to find assistance, check with your city or county's Department of Social Services or of Children and Family Services. Or, in large cities, information may be found at the Health and Human Services division of the city's government.

Websites and Organizations

The Waiting Room

- » <http://www.whatruwaitingfor.com/> -- The film's official website includes a Facebook page, Twitter feed links, reviews, and information on the filmmaker and cast of characters. It also includes vignettes from the waiting room, searchable by "emotion" or "issue," and offering an online opportunity to comment.

The ACA

- » <http://www.whitehouse.gov/healthreform> -- The "Health Reform in Action" section of the White House website hosts the Obama administration's account of the road toward passage of the ACA, including links to key speeches, as well as explanations of the law's components.
- » <http://kff.org/health-reform/> -- The "Health Reform" section of the Kaiser Family Foundation website has extensive information on the ACA (including an animated explanation), health care costs, insurance statistics, links to key federal documents, and more. This is one of the most comprehensive websites on health reform and an excellent place to begin research on the topic.
- » <http://www.hhs.gov/healthcare/rights/law/index.html> -- The U.S. Department of Health & Human Services website has the full text of the law.
- » <http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/affordable-care-act/ama-comments-on-aca-regulations.page> -- This section of the American Medical Association website explains the implications of the ACA for physicians, as well as proposals to improve the initial legislation (which the AMA supported).
- » <http://www.ahip.com/Issues/Affordable-Care-Act/> -- America's Health Insurance Plans is a national trade association for insurance companies; this section of its website provides the industry's perspective on the ACA.
- » <http://healthjournalism.org/secondarypage-details.php?id=1056> -- This section of the Association of Health Care Journalists website is a collection of quotes from political and policy leaders in response to the Supreme Court's decision to uphold the legality of the ACA's individual mandate.

Understanding Market-Based Approaches to Health Care Reform (Opposition to the ACA)

- » <http://www.cato.org/health-care> -- The Cato Institute is a libertarian think tank that provides research and position statements in support of downsizing government and privatizing health care.
- » <http://www.heritage.org/issues/health-care> -- The "Health Care" section of the website of the Heritage Foundation, a politically conservative think tank, provides a variety of research reports and policy case statements on how to use market-based reforms to improve health care.
- » <http://www.wpri.org/Reports/Volume19/Vol19no10.pdf> -- The Wisconsin Policy Research Institute does not reveal its funders, but advertises itself as a "free market think tank." This report by Linda Gorman summarizes the quintessential market-based case for health reform.

Understanding Single-Payer Approaches to Health Care Reform

- » <http://www.pnhp.org/facts/single-payer-resources> -- This section of the Physicians for a National Health Program website explains how a single-payer system would work, while still preserving delivery of care by the private sector. It also includes an excellent set of links to related information.
- » <http://www.healthcare-now.org/whats-single-payer> -- This section of the website of Healthcare-NOW!, an advocacy organization, is an explanation of how a single-payer system would improve health care in the United States.



General Information on Health Care Issues

- » <http://www.hschange.org> -- Funded by the Robert Wood Johnson Foundation, the Center for Studying Health System Change is a research group that provides in-depth studies and briefings on health policy issues, including how health care costs are changing, why the nation's number of uninsured continues to rise, and how employer-sponsored coverage is changing.
- » <http://www.nchc.org/> -- The National Coalition on Health Care is a particularly good source of information on the economic aspects of health insurance and the challenge of bringing down health costs irrespective of how many Americans are insured or who is paying for that insurance.
- » <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/> -- The "Sick Around the World" section of the website for the PBS show Frontline summarizes the health care systems of five capitalist democracies: Switzerland, the United Kingdom, Germany, Japan, and Taiwan.
- » <http://www.unnaturalcauses.org/> -- The website of the documentary series Unnatural Causes is filled with rich resources related to health equity issues, including examinations of how societal, as opposed to individual, situations and institutions influence health outcomes (e.g., how cities build and fund housing, the role of racism, and the availability of healthy food).
- » http://www.pnhp.org/facts/a_brief_history_universal_health_care_efforts_in_the_us.php -- This article on the Physicians for a National Health Program website gives a brief history of efforts to establish universal health care in the United States.

Statistics

- » <http://www.cms.gov> -- The Centers for Medicare & Medicaid Services website provides both historical and projected statistics on health care expenditures as well as comprehensive information about these government programs.
- » <http://www.commonwealthfund.org/Maps-and-Data/ChartCart> -- The "Chart Cart" section of the website of the Commonwealth Fund, which sponsors health care policy research, provides more than four hundred downloadable charts summarizing research results, including statistics about the uninsured, medical costs and their relationship to quality of care, and more.
- » <http://datacenter.kidscount.org/> -- The website for the Annie E. Casey Foundation Kids Count Data Center has statistics and measures related to the well-being of children in the United States, searchable by state or topic.
- » <http://www.who.int/research/en/> -- The World Health Organization provides annual reports on member nations, allowing for comparisons among nations.

Glossaries

- » <http://kff.org/glossary/health-reform-glossary/> -- The "Health Reform" section of the Kaiser Family Foundation website has an extensive glossary of terms related to health reform.
- » <http://healthjournalism.org/core-topic.php?id=1&page=glossary> -- This section of the Association of Health Care Journalists website is an extensive glossary of terms, laws, and organizations that frequently appear in news coverage and policy debates.

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