

Executive Director's Report

By Richard Davis

Now that S.88 has become Vermont law without the Governor's signature, what's next? Let's first take a look at how monumental this bill is or isn't. As our president Mimi points out in her message, the bill became a watered-down version of a single payer bill. Yet, even that diluted product seemed to have little hope for passage only a few months ago.

What happened? The Vermont Workers Center did one of the best grassroots lobbying efforts in recent memory, and their work assured passage of the bill. It would have been nice to have a pure single payer bill but something called politics and compromise got in the way. But now we do have a mechanism that can lead us to single payer, and that is what we must concentrate on.

S.88 calls for three studies. One is to study single payer and its variations, another is to evaluate a public option, and a third is to study the impact of essentially maintaining the status quo. Many people hope that Professor William Hsiao, the man who designed Taiwan's single payer system, will be able to do the studies. It certainly would provide the greatest degree of veracity and non-political credibility.

The rest of the country is looking to see how Vermont uses S.88. I have talked with a number of single payer advocates in states such as New Mexico and Oregon, and they are watching every move we make. As much as those of us in Vermont think we are slow to move ahead with reform, sadly, we are way ahead of many other states.

An issue that comes up is possible impediments written into the national reform bill that passed. There is a provision in the national bill which Bernie Sanders

promoted that would allow states to experiment with a single payer model and receive the necessary Federal waivers. However, that provision does not kick in until 2017. Bernie and others are working to make that happen sooner. If Vermont's single payer study demonstrates that the best way for Vermont to proceed is to set up a model single payer plan, it may provide the push that Sanders and others need to make a case for implementing his provision as soon as possible.

One of the best things about S.88 is that it requires action into 2011 and beyond. This means that reform will continue to be an ongoing process, as it should. It means that the new crop of legislators, as well as our new Governor and his or her team will play a vital role in implementing S.88.

Our immediate work will be to remind candidates during the coming campaign season that they must understand the elements of S.88, and that they must pledge to work to see that the results of the study make things happen. We must then continue our lobbying efforts as the new biennium unfolds.

Vermonters in need are counting on us, and activists from around the country are looking to us for leadership.

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Only the USA and New Zealand allow media advertising of prescription drugs, or lack laws prohibiting same. BIG PHARMA is currently lobbying in Canada and Europe to pass enabling legislation. TV ads especially increase sales dramatically. The sales pitches have less to do with a drug's correct use and more to do with feeling good, sex, relief of whatever. They are accompanied by suggestive music and visuals that help sell. Salesmen rapidly tick off dangerous side effects and add, "Tell your doctor if you are pregnant, have signs of kidney failure or liver disease," and finally, "Be sure to ask your doctor if it's right for you!"

The drugs promoted are still under patent and are all expensive. They are not necessarily better than other drugs on the market, including cheap generic versions. Suffering viewers, seduced by the commercials, often beg their doctors for a prescription for the miracle drug. Every practicing physician has felt that pressure.

America needs Federal laws that prohibit drug ads pitched to consumers in all states.

....Margaret Newton, MD

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NEXT DEADLINE

September 1, 2010

We welcome short articles
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MISSION STATEMENT

To promote universal access
to health care services for
the residents of the State of
Vermont through education,
research and discussion

It's easy to understand why, on May 27, Governor Douglas passed into law but did not sign Senate Bill 88, An Act Relating to Health Care Financing and Universal Access to Health Care in Vermont. The governor takes credit for the creation of Blueprint for Health and he approves of S. 88's provisions to revise and expand Blueprint. In Blueprint, Douglas sidestepped the ongoing crisis of health care affordability and accessibility by focusing on healthy lifestyle choices and chronic disease management. Blueprint was and is a band aid, not a health care system. Because S. 88 revives the dim possibility of Vermont creating a health care system that challenges existing payment methods, Douglas will not sign it.

S. 88, a resuscitated version of an earlier single payer bill, lost most of its single payer teeth as it went through committee wrangling. The bill treads gingerly where other Vermont legislatures have gone before by mandating that the state hire a health care systems expert (remember Lewin in 2001, Thorpe in 2006) But this time, the expert must design three possible health care models for legislators to consider, one of them being a single payer system.

S. 88 will inevitably become a political football during the upcoming campaign. The bill is too radical for conservatives and too conservative for liberals. But it does keep the issue of health care reform and single payer alive.

-Mimi Morton, President of VCCH

**LONG-TERM CARE 2010
Is Anything New?**

By Margaret Newton, MD

"Long term care" is a bridge between independence and death. Ideally, it is carried out by trained, dedicated people in a culture of loving care, in safe, comfortable settings: private homes, adult day care, group homes, residential care homes, nursing homes or other institutions. Some are government or church affiliated, private for-profit or not-for-profit. Over ten million Americans need long term care.

Do the growing numbers of disabled and aged citizens, many without family or with stressed-out families, receive recognition and help from the 2010 Federal health care reform legislation for their long-term needs? Currently, long-term care needs are partially met in these ways:

Home Care: most chronic care occurs at home, with family and friends. Medicaid and Social Security disability recipients may receive home health services. Medicare provides limited short-term home care following hospitalization. Costly private long-term care insurance is available for the few. Home nursing services provide short-term post-hospital care. Private homemaker services are paid out-of-pocket. Quality and availability varies widely. There is little change here. Community non-profit volunteer hospice services continue their work.

- **The new legislation** vastly increases the numbers of low income citizens

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LONG-TERM CARE 2010: Is Anything New? cont'd

eligible for Medicaid, for home care and most other care. Medicaid benefits vary by state. The recent recession has forced cash-strapped states to slash budgets, including health care funding. Unemployment remains high. Medicaid funds may not be sufficient to cover all those who are now eligible, including the newly unemployed.

- Medicaid's financial eligibility criteria mean that enrollees who move in and out of jobs have changing eligibility, with endless paperwork to become reinstated. No change here.
- Private home care agencies have proliferated. Worker quality and state licensing criteria are uneven; and trained workers (underpaid) are in short supply.
- **"The Class Act"** is new legislation and a legacy of the late Senator Edward Kennedy. It establishes the first Federal government-run long term care insurance. A currently employed citizen may enroll and pay monthly premiums through his employer. After five years, he may withdraw ~ \$75/ day for care in any setting,
- **The Administration on Aging**, (Older Americans' Act), awards small grants through the Council on Aging, to assist 'aging in place' at home and prevent institutionalization. This is not new legislation. It is a useful but insufficient band-aid approach to meet a widespread need.

Adult Day Care programs are funded by Medicaid, private pay, and donations, and are cost-effective and valued by families and patients. They reduce the need for nursing home placement and enable caregivers to cope and even maintain their jobs. Currently, states are rationing Medicaid budgets, and private donations are down, thus forcing some Adult Day programs to downsize or close. The Veterans Administration has cancelled its funding for eligible veterans, who now must pay \$67 per-diem if they can afford it.

- **A Medicare Adult Day Services Act** has been held up in Congress for many months. This law would release Medicare funds for Adult Day Services, including transportation, PT, OT and Social Work needs. This **Act** remains stalled.

Assisted Living (Residential Care) Homes: Roughly 20% of beds are Medicaid funded. Other beds are financed by private money and charitable gifts. If a

resident runs out of money, their homes keep the resident, who no longer has a home elsewhere. If a Medicaid- bed is empty, the resident may apply. Otherwise, the Home "eats" the cost. Residential Care Homes that were built with Federal funds may guarantee more rooms for low income people. Residential Care Homes have not directly benefitted by new legislation.

Nursing Home construction flourished in the '60's, with new Medicaid funding. They replaced the "Mom-and-Pop" and County Homes. Many are "for profit" and are numbingly similar. These rectangular boxes warehouse many residents per floor, two to a tiny and dimly lit room. A "day room" doubles as dining room. Sad looking souls sit silently in the halls while some roam about on foot or in wheel chairs. Staff members "pass meds" and assist residents. Multiple Federal and State regulations do not make them homelike. Half the beds are funded by Medicaid and half by private funds. Funding is tight for optimal staffing and staff training, Wages are inadequate.

Reform legislation has not changed this. Like acute care, long-term care remains a patchwork of uncoordinated institutions, caregivers, variable funding, shortages, and red tape.

However, an encouraging development is the rising community awareness that homes away from home need more than Federal and State qualifications and licensing; they should be cozy and caring, built to include resources like gardens, kitchens for residents, music and crafts, outings for those who are able, reading groups, etc. Some now have attractive lounges for visiting, varied tasty menus and pleasant décor. In short, there are efforts to make them more homelike and inviting. Some homes are divided into mini-homes of ten or so residents. People are speaking out. More power to those who demand improved long-term care communities that become pleasant homes away from home. Systemic change for coordinated life care is needed. It is happening for the wealthy, but more is needed for those in the middle. It takes far more than legislation to make this happen.