Online Simulation of Health Care Reform: Helping Health Educators Learn and Participate

Robert Jecklin, M.P.H., Ph.D[1]

Author[1] is affiliated with the Department of Health Education and Health Promotion, at University of Wisconsin-La Crosse. **Contact author:** 209 Mitchell Hall, University of Wisconsin-La Crosse, 1725 State Street, La Crosse, Wisconsin 54601, USA. **Phone:** 608.785.6791; **Fax:** 608.785.6792; **Email: jecklin.robe@uwlax.edu.**

Abstract

Young and healthy undergraduates in health education were not predisposed to learn the complex sprawl of topics in a required course on U.S. Health Care. An online simulation of health care reform was used to encourage student learning about health care and participating in health care reform. Students applied their understanding of high costs, limited access, and modest outcomes to write reform proposals to lower costs, increase access, and improve outcomes. This online simulation of political action engaged students with challenging topics, interesting online resources and varying forms of online political action that were being used by varied interest groups to shape and reform U.S. health care. Student teams learned about a health care topic area. Teams used blogs and webcasts to write about their values and beliefs, describe their health care topic area, propose topic-related reforms, persuade others to support their proposals, and comment on competing reforms. Preliminary and final referendums used voting to indicate the level of peer support for the 3-4 reform proposals made by each team. A process evaluation used experience from three sections incorporating this teaching strategy in 2009 and 2010; the evaluation identified strengths, weaknesses, and suggestions for improvement.

Introduction

When compared to other nations with similar economic and political systems, health care in the United States in 2007 offered less access, required higher costs, and was not achieving the best health outcomes {Secretary General of the OECD, 2009 #9}. These circumstances provoked public debate before and after the 2008 elections and that debate lead to landmark legislative reform of health care in the United States. The online simulation described here challenged health education students to apply their understanding of health care concepts, to explore their use of digital technology as a means for political action, and to fulfill their professional responsibility {National Commission for Health Education Credentialing Inc., 2010 #21} to communicate and advocate for health.

This teaching strategy used digital technology to simulate political reform in a college course on U.S. health care while Congress, the President, and many other Americans actually shaped and passed major health care legislation. The online simulation was used twice: first in a hybrid course during the spring semester coinciding with the inauguration of President Obama, and then in two sections of the course during the following spring semester when on March 23, 2010 President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act 2010. President Obama's campaign for health care reform was accomplished in less than 15 months, but it was only the latest of many incremental reforms dating back to health care proposals by Teddy Roosevelt in 1912.[1] Opponents of the President's reforms were planning further efforts to change health care [2] thereby telling Americans that the organization of health care was likely to be the result of an ongoing political process.

In this time of change it was hard to ignore how citizens were increasingly going online to participate in elections and many things political. According to *The Internet's Role in Campaign 2008,* a report from the Pew Internet and American Life Project, the 2008 campaign was the first where more than half of the voting-age population went online to connect to the political process; online participation included social networking sites, websites, blogs, and other forms of online discussion. Young adults (18-24) were most likely to use online resources with 74% reporting that this was one of the ways they participated in the campaign.[3] A second report from the project described *Post-Election Voter Engagement* in

political activity; 46% of Obama voters and 33% of McCain voters were expecting online communication from their leaders after Election Day. Of Obama supporters who were active online during the campaign, 25% were expecting to go online to seek support from others for the new President's agenda.[4]

Online digital technology was familiar to young adults and going online was an important part of how they learned about health care and how they participated in the political deliberations that were defining the form and function of the health care system. The teaching strategy described in this paper incorporated familiar digital technology to help students learn about health care and about how to participate in health care reform. The following sections were used to explain why it was important for heath educators to understand health care and health care reform, to describe the emerging use of online technology in the politics of health care reform, to provide an overview of a course on U.S. Health Care, to detail an online simulation of health care reform, and to suggest how experience informs future use of this type of online simulation.

Rationale for a Required Course on Health Care

Health care and health care reform represented relevant areas of study for the professional preparation of health educators.   The National Commission on Health Education Credentialing identified seven areas of responsibility that are applicable to health education practice in health care settings. Developing the seventh area of responsibility to "Communicate and Advocate for Health and Health Education"[5] offered meaningful support for helping new health educators understand their roles in health care and health care reform.

Leaders in the profession pointed out that, "Nowhere is the evidence stronger for the efficacy of disease prevention and health promotion than in the health care setting".[6] The *Employers Guide* found on the Coalition of National Health Education Organizations website also documented an important relationship between health care and health educators when it stated, "health education reduces the costs (both financial and human) that individuals, employers, families, insurance companies, medical facilities, communities, the state and nation would spend on medical treatment".[7] Understanding health care was important for health educators who would practice in health care settings, but it was also important for health educators who would practice in worksites,

public health departments, and voluntary health organizations.

Worksite health promotion programs were considered effective in part because focused programs were expected to influence health care costs and this was why some employers were expected to support worksite health programs.[8] The 93.1% of U.S. employers with more than 750 employees who were not yet offering comprehensive worksite health promotion programs [9] signified a world of opportunity for health educators who could communicate with interested employers about health promotion's relationship to health care and health care costs.

Health educators in public health settings were also expected to understand health care because, "For Americans to enjoy optimal health—as individuals and as a population—they must have the benefit of high-quality health care services that are effectively coordinated within a strong public health system." [10] The Institute of Medicine's report went on to detail how public health workers must use their understanding of health care to help people improve maternal/infant/family health, prevent or manage communicable diseases, prevent or manage chronic diseases, prevent or manage injuries, and gain access to neglected services such as oral health, mental health, substance abuse, and preventive care.

John Seffrin, the Chief Executive Officer of the American Cancer Society and a health educator, also connected an understanding of health care to the mission of his voluntary health organization; he described how large numbers of uninsured and underinsured persons found it more difficult to access effective detection and treatment for cancer. Seffrin explained the American Cancer Society's compelling interest in health care reform, "we want everybody to have access to adequate, affordable, available health insurance that is administratively simple and there is no reason that we know of that could not come about if it is made a high enough priority in this nation" .[11]

Fully prepared health educators needed to know that U.S. health care was expensive and that high costs were creating pressure for reform. During the last decade, the growth in U.S. health care expenditures outpaced the rest of the U.S. economy causing health care expenditures to grow from less than 14% of the gross domestic product in 1997 to 16% in 2007. The U.S. spent more per capita ($7,290) and a higher share of current household consumption (19.8%) in 2007 than any other country participating in the Organisation for Economic and Co-operative

Development (OECD). Table 1 was included to compare U.S. costs to OECD nations as a whole and a selection of OECD nations that provide useful comparisons to the U.S.[12] High health care costs made American goods and services more expensive in a global market, and denied Americans what they would otherwise purchase with their money.

Fully prepared health educators needed to understand that despite high costs, U.S. health care was not providing access that was comparable to the access being provided in other developed economies. More than half the 30 developed nations of the OECD had universal health insurance coverage for their populations; in 2007 the U.S. was third from the bottom in population coverage, covering 27.4% with government plans and 57.9% with private plans [12].

Fully prepared health educators needed to comprehend that higher costs and less coverage were occurring while health outcomes were very modest. Out of 30 OECD nations in 2007, the U.S. ranked 25th for life expectancy at birth and ranked 18th for life expectancy at age 65. In the same group, the U.S. ranked 28th in infant mortality and 27th in avoiding low birth weight in newborns. [12]

Health educators who understood the changing face of health care would be better prepared to practice in health care, worksite, public health, and voluntary health organization settings. Unreasonable costs, unjust access, and disappointing outcomes were continuing to make reform necessary. Health educators were obligated to participate as informed citizens and as professional advocates for improving health. This teaching strategy was designed to prepare health educators to participate and advocate in online environments.

Online Participation in Health Care Reform

Health care reform was an important issue during the 2008 Presidential campaign when more than half the voting-age population went online to participate .[3] Following the election, many of the new President's supporters expected to go online to help with the new agenda [4] and health care reform was an important part of that agenda. Online political participation in health care reform was part of a larger shift where each cohort of young people was more familiar with going online.[3] This trend was likely to continue as educators at all levels embraced the realization that, "digital technologies could transform the way kids learn and participate in their communities".[1]

The digital landscape was a rich source of information and opinion for those who were interested in health care reform. Information on health care use, health insurance coverage, and health status was available online from state, national, and international governmental agencies including state health departments, U.S. Census Bureau, U.S. National Center for Health Statistics, U.S. Centers for Medicare and Medicaid Services, U.S. Agency for Health Care Research and Quality, Organisation for Economic Co-operation and Development, and World Health Organization to name a few. To monitor political action within the government, websites were available from state legislatures and governor's offices, and at the national level through the White House, House of Representatives, and Senate.

Opinion and information mixed more in online sources originating from professional organizations, unions, corporations, trade groups, advocacy groups, newspapers, cable and broadcast television, radio, political parties, and many others. Several online sources specialized in health reform including CovertheUninsured.org and HealthReform.org —two efforts sponsored by the philanthropic Robert Wood Johnson Foundation; similar information was available from a website sponsored by the Kaiser Family Foundation.

In the fall of 2009 after a prime-time Presidential speech, press conferences from divergent interests, paid advertising by interest groups, and widely-circulated accounts of angry town hall meetings—Americans were confused about the health care reform being considered by Congress.[14] Responding to criticism from a reader, New York Times Public Editor Clark Hoyt admitted that, "Health care is a sprawling subject that is hard for a newspaper to get right. It involves economics, politics, and philosophical and moral values. There are complex delivery systems and hard-to-explain concepts...".[15] Mr. Hoyt explained how reporters and editors were wrestling with how to cover this vast subject in a way that allows readers to access context and background whenever they were ready to learn more. Like many online editions of newspapers, the New York Times organized reporting about the complexities of health care reform by including search capabilities, a health topic page, and links to blogs including two blogs by the newspaper, Prescriptions and Health Care Conversations. Blogs offered readers access to information and opinion, but blogs also offered readers access to participation in the public discourse about health care reform.

Newspapers were not the only ones using blogs to inform, editorialize, and collect opinions about health care reform. Between January 1, 2009 and the signing of the reform proposals by President Obama on March 23, 2010, 1,044,769 Google blog posts included the phrase "health care reform". From March 23 to May 28 of 2010, Google blog posts included the phrase "repeal health care reform" 11,380 times. Google Blogs was just one of many sources of data on blogging, and blogging was just one of the many possible ways in which Americans were going online to continue their participation in health care reform.

Overview of the Course on U.S. Health Care

This course was offered by the Department of Health Education and Health Promotion at the University of Wisconsin-La Crosse. The course was open to all university students and was required for students majoring in Community Health Education and Radiation Therapy. The following course catalogue description appeared on the course syllabus: "This course provides an overview and a developmental summary of the U.S. Health Care System and its driving forces and offers comparisons to other national health systems. Content includes major elements of the health care system and a consideration of today's major health policy issues in a historical, economic, and political context. The course will also explore current issues confronting the health care system, raise important concerns and questions related to the different approaches to health care delivery, and identify key ethical issues."[16]

The course used two texts, *Delivering Health Care in America-A Systems Approach* [17] and *Narrative Matters-The Power of Personal Essay in Health Policy* .[18] The first text helped students learn the language, concepts, institutions, laws, policies, and countless details of the current system; the second text used the essays of professionals, patients, and families to tell the human side of health care experience. Additional reading was required from related websites, major newspapers, and government documents. Lectures were also augmented by documentary films such as *Living Old* ,[19] *Sick Around the World* ,[20] and *Obama's Deal* .[21]

The curriculum of the course used Shi and Singh's systems approach [17] and was divided into four units of instruction: 1) foundations including history, beliefs-and-values, and political reform 2) system outcomes including cost, quality, and access, 3) system resources including workforce, financing, technology, and markets, and 4) system processes

including outpatient, inpatient, managed, and long-term care. The first two units were shorter than the last two, and the material of the first two units were revisited in the last two units. Reading was punctuated by frequent online quizzes, and each unit concluded with an in-class test. Students also participated in learning teams made up of 4-6 students.

Each learning team was aligned with one of the eight major topics that were the substance of units three and four including workforce, finance, technology, markets, outpatient care, inpatient care, managed care, or long-term care. Teams prepared Dazzling Digital Notes and photovoice slides on their topic. Dazzling Digital Notes were emphatically named in an effort to set those notes apart from typical college reading notes; in addition to a basic outline of the required reading, the rubric for Dazzling Digital Notes required the inclusion of relevant images, related web-links, original questions, and original comments from each contributing team member. Each team created a photovoice on their topic using two PowerPoint slides from each team member; one slide presented an image and one slide presented a comment and a question about the image. The Dazzling Digital Notes and photovoice slides were shared with the class prior to covering the topic in readings and lecture. Both assignments prepared students for the simulation in two ways: 1) teams learned specialized background knowledge in their health care topic 2) students practiced using rich media that enhanced how students presented ideas online. Students received points for individual contributions, and received points for the merged team presentation of Dazzling Digital Notes and photovoice.

Simulating Health Care Reform

The simulation was superimposed on a more typical undergraduate course made up of reading, lectures, films, quizzes and tests (490 out of 900 points). The digital notes and photovoice activities encouraged students to transition from traditional submissions-to-the-teacher to distributions-appealing-to-their-peers (120/900). Simulation activities included team member blogging on their topic and 2-4 reform proposals (76/900), recruiting four guest authors who posted on the team blog (40/900), wording reform proposals for preliminary and final referenda (24/900), team webcasting to persuasively present reform proposals (100/900), and student voting to rank the popular support for reform proposals (50/900).

As part of Unit I (first two weeks) the simulation began during a class session as students discussed the role of values and beliefs in health care. Students were asked to caucus about their beliefs and values, and then to form into teams of 4-6 members. Teams were aligned with one of eight topic areas used to explain health care resources and processes; teams were aligned so that all topics were covered by at least one team. Students were shown how to access Google Blogger and related online tutorials; students were allowed to use another blogging service, but all teams were required to invite all class participants to their blog.

During Unit II (second two weeks) each team opened their blog, and assigned one member the task of writing a post about the team's beliefs and values. At the end of Unit II, another team member posted a brief history and overview of their topic. Students were encouraged to comment on the postings found on other team blogs. The instructor referenced the blogs during class and encouraged both review and comment about what other students were writing.

During Unit III (weeks 5-8) and Unit IV (weeks 9-12) each team shared their Dazzling Digital notes and photovoice projects, and (depending on the size of the team) posted 2-4 health care reform proposals to the team blog. This allowed each member to author one post to the team blog; postings were evaluated using rubrics shared with the students ahead of time. Each team was also required to recruit four guests to author postings to their blog; teams were required to include one or two guests from each of the following categories—patients, health care workers, and health student from another university. Guests authored their post on the blog of the team extending the invitation, and guests were encouraged to comment on any of the other team blogs associated with the class.

Students were expected to understand their beliefs and values, understand their topic area, present persuasive ideas to improve American health care in their topic area, and win the support of their peers. Like voting in a primary election, students voted in a preliminary referendum on proposals with no grade points attached to the outcome; based on preliminary voting, the resulting ranking of all proposals was shared with the class. During the remaining two weeks teams adapted or modified the wording of their original proposals, and concluded their promotional efforts during an oral presentation that was webcast to students participating online.

Teams received points based on how final voting ranked their reform proposals; rankings were determined as students voted for team proposals without voting on their own. The final exam was based on the four highest ranking topic areas; topic rankings were based on the combined ranking of all proposals within each topic area. Unlike the preliminary results, students only received final results about their team's proposals and the four topics that would be the focus of the final exam.

A Process Evaluation: How Experience Informs Future Use of the Simulation

Young healthy students had limited experience with health care and most had limited motivation to explore their own beliefs and values about health care. At the start of the online simulation, students tended to describe themselves in partisan terms or as agreeing with a national leader. The dramatic portrayals of films and the personal stories from *Narrative Matters* demonstrated how specific cases or scenarios helped activate student reflection on their beliefs and helped improve their predisposition to learn about the complexity of health care. This experience suggested that it may be helpful to include films and narratives about personal experience earlier in the course to help students become more engaged at the beginning of the simulation.

Team specialization in one of the eight topic areas identified by Shi and Singh in the required text helped students overcome the sprawling complexity of American health care and participate in the simulation. Students developed expertise by talking and writing about their topic area and used the systems approach to understand how their team's topic fit with other health care topics being discussed by other student teams. This experience suggested that additional organizing strategies would be helpful in the future when students would be trying to understand recently passed reforms and the incremental application of those reforms.

Teams were expected to answer three questions when they explained their reform proposals: 1) how will it influence access? 2) How will it influence cost? 3) How will it influence quality? The rubric for grading reform proposals required that each blog post cite at least five professional sources supporting each proposal. Teams responded to these questions, and they had many interesting ideas about improving health care at many levels. Teams proposed changes to the conduct of individual health workers, the level of collaboration among health care workers, the policies of health care insurance plans and other

health organizations, the roles played by state and federal governments, and the priorities for health care research. This experience suggested that students may benefit from more detailed guidance about how to propose policy change at different levels of social organization including government.

The use of rich media in the Dazzling Digital Notes and photovoice activities did not seem to translate to rich media being used to enhance blogs and webcasts. The instructor was reluctant to encourage more use of rich media because of copyright concerns. This reluctance could be overcome in the future by collaborating with one or more campus librarians or by taking a short course on this topic from the Sloan Consortium (http://www.sloan-c.org/). This experience suggested that rich media could be used more often to enhance the presentation of important messages and that in the future new rubrics should require rich media as part of blogging and webcasting.

Guest authors on team blogs exceeded instructor expectations; guests proved to be meaningful sources of information, opinion, and health care experience. In each of the class sections, students recruited 64 guest authors. Patient guests represented a broad range of ages, different types of health care use, different health problems or conditions, and a vast array of opinions and political perspectives. Health students were from schools near and far representing nursing, medicine, pharmacy, optometry, athletic training, and several allied health fields. Health care workers included nurses, Medicaid outreach workers, health teachers, optometrists, health information managers, claims managers, certified nursing assistants, surgical techs, social workers, lab workers, a radiation therapy professor, physician assistants, and physicians in oncology, dermatology, pediatrics and family medicine. A few individual students commented that this connected their learning to the "real world". This experience suggested that future iterations of this simulation could be improved by showing students examples that illustrate how interesting guest contributions can be.

The preliminary referendum that preceded team presentations helped students assess their progress in organizing support for their reform proposals. Successful teams seemed uninfluenced by their initial results, while teams who experienced less success seemed more likely to change their proposals or make efforts to be more persuasive during their webcasts. In the second year, students seemed more willing or more ready to play their roles, going beyond minimal requirements for the webcast to

create memorable slogans, to distribute bribes and handouts during presentations, to pose more challenging questions to other teams, and to send email reminders to classmates about how to vote. The preliminary referendum seemed to promote more engagement in the simulation.

In spring of 2009 the course was taught as one hybrid section with students splitting attendance between face-to-face and webcast participation. In the spring of 2010 one section was taught hybrid like 2009, and one section was taught face-to-face. In the hybrid sections student teams presented their reform proposals via webcast applications of Mediasite software that allowed all talking heads, all PowerPoint, or split screen with both slides and talking heads. Viewers watched webcasts on any computer with Internet access at any time of day or night, and viewers played recorded webcasts more quickly than real time by adjusting the playback speed. The teams in the face-to-face section did not have access to webcasting, and they presented live to other students in their section. Webcasts in the hybrid sections appeared no differently than the team presentations in the face-to-face section. This experience suggested that adjusting the rubrics for team presentations could make the presentations more interesting and persuasive, and that future students who become interested and informed about health care reform may find it necessary to develop more skills to persuasively present their proposals online to audiences beyond the students enrolled in the class.

Final student voting ranked proposals and the following topic areas were in the top four in one or more of the classes: workforce, technology, financing, outpatient care, managed care, and long-term care. Market segments and inpatient care never appeared in the top four and were not included in a final exam. This was surprising because understanding market segments was about the compelling argument that health care should be based on population needs. The absence of inpatient care was also surprising because inpatient care remained the biggest employer and the largest consumer of resources and arguably the most influential form of care in the health care system; this result could be explained by young college students having limited experience with the need for inpatient care. No students complained about their topic areas being inherently unpopular with voters, but some students felt that since some student voters do not vote for the best proposals, that this made the simulation unlike real politics. In response, students were asked to recognize that the outcomes of a political process

reflect what is popular at the time and not necessarily the best course of action for a society. This discussion of politics indicated a need to include discussion about the role of health educators in helping citizens connect what is known with what is popular.

The most popular individual proposals from different teams reflected many of the ideas that were included in the reforms signed into law in March of 2010. These were the three reform proposals receiving the most support during spring of 2009:

- Electronic medical records should be universal so each patient could access their record wherever they go.
- Health insurance companies cannot discriminate based upon preexisting health conditions, allowing more Americans health insurance coverage.
- Legislation should be passed by Congress to support increased preventive care services in primary care settings.

These were the three reform proposals receiving the most support in the face-to-face section of the course during spring of 2010:

- Congress should pass legislation increasing payments to primary care professionals to attract medical students; schools must then devote a portion of admissions to primary care careers.
- The voter agrees for a shift in funding from traditional long-term care (nursing homes) towards home health care; providing more comfort, options, and financial savings to each individual patient. Additionally, an increased investment in home health care provides higher quality care to specifically meet individual patient's needs.
- Patients will be required to have a Primary Care Provider's referral to visit with a specialist to protect them from unnecessary procedures, costs, and iatrogenic diseases.

These were the three reform proposals receiving the most support in the hybrid section of the course during spring of 2010:

- Congress should pass legislation to support the funding and implementation of Electronic Health Record Systems in all major health care facilities in order to significantly improve the coordination, efficiency, and overall

quality of care, as well as to drastically decrease medical costs and preventable medical errors.

- In order to decrease the inflating costs of health care it is important for our government to put more of an emphasis on preventative services such as screenings, education, and healthy nutritional programs in the school and work places.
- Congress should vote for increased funding for community health centers in low-income communities that are missing effective qualities of primary care, thereby reducing cost and increasing access.

In all three sections students proposed and provided popular support for ideas that were found in both the health care literature and in the actual political discourse at the national level. Some of the wording used by students suggested that future students would benefit from more faculty guidance and a more specific rubric for the task of reducing 700-word reform proposals down to 25-word statements suitable for use in referenda ballots.

Student learning about health care and online political participation was evident, but students seemed to abandon their primary interest in health education. Only a few of the reform proposals showcased the role of health education in health care or health care reform. This experience suggested that future uses of this teaching strategy could require health education majors to include at least one reform proposal that defines or expands a role for health education in a reformed health care system. Restricting the enrollment to health education majors and tailoring the curriculum to their needs was rejected because including other majors in the course and simulation make both more like the rest of the world in which students will apply what they learn.

Initial aspirations for this teaching strategy sought to engage students in a complex topic through a gaming strategy where students were challenged to conceptualize and popularize meaningful dialogue about health care. The experience, especially with guest authors, suggested that students were ready to participate in a discourse about health care that reached audiences beyond their classmates. At times it was hard to hear when the simulation stopped and when actual participation in the public discourse about health care reform began. This experience challenged future iterations of this simulation to expect students to actually join the discourse on

health care reform by using online venues to reach audiences beyond the classroom.

Conclusion

Health education students were like other Americans who wanted to act on their concerns about the unreasonable costs, the unjust access, and the unsatisfactory outcomes of the American health care system—they needed to learn about a complex system and how to participate in the reform of that system. Young adults including undergraduates in health education were increasingly going online to both learn and participate in their society. Using an online simulation of health care reform helped students learn about health care and learn about how to go online to participate in health care reform. A process evaluation of this simulation offered ways to enhance student engagement and learning and thereby hasten their eventual participation in local, state, or national discourse about health and health care reform.

Acknowledgments

References

1. Roosevelt's Own Creed Set Forth. *New York Times.* August 7, 1912.

2. Schwartz J. Health Measure's Opponents Plan Legal Challenges. *New York Times.* March 22, 2010.

3. Smith A. The Internet's Role in Campaign 2008. *Pew Internet and American Life Project* [http://www.pewinternet.org/Reports/2009/6--The-Internets-Role-in-Campaign-2008.aspx. Accessed May 23, 2010.

4. Smith A. Post-Election Voter Engagement. *Pew Internet and American Life Project* [http://www.pewinternet.org/Reports/2008/PostElection-Voter-Engagement.aspx?r=1. Accessed May 23, 2010.

5. National Commission for Health Education Credentialing Inc. National Commission for

Health Education Credentialing, Inc.--Credentialing Excellence in Health Education. Website. Available at: http://www.nchec.org/credentialing/responsibilities/. Accessed May 28, 2010.

6. Green LW, Kreuter MW. *Health program planning: an educational and ecological approach*. 4th ed. New York: McGraw-Hill; 2005.

7. Employers Guide. May 17, 2010; http://www.cnheo.org/.

8. Goetzel RZ, Ozminkowski RJ. The Health and Cost Benefits of Work Site Health-Promotion Programs. *Annual Review of Public Health.* 2008;29(1):303-323.

9. Linnan L, Bowling M, Childress J, et al. Results of the 2004 National Worksite Health Promotion Survey. *Am J Public Health.* August 1, 2008 2008;98(8):1503-1509.

10. Committee on Assuring the Health of the Public in the 21st century. Board on Health Promotion and Disease P, Institute of Medicine of the National A. *The future of the public's health in the 21st century*. Washington, D.C.: The National Academies Press; 2001.

11. Kaiser Family Foundation. Viewpoints: The Health Care Debate American Cancer Society CEO John Seffrin June 4, 2008. *Viewpoints: The Health Care Debate American Cancer Society CEO John Seffrin June 4, 2008*. USA: Kaiser Family Foundation; 2008.

12. Secretary General of the OECD. Health at a glance 2009 OECD Indicators: Organisation for Economic and Co-operative Development; 2009:201.

13. John D. and Catherine T. MacArthur Foundation. MacArthur Webpage on Digital Media & Learning; 2010.

14. Nagourney A, Sussman D. In Poll, Public Wary of Obama on War and Health. *New York Times.* September 24, 2009.

15. Hoyt C. The Health Care Sprawl. *New York Times.* October 11, 2009;Op-Ed.

16. Schumacher D, Severson L, eds. *Undergraduate Catalogue.* 2009-2011 ed. University of Wisconsin-La Crosse: La Crosse; 2010.

17. Shi L, Singh DA. *Delivering health care in America: a systems approach*. 4th ed. Sudbury, Mass.: Jones and Bartlett; 2008.

18. Mullan F, Ficklen E, Rubin K, eds. *Narrative Matters-The Power of the Personal Essay in Health Policy*. Baltimore: The Johns Hopkins University Press; 2006.

19. Navasky M, O'Connor K. Living Old [Television and Webcast]. WGBH Boston. November 21, 2006, 2006.

20. Palfreman J. Sick Around the World [Television and Webcast]. WGBH. April 15, 2008, 2008.

21. Kirk M. Obama's Deal [Television and Webcast]. WGBH. April 13, 2010, 2010.

Table 1. 2007 U.S. Health Care Costs Compared to Select O.E.C.D. Nation

U.S., O.E.C.D., and Select Nations	Costs Per Capita in U.S. Dollars	Costs as a Percent of G.D.P.	Costs as a Percent of Household Consumption
United States	$7,290	16.0%	19.8%
Next Highest Nation	Norway $4,763	France 11.0%	Switzerland 16.9%
Canada	$3,895	10.1%	14.3%
Mexico	$823	5.9%	8.1%
United Kingdom	$2,992	8.4%	10.4%
O.E.C.D. (all 30 nations)	$2,984	8.9%	12.9%