

**CodeBlueNow!**  
**Solving the Unsolvable:**  
**Fresh Perspectives on the Health care Dilemma**

**The Summary Report**  
**How to Build an American Health System**

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“Together we will solve the problem. Exquisite answers will emerge as a result of the process we put in motion. The most important thing is to have good faith, share an issue and share resources. We will never be better than we can imagine ourselves to be.”

Leland Kaiser, Ph.D.  
Health Care Futurist  
Kaiser Consulting, Brighton, CO

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## **MISSION**

**CodeBlueNow!**

*America's Health Care Voice* intends to  
change the health care system  
so it works for the American public.

## **VISION**

**CodeBlueNow!**

Will provide a broad-based,  
non-partisan, independent voice  
for a health care system that is  
affordable, effective, efficient and equitable.

## Table of Contents

	<u>Page</u>
Introduction .....	1
Special Thanks .....	3
Forewords Governor Booth Gardner .....	5
Governor John Kitzhaber, MD.....	7
Thomas Aschenbrener, President, Northwest Health Foundation Judge, Build an American Health System .....	8
Executive Summary Kathleen O'Connor, Founder, CodeBlueNow!.....	10
Category 1. Problems of the Current Health System .....	15
Category 2. Governance .....	19
Category 3. Rights and Responsibilities of the Patients-Consumers .....	22
Category 4. Wellness and Illness .....	26
Category 5. Health Care Delivery Services .....	31
Category 6. Finances and Cost Management .....	34
Category 7. Information Technology .....	41
Category 8. Legislative Changes .....	43
Category 9. Political Changes .....	46
Category 10. Medical Malpractice Changes .....	48
Category 11. Transition and Implementation Plans .....	50
Category 12. Strong and Unique Points .....	53
Appendix A. Finalists Biographies .....	56

Appendix B. List of Template Questions .....	63
Appendix C. List of Challenge Requirements.....	64
Appendix D. Health Care Magna Carta.....	65
Appendix E. Judge Biographies .....	66
Appendix F: Declaration for the Health of America.....	71

## **Introduction**

A growing number of individuals and groups are expressing their concerns with the health system in the United States. In response to those concerns, health care policy analyst, Kathleen O'Connor, decided to sponsor a health care challenge open to any person or group in the world. This summary provides a brief look at that challenge and the summarizing process, as well as an extensive look at the key ideas contained in the top proposals.

### ***The Build an American Health System Challenge***

The “Build an American Health System” Challenge received 109 complete proposals. The Challenge rules defined a number of content areas that each proposal had to incorporate into its health system, including the principles of the Health Care Magna Carta developed by O'Connor and found in Appendix D.

Nine judges read all the proposals and selected the finalist proposals. The judge biographies are found in Appendix E.

Each author presented a brief overview of his or her proposal during a conference held in Portland, Oregon on October 24, 2003. Two winners were selected and cash awards were made. The following day, CodeBlueNow! was launched.

A Summary Committee was formed to summarize the essential ideas of the top proposals for CodeBlueNow!. The four members of the Summary Committee were Dora Barilla, Elizabeth A. Pavka, S. Samuel Shermis, and Gerald Tracy. Their biographical sketches are found in Appendix A, along with the biographies of the other finalists.

### ***The Summarizing Process***

To structure the reviews of the finalists' proposals, the Summary Committee identified twelve subject areas which defined the essential considerations involved in designing a new American health care system. These subject areas were based on the content areas and “Health Care Magna Carta” principles set forth in the application for the Challenge. The twelve subject areas were converted into a review template questionnaire. Copies of the template questionnaire, Challenge requirements, and Health Care Magna Carta are found in Appendix B, C and D, respectively.

The Summary Committee divided the proposals among themselves, assigning two reviewers to each proposal. The assignments were made to ensure that no one reviewed his or her own proposal. Each reviewer was to summarize rather than to evaluate or editorialize on the material. Overall, the process was extraction of relevant ideas by two people, followed by merger of that information, and finally, summarization.

Next, the template summaries were sorted by question number to facilitate analysis and production of this Summary. For example, all responses to template question 1, “Description of Problems in Current System,” were grouped into separate files. Template questions were then renamed “categories” and the summary completed.

This Summary contains the major elements of the Contest finalists' proposals and sets forth certain conclusions to assist CodeBlueNow! with policy development, analysis, and legislative lobbying. A large number of people assisted the Summary Committee in this process. However, the Summary Committee assumes all responsibility for any errors of commission or omission in this work.

### *Summary*

All finalist proposals possess some uniquely interesting and compelling recommendations for making significant changes and improvements to the current health system.

In the considered judgment of the Summary Committee, these recommendations—regardless of whether they are philosophically acceptable to a given reader—are well thought out and deserve to be examined carefully. Somewhere among these fresh, new ideas lie the tools to changing a system that is approaching crisis.

## Very Special Thanks

This report, much less CodeBlueNow! would not have been possible without the work of an astonishing number of people. First, I would like to thank our major donors, without whom none of this would have been possible.

The Northwest Health Foundation; the W.K. Kellogg Foundation; Midge Chadsey; Bill Baldwin, Baldwin Resource Group and Shirley Bridge, Ben Bridge Jewelers. The Fremont Rotary Club and the DoubleTree Hotel of Portland, Oregon helped cover travel and lodging for judges and contestants in the Health Care Challenge.

I especially want to thank Dora Barilla, Gerald Tracy, Elizabeth Pavka and Samuel Shermis, who have collectively donated more than 400 hours to compile this Summary Report. Only Samuel is retired! Everyone else took this on as a labor of love in addition to obligations of work, family and friends. If politicians think the American public doesn't care about health care reform, they have not met these folks and the 100 others like them who entered the contest.

An amazing amount of personal thanks goes to our judges for their exceptional work. We received 43 inches of proposals from 109 individuals and teams. Most of the proposals were 50 pages long and very technical. The nine judges labored to review and critique the proposals, and my hope of finding honoraria for them vanished. I would surmise they spent over 3,000 hours reading and analyzing the proposals.

And, I have to thank Nancy Amidei, School of Social Work, University of Washington, who several years ago had an idea. I was struggling to end my book, and Nancy said: "Why don't you have a contest, Kathleen, like the engineers do to build a better robot?" And I said the two words that have always gotten me in trouble---"Why not?"

And the rest is, as they say, is history.

Many thanks go to the CodeBlueNow! Board of Directors who adopted the world's biggest mission statement: "CodeBlueNow! intends to change the health care system so it works for the American public." They are: Douglas Benn, Pat Briggs, Midge Chadsey, Jose Gonzalez, Pamela Snider, and Gerald Tracy. And thanks to those who served before—Fred Tobis and Joe Nichols. We also have a rare and wonderful corporate counsel, Judy Andrews, JD, who is also a volunteer.

And, where would we be without the contestants? All they keep saying is "Thank you, Kathleen, for giving us a voice." Without their energy, commitment and ideas, we would have nothing to offer. Our job now is seeing that more people hear their voices.

Nothing works without the people who are the guts of the organization; the folks in the trenches who make large dreams come true. We have taken CodeBlueNow! from "why not?" to having members in over 33 states and a solid organizational infrastructure because of the hard work of a lot of people – some for pay, and many more as volunteers.

Phil Sasich, who has the rare art of taking visions and putting them into specific, operational, business plans; Katia Blackburn, who took some early ideas and polished their presentations into

perfection; Kiman Lucas, JD, who understands intellectual property and Internet applications; and Dan Connolly and Kevin Dillon, for our early website architecture and design ideas; Matt Eldridge, who helped with planning and made important internet connections for us, and who has the most artful ability to tell me “no” in a way that I always respect.

I’d also like to thank Jeff Tolbert, Jeff Tolbert Design, who is our web designer and web master; Strategies 360, Seattle, Washington, that helped with initial public relations and event management for the Portland conference; and Marlene Mersh, Administrative Assistant, who organized the entries and the communications from the Challenge and kept things on track when I had to focus on other things.

And last, but certainly not least, our newest employee, who we have just promoted to Assistant Director because of her thorough and diligent work, Dana Robertson Halter, MPA. She jumped into CodeBlueNow! January 6<sup>th</sup>; her first assignment was mastering the new Medicare Prescription Drug Bill and has done nothing but make herself indispensable ever since. We are a great team. I don’t dot i’s and cross t’s, and she does. She takes the vision and makes it concrete.

Not to mention multiple copy editors---Lisa Powers, Dana Robertson Halter and myself. If there are errors herein, they are mine.

This has been one of the most remarkable journeys of my professional life. It has changed me as a person, for the better. I have met some of the most amazing people. As I am fond of telling my friends and colleagues: “I don’t have their proposals, I have their hearts and souls, and dreams of the future.”

We hope you’ll join CodeBlueNow! in our efforts to make the health care system work for the American public. As Dr. Leland Kaiser says, “We will never be better than we can imagine ourselves to be.”

It is now time for us to dream and build that dream.

Kathleen O’Connor, Founder  
CodeBlueNow!  
June 9, 2004

# Forewards

## Governor Booth Gardner, State of Washington

Finally, we have an organization like CodeBlueNow! that is challenging all of us to think about our ailing health care system in a new way. How? By engaging the public and assuring they have a voice this time around when it comes to health system change. It's more than past time the American public has a voice.

I could not agree more with what CodeBlueNow! is trying to do. I also know how hard it is to do what they are doing. I was a Governor of a state for eight years—Washington. We tried to provide more coverage to decent, hardworking people. After several years of meeting after meeting around the state, we gained the passage of the Basic Health Plan, so people can buy health insurance, based on their ability to pay, by using state subsidies.

I also chaired the National Governors' Association from 1990-91, and made health care our highest priority. We had major cost and access problems then. They are the same problems we have now. Only it's worse. We have more uninsured; higher costs; more jobs leaving the country and an unraveling safety net for those who have lost their jobs or work at temporary, part-time jobs. We are the only industrialized nation where health care depends on the job you have, your age ; and your income.

We need to make health care our national top priority again. But, we need to strip health care from the clutches of partisan politics and do what we do best as a nation—roll up our shirt sleeves and do the hard work of building something that will work for the American people and the businesses that employ them. We must find economic health for our people, our employers and our nation.

What is so exciting about CodeBlueNow! is that they have been able to put partisan politics aside and garner consensus on core values. Next they will convene an “American Health Care Congress” on October 12<sup>th</sup> in California, to refine how to make a system work. I invite you to attend.

CodeBlueNow! offers a new conversation and invites all of us to join in. As you will see from the materials in this document, the American people care deeply about health care, are inventive and creative and are willing to work together to find something that serves our families and their communities.

I have more than a formal interest in this. I have Parkinson's Disease. I have faced head on the complications, failures and successes of our health care system. Do I go to Canada for my drugs or support my local pharmacist? Do I need that MRI or am I just amortizing a provider's investment? Why do we focus on diagnosis, when we really need to focus on treatment?

I have made health care decisions as a Governor. I have made personal health care decisions. When push comes to shove, as a person and as an elected official, we need to count on the basic dignity, goodness and decency of the American public. They respond well to a challenge and live up to the expectations we have of them. All we need to do is ask, which is what CodeBlueNow! has done.

The ideas in this report are as good a place to start as any--and probably better than most. CodeBlueNow!'s foundation is the pure, simple belief that it's the ingenuity of the American public that will actually, *finally* make a difference.

Will it work? Nothing else has. It's more than time we gave it a try.

Booth Gardner, Governor, Washington State (1985-93)  
Chair, National Governors' Association, 1990-91

## **John Kitzhaber, MD, Governor, State of Oregon**

I am delighted to introduce you to the findings of the “Build an American Health System” contest. These findings inspired the formation of CodeBlueNow!, which intends to change the health care system by giving the American public a voice in health care reform. CodeBlueNow! had the courage to stand up and say: “The system is fundamentally flawed and needs a complete overhaul. Tinkering at the edges won’t produce the results that the American public wants – and rightfully deserves.”

This report includes an overview of the key findings from the contest finalists. Although they have different approaches to changing our health care system, each of the finalists takes the current system and turns it on its head. For example:

- They put people at the center of the system rather than on the outside
- They focus on health promotion, wellness and early intervention
- They produce savings by eliminating administrative waste and reducing fraud
- They strive to solve problems rather than argue ideology
- They provide realistic timelines to implement their ideas.

These are some of the most refreshing ideas I have seen in a long time.

The time has come for us, as a nation, to have an explicit discussion about these ideas – and brainstorm new ones. We backed into employer-based health insurance during World War II and have never revisited that decision. We created Medicaid and Medicare nearly 30 years ago and have never reevaluated those programs, either.

Our health care system does not work:

- We have no clear, objective health policy at the state or federal levels.
- We have no explicit policy on universal coverage.
- We are under financial pressure to cut programs, services and people.
- We are in denial that we have to manage within a limited budget.
- We allocate resources one person at a time.
- We subsidize health care for the wealthy at the expense of those less well off financially.

We need to acknowledge that health care is as important to the community as public safety and education. This report provides us with a place to start an essential national discussion. Join us now and let your voice be heard.

John Kitzhaber, MD, Governor, State of Oregon, 1994-2003

## **Thomas Aschenbrener, President Northwest Health Foundation**

It is with great pleasure that I introduce you to CodeBlueNow! *America's Health Care Voice* and the findings from their "Build an American Health System" Challenge.

I had the distinct honor of being one of the judges who reviewed over 100 proposals. Inside these pages are the key ideas of the top finalists. While this may be dry reading, because it needs to be, this is a summary of the key findings which were detailed and specific. Refreshing and thoughtful new ideas and insights are inside these proposals, which were written by people who passionately believed they could make a difference.

What is inside CodeBlueNow! and these proposals, however, is more than is what is written here. What CodeBlueNow! has is the energy and commitment of the people who not only participated in this competition, but who remain committed to working for health care reform and making sure the public's voice is heard. What is not so evident herein, are their dreams, their beliefs and the hopes that their voice will make a difference.

I read the proposals, but more importantly, I have seen and heard the finalists present their ideas and witnessed the ingenuity, sincerity and diversity of their ideas, and their genuine respect for each other and each other's ideas.

What surprised us all at the Portland conference following the competition was the rapidity with which we reached unanimous agreement on the guiding principle on what should be the goal of an American health care system:

"An American Health System should support the health of the people and the communities in which they live."

We were also surprised at the concurrence on goals, purposes and core elements of a health care system, as outlined in Appendix F "Declaration for the Health of America." While the wording took time to master for this document, these elements all emerged independently and separately from the finalists proposals. Where there are differences, they are largely variations on *how to* do this. It was fascinating watching the finalists at the competition. While one group was presenting, others were quickly scribbling notes, and you could see them thinking, "Darn. Why didn't I think of this?"

What is really in these pages is the belief that we can do better with our health care system than we are now doing, as well as the belief that we can do this together with a civil and civic dialogue.

Step one on this journey was the Challenge on October 24, 2003. Step two is the "American Health Care Congress" which will be held on October 12<sup>th</sup> in Ontario, California, an event co-sponsored by the Loma Linda University School of Public Health, West End Health Advisory Committee, Ontario and Montclair, California, and Nexus Forums, Los Angeles, California.

What CodeBlueNow! wants to do is share these ideas, find common ground, and move forward so we can build a health care system that works for the American public.

It is time to return to traditional American values—to turn away from health care based on privilege and turn to a compassionate, supportive system of health care that recognizes that the health of one affects the health of us all.

Our patriotic American Senator, Mark Hatfield, says: “You cannot build a strong nation; a nation strong economically, strong militarily, strong spiritually, on the backs of sick people.”

The health of America depends on the social values each of us brings to our own health choices.

Thomas Aschenbrener, President  
Northwest Health Foundation

## Executive Summary

“Power is the unity of diversity. When we come together with a shared intention, things work. We will never be better than we can imagine,” says Dr. Leland Kaiser, President of Kaiser Consulting.

Welcome to CodeBlueNow! *America’s Health Care Voice*. We are imagining a better health care future. What follows in this report are views of possible futures created by people who passionately believe that we can do better than we are doing now when it comes to health care. These ideas reinforced our conviction that the American public is vastly smarter than they are given credit for when it comes to health care.

The ideas herein are not from advocacy groups or political parties. They are from people all around the country who believe our health care system must change and that it can change for the better.

What emerged from our “Build an American Health System” Challenge in October 2003 was an independent and unanimous consensus on what a health care system should do:

**Our health care system should support the health of our people and the communities in which we live.**

What also emerged from the top finalists was an amazing congruence on core values and core elements of a health care system. Why does this matter? Until our Challenge, no one had ever asked or articulated what a health care system should do other than focus on the traditional three-legged stool of health care—“cost, quality or access—pick two.” This is the wrong focus and that is the wrong question.

My first op-ed on the health care system, written in 1991 for the Puget Sound Business Journal, was: “Without a goal, health care will remain a mess.”

That remains as true today as it was in 1991, but now we are in an even bigger mess. Unless we have a goal for a health care system, we can’t fix the mess we’re in.

As I am fond of saying: “You can’t build a ship unless you know it’s supposed to float.”

## **I. Key Findings**

What emerged from these proposals is a vision of what a health system should do. Once we know what it should do, then we can build accountability and responsibility into the system.

These proposals have turned the health care system on its head and provided roadmaps to migrate from where we are to a preferred future.

### **1) Citizen-Driven Health Care**

The finalists wanted real Citizen-Driven health care. They all give the individual the power, authority, resources, tools and responsibility to make health care decisions. They took the employer and the insurer out of the center of the circle and moved them to secondary positions. Only a few eliminated them altogether.

This “citizen-driven health care” is vastly different from the so-called “Patient-Centered Care” or “Defined Contribution Health Plans” on the market now. In reading the proposals and working with the finalists over the past eight months, it is clear these folks are tired of being disenfranchised and want to be in the driver’s seat.

### **2) There’s Probably Enough Money To Do This**

Several proposals calculated the savings we could reap if we truly focused on health promotion, wellness and early intervention. Most found savings by eliminating administrative waste. One found billions of dollars at the state and federal levels by aggressively tracking down fraud.

While there are differences in the financing mechanisms of the various proposals, these differences are not so ideologically different that they make blending the approaches impossible. The freshness of proposals stems from their total lack of partisan politics and ideological positioning.

### **3) Really Invest in Prevention and “De-medicalize” the health care system**

All the finalists advocated for prevention and wellness. They made this pitch not only for our improved health, but also because it would create documented savings.

They believed that individuals, given good information and the right tools, could make many health care decisions without necessarily relying on medical doctors. Most proposed having health advocates or coaches, but they wanted the freedom to chose the providers themselves.

Given the fact that studies show that nearly 50% of our current medical procedures are unnecessary, fixing that issue would also bring savings.

### **4) Locus of Control**

Not only did the finalists want the individual to have the power and authority to make decisions, they also wanted coverage decisions and management at a more local level. How they did that varied; some recommended using a public education model or public utility model to manage health care. None advocated for a large national organization to manage the financing and delivery of health care.

Again their divergences they were not ideologically driven, and many could actually be blended.

### **5) Seamless and Integrated Health Care System**

Not only did the finalists want more control at the local level, they wanted a seamless system without all the barriers to access in the current system. How they designed their system varied by their experiences, but they felt the health care system should be accountable to the individual and the community for the quality of health care outcomes.

### **6) Information Technology**

Technology is the Achilles Heel of the American health care system. Everyone believed that using the power of information technology would not only improve the delivery of health care, but would save funds in the long run by eliminating administrative waste.

If there were a major federal role all would agree on, it was financing the information technology infrastructure.

### **7) Legislative Changes and Timelines**

The finalists addressed these issues very carefully and again, while they differed, they all outlined various routes on how to get from where we are to where we could be.

### **8) Malpractice Reform**

We had truly refreshing ideas on what to do with the malpractice/liability issue. A recent query by a journalist—“Is it really just about doctors vs. lawyers?” unleashed an intense response on the Association of Health Care Journalists’ Listserve. Well, we have found that it is more than that. Several novel new suggestions were made—from no-fault insurance to medical courts staffed either by expert judges or expert medical professionals.

### **9) Political Will and a Civil, Civic Dialogue**

No one deluded themselves that this would be easy. All the finalists agreed that health system change would not occur without a major effort to galvanize the political will to get from here to there. This is why we founded CodeBlueNow!: to generate interest and grow our membership so the American public can finally have a voice rather than choosing from someone’s pre-packaged solutions.

Health care reform has failed in this country because it has been held hostage to partisan politics and special interests. It failed during World War I. It failed under Truman. It failed under both

Nixon and Clinton. We are again bogged down in partisan efforts to fix the health care system. But this is about to change.

What has truly surprised us all was the extent of our common ground as outlined in our Declaration for the Health of America, Appendix E. Despite our various political beliefs, we discovered we *can* actually participate in a civil, civic dialogue if we focus on the outcome--creating a health care system that works for the American public. Actually, the finalists did the unthinkable – they combined medical savings accounts with single-payer, universal coverage.

To reiterate Leland Kaiser’s point: “We will never be better than we imagine ourselves to be.” CodeBlueNow! has over 100 visions of a health care future; and all these visions focus on working together to solve problems.

We’re not alone in this. Mark Satin, Author, *Radical Middle*, stressed his research: "We looked at the work of credible pollsters and found that many people -- sometimes a majority! -- are inclined to take the best of the right and the best of the left and combine them and go forward. But even synthesizing is not enough. We need to innovate. We need to think deeply about how to serve people's needs in the 21st century. After all is said and done, how we design systems is the most important thing; it’s not primarily about how much we spend.”

## II. Where the Public Stands

Numerous studies show what the American public wants. The Commonwealth Fund found that most Americans would be willing forego tax credits in return for guaranteed health care (62%)<sup>1</sup>.

The work of the Frameworks Institute shows that the public knows health care is complicated and distrusts “bumper sticker health care.” They want a clear road map to change rather than one big, quick fix<sup>2</sup>. They also know that prevention would yield greater savings over time<sup>3</sup>.

They trust neither business nor government to take over the health care system. The public wants multiple approaches to address cost and access issues<sup>4</sup> and they clearly want to keep our current model that builds on shared responsibilities (59%)<sup>5</sup>. Health care is an important issue to them in the presidential and Congressional elections.<sup>6</sup> They want greater economic security when it comes to health care and they are worried that the quality of their care will erode as health care costs increase.<sup>7</sup>

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<sup>1</sup> The Commonwealth Fund, *The Affordability Crisis in US Health Care*, March 2004

<sup>2</sup> The Frameworks Institute, *Presentation at Arizona CAN Conference*, March 19, 2004

<sup>3</sup> *ibid.*

<sup>4</sup> The Commonwealth Fund, *op.cit.*

<sup>5</sup> *ibid.*

<sup>6</sup> The Frameworks, *op.cit.*

<sup>7</sup> *ibid.*

### **III. What CodeBlueNow! Has**

1. Core of basic values that emerged from non-partisan proposals
2. Practical suggestions for health system change that can be blended and refined
3. Potential pilot/demonstration projects
4. A road map to get from here to there
5. A core of committed citizens who are willing to work together toward a common goal

### **IV. What CodeBlueNow! Is Doing**

We are embarking on a ‘Whistle Stop Tour’ starting in the Northwest, moving into California and then heading East. We intend to tap the ingenuity of the American people and engage them in real problem-solving discussion around key issues in health care.

We will use our Declaration for the Health of America to garner consensus on the core values of a health care system and discuss on what a health care system should do. We will use the Declaration to demonstrate our commitment and to grow our membership.

Then we will hold an American Health Care Congress on October 12<sup>th</sup> in Ontario, California. This “Grassroots Congress” is co-sponsored by Loma Linda University School of Public Health, the West End Health Advisory Council, Ontario and Montclair, California, and Nexus Forums, Los Angeles among others.

At our Grassroots Congress we will reaffirm these core values and work on the “how to” parts of the puzzle—financing, management and delivery. Ontario and Montclair will create their local action plan. We will compile those findings and present them to the Beltway Congress, the National Governors’ Association and the White House.

Will this work? Nothing else has.

To go forward, as Dr. Kaiser says, we must find the unity in our diversity, come together to solve a problem and trust in the process that our combined good intent can bring us to the exquisite answer.

So, ladies and gentlemen of America, please allow me to introduce you to some possible and probable futures. Welcome to CodeBlueNow! America’s Health Care Voice...and yours.

Please join us on our journey.

Kathleen O’Connor  
Founder  
June 10, 2004

# **Category 1. Problems of the Current American Health System**

## ***Introduction***

The proposal writers describe many serious problems in our current health care system. They do not necessarily agree as to the nature of the problem, but many concur in the conviction that the large number of Americans without insurance poses a major challenge to the entire health system. Some might argue that the root problem is that the current health care system emphasizes curing sick patients rather than educating the populace in the principles of good health. A “perverse incentive” exists whereby it is economically beneficial to some to permit and even encourage illness. Every author views the American health system as fundamentally flawed and in dire need of significant reform. While these represent obvious areas of agreement about the problems of the American health care system, each proposal offers unique perspectives.

## ***Uninsured and Underinsured Americans***

Most authors identify health insurance as one of the key problems of the American health care system. Five of the proposals cited the large number of uninsured Americans as a major factor affecting the entire system.

Yuse states that over 41 million Americans have no health insurance and many more are underinsured, while an increasing number of employees and early retirees are losing their health benefits (Yuse, 1).

Loma Linda University School of Public Health (LLUSPH) identifies a lack of insurance as the most significant demographic or economic barrier to accessing health care because it often determines the timeliness and quality of care delivered, if at all. Being without health insurance often results in receiving less preventive care, being diagnosed at more advanced stages of disease and, once diagnosed, receiving less therapeutic care. This mode of treatment is more costly and more burdensome to society and the individual (LLUSPH, 4).

In a section titled “The Plight of the Uninsured,” Rollins School of Public Health discusses the primary problems as both access to health insurance and payment of coverage for everyone. The structure of insurance benefits the employers and not the policyholders. By means of policy increases, higher co-payments, and reduced benefits, insurance companies squeeze policyholders. The lack of insurance leads to the overuse of emergency care which creates not only the health problems discussed above, but also financial problems (Rollins, 5-8).

## ***Rising Health Care Costs***

Every proposal states that the rising costs of health care pose a significant challenge to the system. Many authors argued that the system will collapse without significant and basic changes. The institutionalization of third party management, with its vast increase in bureaucracy, was mentioned by many proposal writers as a contributor to the rising costs of health care. Cost shifting, wherein those with insurance wind up paying for charity cases, is mentioned by three proposals as a major

factor in rising costs. Poverty, prescription drugs, litigation, and the future medical care needs of the aging baby boomers are other factors discussed by the authors.

According to three proposals, inequitable access to the system is related to poverty, lack of primary care physicians, and the complexity of the health care system (Benn, 4; Rollins, 5).

Anthony attributes the rising cost of health care to inflation, a lack of competition, and the absence of adequate controls (Anthony, 5). Lawsuits that are attributed to managed care have increased. Excessively high jury awards have swollen costs (Anthony, 3). He also notes that the aging cohort of baby boomers will demand increasingly expensive medical treatment (Anthony, 2).

Benn states that micromanagement administrative costs have doubled (Benn, 5). Discrepancy in treatment is traceable to difference in class affiliation and income. The poor consistently receive inferior medical treatment (Benn, 8).

Miller discusses how our country suffers from a “rigid paradigm” in which the only way to finance health care is through insurance that pays all large expenses (Miller, 2). Society suffers from an anxiety about a single-payer system. This has led to a proliferation of different requirements, more paperwork, and the hiring of people who do nothing but track the paper trail (Miller, 3). In a section titled “The Balanced Choice Pharmacy Benefit System,” Miller provides a strong argument for identifying the pharmaceutical industry as one of the worst offenders because it manipulates the political system to avoid price controls and price competition (Miller, 12-20).

Our nation has created a health care system that is as expensive as it is ineffective. Therefore many people can no longer afford the high cost of health insurance. In addition, our obsession with private sector profits drives the system in non-productive directions. “Patients have been held hostage in a gigantic struggle over money between medical providers and payers” as a result of increases in cost cutting and top down management practices (Tracy and Clark, 10).

### *Quality of Care*

Richardson, Benn, and Tracy and Clark identify serious problems with the quality of care delivered by the current American health care system. They emphasize the poor health outcomes experienced by Americans compared to the health outcomes of other developed nations. “The stunning fact is that the United States is not the leader in health care outcomes. We are not even close to being the leader, not even making the top ten in measures such as age-adjusted mortality, infant mortality, and iatrogenic injury prevention” (Tracy and Clark, 8). Richardson quotes a 2003 Institute of Medicine Report which finds that “health care professionals are not being adequately prepared to provide the best and safest medical care available, and there is insufficient assessment of their ongoing proficiency” (Richardson, 20). Benn cites a 1999 Institute of Medicine study that chronicles high rates of preventable deaths and other studies identifying significant levels of unnecessary services provided matched by significant under-use of necessary services (Benn, 10).

## *Sick Care Versus Health Care*

We suffer from “perverse incentives,” because it is economically advantageous to some groups for people to become sick and to be treated with expensive technology, which raises the cost of health care for all. Many of the proposal writers make a similar point that the focus of the health care system is on illness and not wellness or disease prevention.

Pavka and Shermis explore the benefits of health to the individual, to society, and to the health system in a section titled “Benefits of Health” (Pavka and Shermis, 15-16). Benn states that our “insurer controlled medical malpractice system” has failed to properly compensate victims of medical error or to promote quality care. He also discusses the insufficient focus on fraud detection and reduction (Benn, 14).

## *Cultural Values*

Several proposals argue that the underlying problems of our health care system derive from our culture and the philosophical assumptions held by individuals. A number of writers argue that health has become perceived as simply one more economic good, rather than a human right available to all and dependent upon need, and not upon social class, income, or possession of insurance.

People forced into bankruptcy by health costs cannot support their families properly or even participate in ordinary citizenship activities. Thus society is weakened when it does not properly care for its ill members (Yuse, 3).

One proposal (Tracy and Clark) makes a distinction between health and health care. They state that health “refers to the optimal functioning of a complex natural organism, a human being, and to the individual’s physical, mental, and spiritual well-being” (Tracy and Clark, 5). They argue that individual consumers have given control of their health to health care providers and third party payers. “As individuals and communities, we have forgotten that we are the ultimate payers and supporters of our medical care, and that our medical care providers and payers should serve us in maintaining our health. Therefore, we now incorrectly view basic medical care as a benefit given us by our employer or an insurance entitlement granted us by government” (Tracy and Clark, 6).

Pavka and Shermis posit that the current imbalance between rights and responsibilities leads to the widespread cultural assumption that individuals can lead sedentary lives and consume harmful food, but then expect that someone will cure them if they become ill (Pavka and Shermis, 3).

Richardson discusses an asymmetry between what the doctor knows and what the patient knows (Richardson, 4). This is significant because an uneducated consumer cannot make informed choices of life and death (Miller, 9-10).

Benn suggests that one must first look deep into the culture of American society in order to understand the driving forces behind the U.S. health care system. Americans pride themselves on self-reliance, independence and on the ability to generate wealth through a market economy.

The U.S. health care delivery system reflects these values (Benn, 4). However, there is a failure to recognize the importance of social capital and education in improving health outcomes (Benn, 4).

### ***Patient-Consumer Interests Versus Special Interests***

As will be discussed in Categories 2 and 3 below, several authors advocate re-aligning the health system to address patient/consumer needs. In converse of this point, others emphasize that the current health care system is organized to meet the needs of special interests rather than patient/consumer interests. Tracy and Clark argue that patient/consumers have ceded control of the delivery and financing of their health care to profit-driven payers and providers. (Tracy and Clark, 5-9). Miller singles out the pharmaceutical industry as manipulating the political system to avoid price controls and price competition (Miller, 12-20).

### ***Other Problems***

Pavka and Shermis argue that the fragmentation of our health care system has led to widespread and deep dissatisfaction among patients, physicians, employees, employers, and other parties in the health care system. The authors assert that the health care system is so sprawling and complex that it is both unintelligible and unmanageable. The health care system is a smaller component of the larger society. Therefore, all of the problems enumerated above are related to one another and connected to many aspects of society (Pavka and Shermis, 1-4).

Pavka and Shermis also argue that dissatisfaction and discontent for many stakeholders in the system, imbalance of rights and responsibilities, self-defeating assumptions, unreasonable expectations of all stakeholders, and perverse incentives are some of the “not so obvious” problems plaguing our health care system (Pavka and Shermis, 2-4).

### ***Summary***

The current U.S. health care system has many problems. These include a fewer people with health insurance, increasing health care costs, a preference for a model of health that emphasizes disease and sickness rather than prevention and wellness, conflicting cultural values, fragmentation, special interests, administrative complexity, and consumer dissatisfaction, among others. Many of these problems are addressed in the following pages.

## **Category 2. Governance**

### ***Introduction***

Each proposal author advocates for continuation of a strong federal government presence in health care. Some argue for some expansion of the federal government's role. As discussed in Category 3, all the proposals find ways to cover everyone. But the proposals vary in how they locate authority among the employers, federal, state and local branches of government. They also differ in describing the partnerships that government will have with groups in the private sector, including employers, private insurers, and consumers.

### ***Federal Government Authority***

Three proposal authors locate the governance of their expanded national health insurance program in specific agencies of the federal government. Yuse proposes to expand the federal Medicare program to cover citizens of all ages. He recommends that the program be jointly managed by the U.S. Department of Health and Human Services, the Social Security Administration and CMS, and a new Board of Trustees representing medical providers and consumers (Yuse, 4, 5).

Richardson recommends implementing a new system managed by the federal Medicare agency and collaborating with a wide variety of other governmental and private sector organizations as employer-sponsored health insurance plans are gradually phased out (Richardson, 3, 7).

Miller suggests creating a subscriber-elected Consumer Health Advocacy Organization and a Balanced Care Governing Board appointed by the President and Congress to oversee his Balanced Choice program, along with expanding the federal Public Health Service (Miller, 48).

Three proposal authors advocate the expansion of existing federal health insurance programs, but don't fully describe the federal governance process. Benn proposes expanding public health insurance to cover the working poor as well as the Medicare and Medicaid populations. He also proposes creating an extensive range of delivery system reforms, e.g., drug price controls, demand management by patients rather than supply management by doctors, capitation rather than fee-for-service, self-care patient management, reduction of administration and for-profit costs, and malpractice litigation caps. However, he does not set forth the governmental agencies that would be needed to implement and maintain these programs (Benn, 20).

Pavka and Shermis propose a single-payer approach that ensures that basic wellness, sickness, and catastrophic coverage is available to all Americans. (Pavka and Shermis, 24).

### ***State and Local Government Authority***

Some proposal authors would implement their versions of universal health care coverage primarily through state and local governments, rather than the federal government.

The Rollins School of Public Health designates state governments as the managerial focus of its State Resident Based Health Insurance programs, while allocating authority and responsibility among the federal government, state governments, counties, and public centers (Rollins, 30).

LLUSPH advocates a public utility model for health care governed by several coordinated levels of government that include a national health commissioner appointed by the President, state and county directors of health services appointed by the national commissioner, and county advisory health boards (LLUSPH, 1-5). Tracy and Clark propose a decentralized federal model with state and local partnerships modeled after the American public education system, with regional health boards operating community public health care systems (Tracy and Clark, 2-4).

Anthony's Community Health Care Purchasing Cooperative proposal addresses governance issues somewhat differently than the others. He expands current federal legislation promoting employer-sponsored health plans to enable the development of community health care purchasing cooperatives managed by local boards of trustees and overseen by a Federal Health care Insurance Corporation (Anthony, 22).

### ***Employer and Insurer Authority to Provide Health Insurance***

The American health care system currently grants considerable autonomy to employers and to the insurance companies in making decisions about whether to offer health insurance to employees or not, and what types and levels of health insurance are offered. Each proposal author addresses the role of employer-sponsored health plans and private health insurance in their reformed American health care system. However, the proposals differ widely in the roles they assign to private payers.

The role of private health insurance recedes in many of the authors' proposed reforms to the U.S. health care system. Yuse, Richardson, Benn, and Pavka and Shermis envision the private insurance sector as evolving to a supplemental insurance resource for individuals, rather than remaining a primary source of basic and catastrophic coverage.

Some authors propose to significantly reduce the authority and tax advantages currently enjoyed by employers in sponsoring health plans for their employees. Tracy, LLUSPH, Yuse, and Miller disconnect employer sponsored health plans from the funding of health care services, and instead require employers to make their contributions to government sponsored health insurance programs. Pavka and Shermis allow employer sponsored plans, but eliminate employer tax deductions for health benefits (Pavka and Shermis, 26).

Other authors support continuation of employer sponsored health plans but increase federal and state government regulation over such plans and typically envision a highly regulated health insurance industry. Rollins proposal requires employers to offer coverage to their employees, but relocates the authority for benefit plan design and provider contracting to governmental agencies (Anthony, 11; Rollins, 29). Rollins further advocates state regulation to ensure community rating and sliding-scale co-payments for lower-income citizens (Rollins, 15).

Benn envisions employer sponsored private health plans covering fifty percent of the population while his Medicare for the working poor system would cover the other fifty percent (Benn, 24). "Employers would remain responsible for payment of health care insurance premiums for the non-poor employed workforce, either through employer sponsored health plans, or by paying into the federal health insurance program. The public system could be offered to employers to purchase in direct competition to existing private insurance" (Benn, 21, 24).

## *Consumer Power and Authority*

Many authors note that patients are relatively powerless in a health care system dominated by other more powerful stakeholders, such as managed care organizations, hospitals, insurers, and pharmaceutical companies. They propose to correct these imbalances by placing consumers in the center of their new health systems, while assigning supporting roles to all other stakeholders. Tracy and Clark state that a new paradigm for public health is required in which “citizens should move from the periphery of our health care system to the center of the system, a center now dominated by private payers and private care providers” (Tracy and Clark, 1). They grant consumers direct control over the governance and financing of their local health system. Anthony proposes to increase consumer power by enabling them to serve as trustees of Community or state health care purchasing cooperatives (Anthony, 21).

## *Summary*

The structure and function of governance varies widely in the proposed health systems. Some involve only an expansion of existing governance institutions. Others involve the passage of legislative initiatives leading to basic institutional changes. Some will involve three to four levels of governance. Others will require minimal governmental changes, relying instead upon building coalitions between cooperative institutions. Each proposal flows from different conceptions of the problem and in turn, each leads to very different consequences for the U.S. health care system.

One proposal contains a methodical, systematic discussion of governance, management, and finance. Another argues for a cooperative movement as the model for their health care system. Another uses arguments from the economic theory of laissez faire to suggest that it is possible to avoid control and extensive legislation by balancing the public and private sector and giving individuals their choice of what kind of medical care to select. A third proposal rests its case on the definition of politics as the 'art of the possible' and argues that since wholesale health care reform has not been successful, Medicare should be expanded on the grounds that it has been the only program that is politically successful and has appealed to a large segment of the populace.

## **Category 3. Rights and Responsibilities of the Patients-Consumers**

### ***Introduction***

A new health care system must explicitly address what rights and what responsibilities each patient-consumer has in the system. This category explores these topics in greater detail, in addition to related topics of education and balancing individual and public good. The hyphenated terms, patient-consumer, are used here to distinguish between a patient who is an ill person seeking help and a consumer who is a well person seeking ways in which to stay well. This is discussed more in Category 4 on pages 16-20.

### ***Basic Coverage for All Americans***

There is universal consensus among the proposal authors that all Americans need basic health care coverage. However, as illustrated below, the proposals vary in the number and types of services included in that coverage.

The Loma Linda University School of Public Health (LLUSPH) proposal authors state that “Benefits will include at a minimum, all medical care deemed medically appropriate by the patient's health care provider, including: inpatient and outpatient care, diagnostic tests, prescription medications, durable medical equipment, podiatry, dialysis, medical transportation, rehabilitation, language interpretation, preventive care, long-term care services, mental health care, and dental and vision benefits” (LLUSPH, 5).

Yuse proposes that all people have access to preventive and curative service, including prescription medications, dental procedures and mental health care, and are assured inpatient care at hospitals, access to critical care at hospitals, skilled-nursing facilities, and hospice care (Yuse, 4, 6, 12).

Rollins School of Public Health outlines a health plan that would include the same mental health, maternity, immunization, dental, vision, and prescription drug health care services that are currently covered under the Federal Employees Health Benefit Package (Rollins, 8, 42-44).

Pavka and Shermis include in their basic health care package such services as routine physicals, preventive care, immunizations, birth control, maternity, dental care, and basic mental health care (Pavka and Shermis, 24).

Tracy and Clark argue for a “public health care system that would guarantee citizens access to basic medical, hospital, diagnostic, pharmaceutical, dental, behavioral and rehabilitation services at little or no cost” and that the “definitions as to what constitutes ‘basic essential’ services will be made in the open forum of state legislatures” (Tracy and Clark, 3).

Anthony writes: “the participants will all share the same benefits, share the same cost, and bear the same responsibility” (Anthony, 31). He lists eight types of services to be covered--wellness, clinical, hospital, professional, diagnostic, ancillary, pharmaceutical, and dental care. (Anthony, 12). Miller also suggests that the full range of health care services available in the current Medicare program should be included in addition to “full dental services for children, mental health benefits, long-term care, and pharmacy benefits” (Miller 46).

The following two statements from different proposals illustrate similar thoughts about public health services available in neighborhoods. Patients have access to prevention and treatment services delivered through “one-stop shopping” at public health clinics available in every neighborhood (Richardson, 14). “At the core of the new system are publicly financed community health systems, delivering essential services to citizens at little or no cost” (Tracy and Clark, 21).

### ***Right to Catastrophic Coverage***

A growing problem with the current system of financing health care is the increasing number of people who suffer bankruptcy because they can’t afford to pay the fees incurred as from an unexpected health crisis or long-term illness. Four of the proposals included a right to catastrophic coverage. Pavka and Shermis “provide basic coverage and catastrophic coverage” under their proposed hybrid system (Pavka and Shermis, 24). “Catastrophic coverage would be purchased by the insurance carrier or directly by the Cooperative” (Anthony, 18). Tracy and Clark argue that “because citizens will have the legal right to access to core medical services at a no cost or low cost basis, serious medical illness or injury should no longer lead to financial catastrophe” (Tracy and Clark, 15).

### ***Responsibilities***

In many proposals, the balance between rights and responsibilities in the new system shifts towards the patients-consumers who are encouraged to take more responsibility for their own health. Such responsibility includes engaging in certain behaviors that support good health and deciding how to allocate money for their health care expenses.

Benn defines a “self-care” model in which the patient-consumer assumes responsibility for health promotion and self-management of his or her illnesses.

Miller, too, places an emphasis on the patient-consumer taking more responsibility for their health “All people are ultimately responsible for their own health. In general, people deserve to be respected for using their own judgment and motivation for taking care of their health. In some cases, people are self-destructive, do not take responsibility for reasonable health care, or abuse the system through overuse” (Miller, 46).

### ***Miller’s Balanced Choice Program: Standard and Independent Side***

Miller divides his proposal into the Standard Side and the Independent Side. On the Standard Side, the patient pays the full cost of all medical visits, using a Standard reimbursement schedule. It is similar to the current Medicare system with the addition of coverage for pharmacy benefits, mental health and long-term care. However, the Standard Side service option has no co-payment or deductible for doctor visits. This option is intended to offer the services proposed by advocates of a single-payer system. Under Standard Side, a person can be assigned a case manager who can coordinate treatment services. Patients are responsible for either accepting the Standard Side services or seeking out Independent Side services. (Miller, 49-50). Miller suggests this unique responsibility: “. . . verifying the accuracy of billing even when the consumer is not charged, and consumers who resolve billing errors are rewarded with a portion of the Balanced Choice funds recovered” (Miller, 50).

The Independent Side pays most of the first dollar cost of treatment for services. Under this service option, the patient pays the last dollars or the gap between the standard government payment schedule and the fees charged, which the provider can set at a rate higher than the Standard Side. For example, Balanced Choice might pay 85% of the cost that would be paid on the Standard Side, and the patient would pay the gap between the Balanced Choice payment and the provider charges. This Side is managed less than the Standard Side (Miller, 4).

Anthony's system is "a participant-driven system in which patients select physicians, specialists and treatments" (Anthony, 4). Patients are put in charge of their own health care and health care decisions. They have a financial responsibility for their own decisions and also share in the viability of the entire trust (Anthony, 33).

Tracy and Clark's model empowers the individual to take responsibility for his or her own health care by providing basic services at no or low cost, with the opportunity to self-fund additional supplemental health medical care. "The individual's health care choices rest in the hands of the individual and his neighbors. . . . But consumers are responsible to pay for this health care system" (Tracy and Clark, 16, 19).

Pavka and Shermis' model describes the respective responsibilities of the patient, the health system, and society in relationship to health and wellness (Pavka and Shermis, 18-21). Individual responsibility in health decision-making is directly addressed via imposition of a Sickness Treatment Surcharge that taxes activities and substances which have been proven detrimental to health (Pavka and Shermis, 26).

### ***Education About Rights and Responsibilities***

Most proposal authors acknowledge that a new health system will require huge amounts of education to teach people about their rights and responsibilities. Yuse asserts that his plans are to "educate consumers about their health rights and responsibilities" and "educate the public on the benefits covered" (Yuse, 6). Richardson argues that it is the patient's responsibility to become more educated about health and his or her illness, and that patients-consumers will become empowered with the health care information available to them over the Internet (Richardson, 10-19).

Pavka and Shermis include a 100-year look at the system with its strong education component in a description of their proposed health care system. "Anne is a member of the first class at Asheville High School to participate in eight semesters of health promotion classes required for graduation" (Pavka and Shermis, 31). LLUSPH notes that "statewide teleconferences will be held to inform health care providers and patients of changes regarding coverage" (LLUSPH, 15).

### ***Achieving Balance Between the Individual and Society***

Any optimally functioning health care system must strive toward a balance between what benefits the individual and society. Yuse discusses the social contract philosophy underlying his Medicare For All proposal (Yuse, 3). Anthony's proposal asserts that "all individuals have a right to join the Community Health care Co-operative in which--by means of democratic processes--the individual will meet his or her needs and the cooperative will flourish and acquire sufficient resources for the future" (Anthony, 3).

Pavka and Shermis argue that their new system will foster a balance of rights and responsibilities as it affects individuals, groups, as well as the whole health system (Pavka and Shermis, 28). Their proposed health system balances promotion of individual wellness with societal responsibility to manage health care resources wisely for future generations (Pavka and Shermis, 28). Tracy and Clark note in their proposal that “while individuals must take responsibility for their own health, health is a matter of public concern, with significant social and economic, as well as personal, consequences” and proceed to offer citizens the opportunity to govern and finance their community health care system just as they do their school systems, police and fire departments (Tracy and Clark, 6, 15).

### *Summary*

The rights and responsibilities of people using the health system must be clearly thought out and taught to all people using the health care system. All proposals agree that each person has a right to be guaranteed coverage for a basic set of important health care services. Several proposals state that catastrophic coverage is essential, and most think that health promotion education is vital. Some proposals look at the balance between what is good for the individual and what is good for society, one of the many issues that should be carefully considered when proposing changes to the U.S. health system.

## Category 4. Wellness and Illness

### *Introduction*

Although we call it a “health care” system, our health care system is, in reality, a “sickness treatment” system. In this section we explore what the proposal authors have to say about the full spectrum of health and health care, including health, wellness, prevention, causes of illness, intervention, end of life issues, and education.

### *Health, Wellness, and Prevention*

There is consensus among the proposal authors on the importance of maintaining health and preventing illness. The assumption is that wellness and illness prevention both reduce health care costs and raise the level of health of all Americans. Many proposal authors wrote extensively on this topic, indicating the need to shift the focus of the health care system away from the traditional emphasis on treating illness to prevention and wellness.

Tracy and Clark make a clear, yet subtle distinction between the terms “health” and “health care” (Tracy and Clark, 5). “With all their knowledge and facilities and clinical tools, medical care professionals cannot ‘provide’ an individual with good health” (Tracy and Clark, 5).

Yuse’s discussion of the Hippocratic medical philosophy and self-cure is similar to Pavka and Shermis’ position that the human body has a natural ability to heal itself (Yuse, 6; Pavka and Shermis, 14). Pavka and Shermis present concepts of wellness, health, illness, and medical care, and design their new system around these principles. They recommend integration of the biomedical and holistic models defined by Mark Woodhouse. Using this design, the new system will gradually subsume our current medical treatment system under a more comprehensive health and wellness oriented system (Pavka and Shermis, 14-21).

Tracy and Clark write that “Personal health depends on many other factors than medical care including clean water, clean air, nutritious food, a safe workplace, exercise, genetic make-up, stress, social relations, and a peaceful society” (Tracy and Clark, 5). Yuse’s Medicare For All Health System will “educate consumers regarding diet, life-style, environment, and accident prevention . . . and emphasize wellness and prevention of illness and accidents” (Yuse, 6).

In Miller’s Balanced Choice model, the system is responsible to everyone for their health care on a no-fault basis from birth to death. In such a system, prevention becomes more important because the system will capture many of the benefits of prevention (Miller, 10). Miller asserts that his Fair Balance system will create incentives to promote long-term preventive service and that the Public Health Service will be given funds for prevention and education regarding wellness (Miller, 48).

Benn describes the importance of health promotion and disease prevention programs in his proposal. He criticizes our current health care system’s over-emphasis on treatment at the expense of prevention (Benn, 5-6). To correct this imbalance, he defines a “Self-care” model, illustrated as a bulls-eye with five rings of care: community health promotion, patient self-management, nurse

consultation; acute consultation from a MD or DDS, chronic disease management by an MD or DDS (Benn 7-8, 34).

Anthony 's Community Health care Cooperatives model provides wellness services, activities, and products for the whole family which are paid for 100% (Anthony, 20). "Health promotion and education activities will be spearheaded by Health Education Specialists, working in conjunction with the team and the Public Health Department" (LLUSPH, 14). "Prevention and intervention in a timely manner to all must be the ultimate goal in rebuilding the American health system . . . ." (Richardson, 26).

### ***Causes of Illness***

If the new health system is to truly promote more wellness, it must look at the causes of illness, as have some proposal authors.

Benn argues that one cause of illness includes the social aspects, or what he calls "social capital." Our lack of concern for social factors, including poverty, deepens the problems of both cost and the relative ineffectiveness of our current health care system (Benn, 6-7). Benn's proposal is unique in addressing the non-medical causes of illness, like poverty, through creation of non-profit "vocational villages." In these villages, single mothers and their children are provided room, board, day-care services, and Licensed Public Nurse training, in proximity to and association with nursing homes (Benn, 19-21).

Pavka and Shermis suggest that individual choices effect health. They posit that "the building blocks for every cell and substance in a person's body come from what he or she eats, drinks, and breathes" (Pavka and Shermis, 14). Thus, a person's health status is largely determined by the choices they make every day.

Pavka and Shermis also discuss the role of environmental pollutants in causing illness and suggest that illness prevention activities would include the identification of unsafe waters, rivers, lakes, etc. by state and county health departments. Yuse adds that "such examinations of our outdoor surroundings, homes, workplaces, drinking and recreational waters, highways, and vehicles are helpful to ensuring a healthy society, avoiding suffering, and preventing exorbitant [health care] cost[s]" (Yuse, 17). Pavka and Shermis also address this topic in their "Scenario: Ann in the USHeS" (Pavka and Shermis, 30-33).USHeS was used by the authors to catch the readers attention for a new system, and to differentiate it from USHCS—United States Health Care System.

### ***Intervention for Acute and Chronic Illnesses***

Certainly people become sick. How will the new system handle acute and chronic illness? Here are some answers proposed by the authors.

Miller suggests that as a comprehensive solution for health care, Balanced Choice will cover long-term care on both the Standard and Independent Sides. Because Balanced Choice is responsible for the long-term health of all patients, it is in a position to promote, through its funding mechanisms, the education and coordination of effective disease management programs through the traditional provider network (Miller, 10). Providers no longer need to be concerned with whether a condition

is preexisting, preauthorized, or a covered benefit. Referrals can be made to the most appropriate professional without concern about participation on a provider panel or other hidden gaps in a patient's insurance coverage (Miller, 40).

Richardson similarly advocates health education and illness prevention, and provides a variety of approaches, one of which is use of the U.S. Public Health Service to provide prevention, screening, eldercare, disabled care, chronic condition/chronic multi-system illness and health awareness as needed (Richardson, 14-19).

Tracy and Clark posit that their community-based health care system will be only responsible for basic essential health care services, not for all services individuals desire to promote their own health, and that these basic essential services should be determined in the open forum of state legislatures. Citizens are free to seek additional health services, including wellness, performance enhancement and custodial care, from the private sector and to pay for such service themselves (Tracy and Clark, 3). They advocate that their community health care systems will be coordinated with the epidemiological and prevention work of traditional public health systems. Community health data and individual medical data will be collected and monitored. Prevention programs will be developed, monitored, measured, and adapted (Tracy and Clark, 4).

LLUSPH propose that “benefits will include at a minimum, all medical care deemed medically appropriate by the patient's health care provider, including: inpatient and outpatient care, diagnostic tests, prescription medications, durable medical equipment, podiatry, dialysis, medical transportation, rehabilitation, language interpretation, preventive care, long-term care services, mental health care, and dental and vision benefits” (LLUSPH, 5).

The Rollins School of Public Health proposal sets forth the concept of “Public Health Centers.” These Centers involve a greatly expanded version of public health departments, for they also perform screenings, health education, prescription drug programs and act as primary care providers where they provide referrals to specialists outside the clinic (Rollins, 14).

Another aspect of intervention is prescription medications. In his section, “The Balanced Choice Pharmacy Benefit System,” Miller argues that existing means of paying for pharmaceuticals contains deceptive practices, are unfair to those without insurance, and limit patient choices. Miller applies his Balanced Choice theory to pharmaceutical costs by “having Balanced Choice pay the first dollars instead of the last dollars and by creating a price list suitable for comparison shopping” (Miller, 12-22). Benn, too, explores various aspects of prescription medications. “A large and increasing proportion of health expenditure is for drugs, many adverse events are drug related, and a large proportion of drugs are used to treat preventable diseases. There are good opportunities for reducing drug use through demand management utilizing prevention self-care programs” (Benn, 11-12).

### ***End-of-Life Issues***

End-of-life issues are another important aspect of a new health system from a clinical perspective, a cost perspective, and a quality of life perspective.

LLUSPH maintains that “enormous amounts of money are spent in the face of an extremely poor prognosis searching for miracles. Social marketing campaigns regarding the acceptance of death as a natural occurrence will be conducted to help society to deal with the reality of death” (LLUSPH, 16). Other proposal authors suggest that a more realistic system will not permit unlimited expenditures on patients whose prognosis is extremely poor. Patients and relatives will have to make hard choices. Anthony says: “No longer will a relative or patient be able to say to the doctor ‘do everything possible’ and expect someone else to pay for it. Now all medical decisions by patients and relatives will have a personal family financial element to them. There will be times when enough is enough” (Anthony, 18).

### ***Education***

Education of patients-consumers about their own health and illness is a strong and universal thread woven through all the proposals.

Richardson discusses health education in detail on pages 18-21. “Providing educational materials that are easy to read and understand . . . are essential and key. This includes audio and visual learning – books, TV, tapes, CDs, computer – as well as direct teaching. This is available on the Internet with health sites for kids like [www.kidshealth.org](http://www.kidshealth.org) and [www.bam.org](http://www.bam.org)” (Richardson, 19).

Miller posits that education of consumers and providers is the method of first choice to correct problems that cannot be corrected by the market adjustments periodically made by the Balanced Choice Governing Board (Miller, 46).

LLUSPH suggest that “educational strategies in the workplace, colleges, and schools will be implemented to promote consumer awareness of health care recommendations to determine the best and most cost-efficient mode of care. Large-scale forums and other means of creative communication strategies will be used to convey information that will promote interest in positive behavior” (LLUSPH, 15).

Pavka and Shermis argue that pervasive education, through traditional, emergent, local, national and experimental means will be designed to teach both the principles of good health and the workings of the health care system (Pavka and Shermis, 33).

### ***Summary***

Health care—ranging from intrinsic wellness, to prevention, to treatment of serious disease and trauma, to end-of-life management—is a crucial consideration for any new system. For a number of authors, a combination of wellness and prevention are the sine qua non of their entire proposal. One proposal recommended an integration of the current biomedical model with an emergent model of health. The same proposal includes a set of criteria for defining what is meant by ‘wholistic’ care, arguing that what is needed is a new conception of what it means to be healthy. For others, wellness and prevention are up to the individual who will either pay for both out-of-pocket or through a voucher system.

Consistent with claims that we have do not have a health care system but rather a sickness system, the authors emphasize wellness and preventive care while not neglecting issues surrounding acute

care, chronic illness and emergency care. Finally, the kind of delivery provided is inextricably bound up with how the delivery system will be changed.

Transforming our sick care system to a health care system will require a paradigm shift in the cultural values and expectations of all stakeholders in our health system. In order to accomplish this transformation, the core issues discussed in this section must be fully acknowledged and openly debated.

## **Category 5. Health Care Service Delivery Systems**

### ***Introduction***

The strong emphasis the authors place on prevention and health promotion is highlighted in Category 4. However, they do not neglect discussing the treatment of illness. This section concerns descriptions of how health care professionals and facilities will provide emergency, diagnostic, and treatment services under the proposed systems. The health care delivery systems discussed in the nine proposals are sufficiently unique that generalizations are difficult to make. Eight of the proposals argue that existing delivery systems are inadequate. In ways described below, each author argues that health care services will be delivered more effectively and efficiently under their proposed system.

The proposals can be clustered by the type of change advocated in the current delivery system:

- 1) no fundamental change;
- 2) fundamental alteration of provider-patient relationship;
- 3) fundamental alteration of provider management and payment incentives;
- 4) transformation to a public sector health care delivery system.

### ***Maintain and Enhance Existing Delivery System***

Rollins seeks to preserve the major elements of the current health care delivery system rather than generate radical transformation. Their State Resident Based Health Insurance Plan would not require major changes in physician practices, hospitals, and pharmaceuticals (Rollins, 35-36). Rollins also notes any large scale restructuring of the system would create stress among stakeholders and advocates that information must be made available to providers and other stakeholders to ameliorate stressors (Rollins, 34). However, Rollins does advocate for an increase in public health clinics, as do Richardson and Tracy, as is discussed below. Yuse states that the current provider system will be utilized with a modification of the incentives to provide quality care (Yuse, 13).

### ***Modify Provider-Patient Relationship***

Pavka and Shermis propose fundamental changes in the provider-patient relationship. These changes flow logically from their concept of the empowered patient. Pavka and Shermis also envision a new relationship between care provider and patient in their USHeS model. Both parties assume certain responsibilities in the process of becoming well or maintaining wellness under a covenant of mutual obligation (Pavka and Shermis, 19-20).

### ***Alter Health Care Provider Payment Incentives***

Many proposal authors advocate that changes in current provider payment methods are essential to improve the American health care delivery system.

Miller's Balanced Choice system enables patients and providers to choose between a Standard Side and Independent Side financial relationship. In the Balanced Choice system patients would be free to select their provider of choice and to change providers as they choose. All licensed health care

providers would be eligible for participation in Balanced Choice. Providers would be able to choose either side of the system they use when they contract with new patients, and could design their practices to create any mix of Standard and Independent Side they desire (Miller, 38).

LLUSPH does not discuss in detail how health care professionals and facilities would be organized or how they would collaborate in their new system. Most individuals would seek basic care services from locally available medical providers. However, they propose that the 20% of the population needing chronic illness and/or catastrophic care be enrolled in special “at-risk” health plans. Local community boards would contract with local provider health plan organizations to provide services to high-risk patients. These contracts will be designed to reward providers for effective, efficient and wellness oriented care (LLUSPH, 5-8). Organized provider groups would be integrated delivery systems, including HMOs, PHOs, and PPOs, capable of providing comprehensive services to at-risk patient groups (LLUSPH, 7-8).

Yuse proposes the use of standardized rates for inpatient and outpatient services in order to control costs, as is currently used with Medicare. His proposal also modifies incentives in order to provide quality care (Yuse, 12-15).

Anthony does not focus on delivery system modifications, but posits that, if accountability is placed in the hands of consumers and providers, the delivery system will change as a result of changed financial incentives (Anthony, 16-20).

Benn proposes that health care providers be offered individual capitation fee contracts to care for patients under the public health insurance program, along with certain population incentives. Under this system, a national board would provide guidelines to assist in setting such capitation rates (Benn, 23, 25).

### ***Move From Private Sector Health Care to Public Sector Health Care***

Most of the proposal authors implicitly or explicitly advocate continuation of the current private-sector, private-practitioner system of providing health care. However, several proposal authors advocate increased use of government-run health centers and community health systems.

Richardson proposes development of “one stop shopping” medical clinics, so that health care “will be available at any street corner much like the neighborhood convenience store” (Richardson, 14). She proposes attracting high quality medical care providers to these public health clinics, by building prestigious facilities, and providing them with competitive compensation packages. Richardson quotes extensively from a 2003 Institute of Medicine study on the health care professions, which proposes sweeping changes in professional training and professional licensure. These recommendations include: 1) all-state licensure; 2) primary care orientation; 3) training in collaborative practice; 4) information technology; and 5) evidence-based protocols (Richardson 19-21). She notes the need for many more geriatric practitioners to care for an increasingly aged population (Richardson, 21).

Tracy and Clark propose a public utility model for health care modeled after the successes of the American educational system (Tracy and Clark, 1). The doctors, nurses, and other health care practitioners working in the new system will be fairly compensated on a salaried basis. Performance

incentives will be acceptable, but the perverse incentives embedded in the current system to over-treat or under-treat will be eliminated. Managed care hassles will be reduced or eliminated because private-payer managed care will be eliminated. The system will be designed to attract practitioners desiring to carry out high-quality medicine rather than to run businesses. Defensive medicine will be eliminated as the fault-based malpractice system is phased out (Tracy and Clark, 4). As in American education, patients would have a comprehensive health care system available in their community or region at little or no cost, but would be free to seek private sector services if they are willing and able to pay for such services (Tracy and Clark, 2).

### ***Improve Quality of Care***

Improving the quality of care was addressed by all proposal authors with distinct differences in their approaches. Tracy and Clark and Benn emphasize the poor health outcomes experienced by American citizens compared to the results of the health outcomes of other developed nations (Tracy and Clark, 8; Benn, 5, 6). Richardson, Yuse, Benn, and Tracy and Clark stress the importance of basing treatment decisions on evidence-based medicine (Richardson, 19; Yuse, 17; Benn, 25; Tracy and Clark, 31).

Several finalists propose provider reimbursement models which they argue will foster quality care. LLUSPH advocates that local providers organize specialized health plans to treat high-risk patients, whose contracts will be designed to reward providers for effective, efficient, and wellness oriented care (LLUSPH, 7-8). Anthony allows only non-profit organizations to provide wellness services (Anthony, 12). Tracy and Clark argue that the removal of the profit motive from health care delivery will enable physicians to focus on medicine instead of business, and that quality improvement is always subservient to financial considerations in the current system (Tracy and Clark, 11).

### ***Summary***

According to most authors, re-aligning incentives is the key to changing the delivery system. Some suggest the key is making patients the focus of the health care system. For some, a useful strategy is a provider or mentor/advocate who acts in resourceful ways to keep patients in optimal health. Some wish to see tighter controls on some elements of the system, while others believe that avoiding controls is better. Some believe that simply by making significant administrative changes, the delivery system will be radically impacted. Others argue that giving patients a choice of the public or private sector is instrumental in changing the delivery of services. One strongly argues that non-medical factors need to be changed before we can improve the state of health in this nation. And finally, several contend that only through radically reconstituting our society, changing the political and economic system, can we deliver the right services to the most people.

## **Category 6. Finances and Cost Management**

### ***Introduction***

Underlying each proposal is the question of financing the new health care system: who will pay and through what funding mechanism(s)? This section considers the role of government, individuals, and private insurers in paying for medical costs. The related question of controlling health care costs also arises, given that all the proposals identified escalating and excessive costs as a major problem in the current health care system.

### ***Government Financing***

Many of the proposals advocate some expansion of government funding to:

1. ensure coverage for the currently uninsured;
2. provide catastrophic coverage for the very sick;
3. expand needed new benefits;
4. enlarge public health education and prevention programs;
5. or some combination of these objectives.

Accordingly, the proposals can be grouped by the type of government financing they contain, although there are important variations within groups as well as ways they address the role of employers.

### ***Federal Government Financing***

Some authors offer some version of a federal 'single-payer' system. They propose extending the federal Medicare and/or Medicaid programs to cover currently uninsured citizens and/or to provide new health care benefits. These proposals involve federal governance, as discussed in Category 2, federal legislation, as discussed in Category 9, and federal taxes, discussed below.

Yuse proposes to expand Medicare to all 280 million American citizens, which will both spread the risk and save the taxpayers money in the long run (Yuse, 4). All citizens will be included in an expanded Social Security system, funded by federal taxes and placed in a national health insurance trust fund (Yuse, 5). Individual assessments will be based on gross income and ability to pay, with tax credits and/or waivers and co-payments available for those in need (Yuse, 1, 6). Employers will not be responsible for collecting the health taxes or for health benefit plans (Yuse, 5). Initial operational funding of \$75-100 per month per person will be needed (Yuse, 8).

Benn recommends the expansion of the Medicare and Medicaid programs to cover the uninsured, and estimates the expanded program would comprise approximately 50% of the population (Benn, 20-21). The remaining 50% will be covered by employer paid premiums, disbursed either to insurance companies or to buy access to the federal health insurance program (Benn, 20-24). Self-employed people will be able to buy public program coverage but will not be penalized by higher premium rates (Benn, 24). Benn's vocational village program would be separately funded by the federal government, at a direct program cost of \$50,000 per year per family, with an estimated total of \$14 million for a five-year pilot (Benn, 19).

Richardson would fund her universal coverage and public health services program through the federal government supplemented by other sources:

1. directly through government;
2. insured person's co-payments;
3. savings from cost-cutting measures;
4. re-allocation of other government monies;
5. monies from regulatory fines;
6. savings from new cost-containment regulations (Richardson, 21-24).

As illustrations, she cites state government initiatives extending health care services to medically underserved populations such as Tennessee's Options for Community Living program, which saves about \$2,000 per month per person, Arkansas' Cash and Counseling program, and Maine's expanded Medicaid program (Richardson, 25). But she clearly favors ensuring universal coverage through national health insurance and federal and state public health programs to pay for education, prevention, and community clinics (Richardson, 2, 27).

Miller outlines a combination of public and private funding in his Balanced Choice program. The Standard Side program guarantees universal basic coverage through a federal Medicare-style health insurance program. An Independent Side program enables individuals and health care providers to negotiate higher fees for services (Miller, 32-36). The Standard Side program is funded through a payroll tax, federal funds, and state and local funds, and will establish standard rates for services as is currently done in Medicare (Miller, 34-35). The Independent Side program permits consumers and medical providers to negotiate fees and services over and above Standard Side rates, creating a free market exchange of services.

Miller supports central government funding in his Standard Side program, and delineates the advantages of a national insurance program:

1. risk spread over large population;
2. reduced channeling of the healthy to private insurers and the ill to public programs;
3. avoidance of cost shifting;
4. continuity of health insurance for all workers regardless of health status;
5. Medicare tax increase by employers which would continue as a tax-exempt benefit for employees;
6. employers relieved of the administrative costs and headaches of sponsoring health plans;
7. increased cost predictability and efficiency in system;
8. process opened to public scrutiny (Miller, 33-35).

The Independent Side is further discussed under the Consumer Direct Purchase section below.

Pavka and Shermis' financing is embedded in a theoretical framework in which, as wellness and prevention become dominant, conventional medicine—and therefore traditional expenses—will radically decrease (Pavka and Shermis 22-27). Their USHeS model is financed by a hybrid of single-payer and free market systems. They envision a single-payer system that provides basic wellness, sickness, and catastrophic coverage for all citizens. These funds will come from Medicare, Medicaid, and also a federal Sickness Treatment Surcharge that taxes activities and substances proven detrimental to health (Pavka and Shermis, 24-25). Secondly, the USHeS permits individuals to supplement the federal health insurance coverage through Wellness Savings Accounts, Medical

Savings Accounts, secondary insurance, and out-of-pocket payments, as is further discussed in the Consumer Direct Purchase section below.

### ***State and Federal Government Financing***

Three of the proposals advocate expanded government health insurance, but these give the states, as well as the federal government, significant funding authority and responsibility.

LLUSPH makes the federal government primarily responsible for funding their public utility-based health care model, and delineates the following financing sources:

- \$624 billion—current federal government health care expenditures
- \$420 billion—increased co-pays, deductibles and out-of-pocket fees
- \$200 billion—tobacco and alcohol taxes
- \$50 billion—new taxes on purchases of unhealthy food and dangerous activities
- \$170 billion—new revenue on taxes generated by more profitable U.S. corporations, \$442 billion now spent on health care @ 39% tax rate
- Total = \$1.464 trillion dollars

LLUSPH assigns a federal Health Commissioner, state and county health services directors, and local boards with various responsibilities for financial management, establishment of benefits, quality assurance, and other functions associated with managing this system (LLUSPH, 1). The federal government will provide individuals and families with vouchers to purchase basic health care coverage from providers, ranging from \$2,000 to \$18,000, depending on health risks (LLUSPH, 6-8). Special health plans will be available for the 20% needing catastrophic care (LLUSPH, 8). Funding for management will be allocated from the federal budget to the states and local regions. There will not be a minimum charge and coverage of the basic benefit cannot be sold for more than an age-adjusted price, i.e., ceiling price. This basic benefit will be covered under private health plans or a government plan. All licensed providers have the option to participate in the government insurance product and may arrange contractual arrangements with designated health plans (LLUSPH, 5).

The Rollins School of Public Health State Resident Health Insurance (SRHI) system is financed by the federal government from incomes taxes, payroll taxes, and general revenue (Rollins, 9). These funds will be transferred from the federal government to the states, with contributions determined “not only by per capita income, but also by cost of living and other relevant measures of poverty and need” (Rollins, 9). The states would supplement these federal health care funds with additional funding for catastrophic care and services for the medically under-served (Rollins, 28-29). The states manage the delivery of the SRHI program through a highly regulated and radically altered private insurance sector, further described in the insurers and employers section below. “Under SRHI, all the plans contracted with a state will be community rated and independent of an individual’s health status. The plans should therefore have a more consistent mix of high-and-low-risk people” (Rollins, 30). Regressive taxation policies would be eliminated in favor of a non-regressive, but higher, income tax (Rollins, 27-31).

Tracy and Clark’s community public health model would coordinate federal, state, and local laws to guarantee all citizens’ rights to basic health care services. Their model would require state and local governments to establish, fund, and operate health care delivery systems. The funding levels and

allocation of medical resources needed to deliver essential services in each community will be determined by state and local governments, similar to the way communities allocate funds for, and oversee delivery of, government-mandated free elementary and high school education, and subsidized higher education (Tracy and Clark, 18). The community health systems will be financed primarily through state, and to a lesser extent local and federal taxes, including both employee and employer contributions. Employer-sponsored health plans would be eliminated. The plan is funded by “all state citizens (including corporations) and the currently fragmented approach which divides citizens into special need groups by age, economic status and medical condition would disappear” (Tracy and Clark, 18). Tracy and Clark also propose that a private health care services sector would operate beyond the core public health care services, as discussed in Consumer Direct Purchasing section below.

Anthony’s proposal differs from the others with respect to financing. Its centerpiece is a modification of the ERISA laws (Employee Retirement Income Security Act—that act enabled employers to self-insure their health care insurance and exempts them from state insurance regulations) that govern and promote employer-sponsored health plans to cover employees not currently covered by employer sponsored ERISA plans and unemployed persons (Anthony, 11-16). Specifically, he amends the VEBA (Voluntary Employee Beneficiary Association) provisions of ERISA law to enable all citizens to join Community or State Health Care Cooperatives. These Cooperatives have health care purchasing power equivalent to that enjoyed by large employers (Anthony, 12). The federal and state government pay the Cooperative enrollment fees for Medicaid and Medicare participants “based on head-of-household, head-of-household plus one, head-of-household plus family” and the states pay the enrollment fees of the unemployed (Anthony, 12). He provides a detailed breakdown of benefit recipients, funding sources, expected benefits, and how funding is secured (Anthony, 13-16). All people in a community or state will be participants in the Cooperative and defined contributions of equal amount will be made on behalf of each participant. Every participant has a financial stake in all health care decisions and choices that are made. Individuals will be able to invest in Health Savings Accounts, as described in the next section.

### ***Consumer Direct Purchase of Health Care Services***

Our current system is dominated by third-party payers. Most individuals directly pay only a fraction of their total health care costs. Most proposals advocate providing individuals with more authority and responsibility for purchase of their health care services, in order to make the process more rational, reduce health care costs, and increase the individual’s control over his or her own health care.

Two proposals emphasize the virtues of Health Savings Accounts (HSA). Pavka and Shermis’ USHeS model would enable individuals to supplement their federal basic and catastrophic health coverage with Wellness Savings Accounts, Medical Savings Accounts, secondary insurance, and out-of-pocket payments. Anthony identifies the long-term financial benefits of consumers investing in an HAS. Rolling the amount over each year with accumulated interest will create a substantial savings account. The federal government should be interested in this idea, because in 20 years 50% of the population will be over 50 years of age (Anthony 15-16).

Yuse proposes that individuals retain direct responsibility for funding 20% of their health care costs, akin to the current 80-20 coverage split under Medicare, and that they do so through private

insurance or out-of-pocket (Yuse, 7). LLUSPH proposes that the federal government provide individuals and families with vouchers to purchase basic health care coverage from providers, ranging from \$2,000 to \$18,000, depending on health risks (LLUSPH, 6-8).

Miller proposes making the purchasing of health care services more consistent by establishing offsetting, interacting governmental and free-market systems. Providers notify consumers whether they are offering Standard Side or Independent Side services. The consumer decides whether to pay the differential between Standard Side and Independent Side rates. Miller argues that the government and the taxpaying public will be motivated to keep Standard Side rates sufficiently high to attract and retain medical providers, and medical providers will be motivated to keep their rates reasonably low to attract Independent Side patients (Miller, 32-36).

Tracy and Clark propose a different model of “interlocking public sector and private sector health care services, each with distinct funding mechanisms, and modeled on the American public/private education system” (Tracy and Clark, 18). As occurs in the education system, individuals will be free to go outside the public health care system and seek services from private health care providers and health care facilities. However, they will be required to pay for these services out-of-pocket, and required as taxpayers to contribute to the public health care system. LLUSPH proposes a similar concept (LLUSPH, 5).

### ***Insurers, Employers, and Other Payers***

The American health care system differs from the systems of most other developed nations in its reliance on private health insurance—specifically, employer-sponsored health plans. Many of the proposals decrease employer and private insurer funding of health care, and several recommend the elimination of such funding.

Seven proposals phase out employer-sponsored health plans in varying degrees. Pavka and Shermis would allow employer-sponsored plans, but eliminate employer tax deductions for health benefits (Pavka and Shermis, 26). Rollins would retain employer responsibilities to offer coverage to their employees, but relocate the authority for benefit plan design, contracting with health care providers, and furnishing health care benefits to governmental agencies (Rollins, 29). Tracy, LLUSPH, Yuse, and Miller would simply eliminate employer-sponsored health plans from the funding of health care service, while requiring employers to contribute to governmental health insurance program funding through payment of corporate taxes.

Benn, Anthony, and Rollins retain employer-sponsored health plans and other private health, but envision a significantly regulated health insurance industry. “Employers would remain responsible for payment of health care insurance premiums for the non-poor employed workforce, either through employer-sponsored health plans, or by paying into the federal health insurance program. The public system could be offered for employers to purchase in direct competition to existing private insurance” (Benn, 21, 24). “Insurance premiums will be community-rated across the state and set by the insurance companies, and plans must incorporate sliding-scale co-payments based on income” (Rollins, 15).

Yuse, Richardson, Pavka and Shermis, and Benn envision the private insurance sector becoming a supplemental insurance resource for individuals, rather than the primary source for basic and catastrophic coverage.

### *Controlling Costs and Managing Finances*

All proposal authors identify escalating and excessive costs as a major problem with the current health care system and set forth a variety of cost control measures.

While almost all proposal authors advocate the value of health promotion and prevention programs for improving health care outcomes, as discussed in Category 4, Benn, LLUSPH, Shermis and Pavka, and Richardson emphasize the cost-savings potential of such prevention programs. “Through the use of community health promotion and disease prevention programs, the cost of provider services should be reduced allowing the existing public expenditure to cover 50% of the population” (Benn, 21). Richardson lists the fifteen costliest medical conditions, and argues that many of these can be prevented or significantly reduced (Richardson, 16-17). Pavka and Sherman and LLUSPH advocate taxation of substances proved detrimental to health, like alcohol, tobacco, certain foods such as sugar, and other illness causing activities. This tax would simultaneously increase health care system revenues and motivate health-promoting behavior (Pavka and Shermis, 24-25; LLUSPH, 5-6).

A number of proposal authors target reduction of administrative inefficiency and waste in the health care system, with several proposing improved use of information technology (Richardson, 8, 10; Tracy and Clark, 4). Others increase standardization of billing forms and procedures (Yuse, 6; Benn 20-21). Many argue that the 25% level of administrative costs in our health care system will be significantly reduced by replacing or reducing the privatized health insurance system with a government health insurance system. Tracy and Clark propose completely eliminating profit from their (publicly-funded and governed) community health system. “The public utility model will reduce or eliminate expenditures on extraneous functions, including sales, marketing, benefit plan design, many insurance and claims management functions, and medical billing transactions” (Tracy and Clark, 11).

Some proposal authors advocate increased regulation of the health care delivery system, including hospitals (Yuse, 7, 14), physicians (Richardson, 20-21), geriatric nursing care (Richardson, 9), and the pharmaceutical industry (Yuse, 13-14; Richardson, 24; Benn, 11). Others highlight various changes in medical provider reimbursement as required to control costs:

1. specialized health plans for at-risk patients (LLUSPH, 7);
2. capitation provider contracts (Benn, 21);
3. reliance on salaried community public health professionals (Tracy and Clark, 3; Richardson, 14).

Miller, Pavka and Shermis, Anthony, and Rollins believe that their proposed systems will encourage more rational and, therefore, cost-effective health care purchasing behavior by individual consumers. Benn is alone in focusing on the extent of medical fraud, and in proposing that allocating dollars to combat fraud would recoup the saving many times over (Benn, 14).

LLUSPH and Rollins emphasize the financial benefits to employers inherent in discontinuing their sponsorship of health plans for their employees. LLUSPH estimates that employer profits would collectively increase by \$442 billion, with \$170 billion going into the federal treasury as additional tax revenue (LLUSPH, 6).

### *Summary*

The proposals include a wide variety of financing mechanisms. Most anticipate some increase in governmental funding, yet their models range from federal single-payer, to state-federal partnerships, community health boards to an expanded ERISA. Most retain private health insurance, although private insurance is reduced to the status of re-insurance and/or supplemental insurance. Most seek to increase individual consumer control over purchasing health care services. Most anticipate cost savings by a heavy emphasis on wellness and prevention, often through vouchers or wellness grants. Some believe that a tax on dangerous and unhealthy products will shift money to the health care sector. Some seek to remove the hidden subsidies and profit-taking that occurs in our current system.

## **Category 7. Information Technology**

### ***Introduction***

Seven of the authors address the applications of information technology (IT) in their health systems. The virtues of IT are described in five areas below. Because of the importance of confidentiality and privacy issues, these are discussed first.

### ***Privacy and Confidentiality Issues***

Rollins and Tracy and Clark note the importance of privacy and confidentiality protections in an increasingly electronic health care environment. In the section titled, “Hospital Information Computerization,” Rollins writes about improved control over who can and cannot see certain kinds of information by utilizing digital signature cards. “Proper training will be provided to all individuals who will be utilizing the system [to include] compliance, ethics, patient confidentiality, and security” (Rollins, 13-14). Tracy and Clark also warn that “use of such information technology requires parallel development of strong safeguards to protect the security and confidentiality of personal health information” (Tracy and Clark, 15-16).

### ***Overviews***

According to Rollins, information computerization under their State Resident-Based Health Insurance (SRHI) will:

1. improve coordination of patient care;
2. decrease duplication of services;
3. decrease time needed to transfer information;
4. comply with confidentiality requirements;
5. simplify documentation processes;
6. reduce administrative costs;
7. reduce medical errors (Rollins, 13-14).

Digital Imaging and Communications in Medicine (DICOM), as the model for computerization, will set standards for transmission of medical information and guard against tampering with medical records. The extension of DICOM would help federal, state, county agencies, and hospitals share medical data. IT will be used to evaluate the health care system (Rollins, 13-14).

“IT is important primarily for communication, information, automation” (Richardson, 8-14). She extols the potential value of IT for almost every aspect of health care: billing, clinical research, medical records documentation, patient-provider communication, provider-provider communication, health education, and telemedicine. Richardson also provides nine IT related websites and references.

### ***Delivering Health Information to Patients and Providers***

IT can be utilized to empower and educate patients in order to teach them how to prevent illness and mitigate chronic illness. In addition, IT can be a tool to educate providers.

Pavka and Shermis posit that IT tools “will transfer information throughout their new system and provide individuals with a way to search for health information” and “. . . consciously create a better balance between advanced technology and personal attention as these relate to a new definition of ‘caring’ in the new health system”(Pavka and Shermis, 29). However, these authors note that more technology does not always bring better health (Pavka and Shermis, 12).

### ***Improve Quality of Care and Services***

IT can improve quality of care and the services rendered in a variety of ways. Health care IT will become more valuable in the new system. Tracy and Clark argue that while current e-health technology focuses on billing transactions, their new system will apply IT to service coordination, clinical care, and research (Tracy and Clark, 4). The authors also write that “the medical care system should employ sophisticated information technology that appropriately collects, uses, stores, and disseminates personal medical information to all health care professionals participating in that individual’s care” (Tracy and Clark, 15). “The federal government can adopt uniform standards for electronic connectivity, research protocols, and treatment guidelines” (Tracy and Clark, 16).

Richardson suggests that “vast amounts of information from medical records to medical images will be delivered in life-saving seconds, even in real time”(Richardson, 13). “Telemedicine will prove to be an invaluable tool in patient care . . .” (Richardson, 12). In addition, Richardson writes that “the physician-patient relationship can be enhanced and more productive with IT . . . [and] the physician-physician relationship is upgraded” (Richardson, 9).

### ***Improve Administration and Reduce Paperwork***

LLUSPH states that, “Technological advances will be utilized to streamline billing. As individuals access services their information will be transmitted to the health insurance provider or government plan. This will facilitate timely payment to health care providers for services rendered and therefore eliminate the need for multiple levels of bureaucracy” (LLUSPH, 11).

Richardson argues that “IT communication has increased the efficiency, transmission, and handling of all other health documents as well as the medical record. This includes the technical aspects like claims for services, billing, payment, etc.” (Richardson, 10). Benn writes about the use of computer-based, online systems in administering vocational village programs (Benn, 19-20).

### ***Summary***

Information Technology has been used in billing and accounting departments, and technological developments are occurring so rapidly that its use in many other components of the health care system is inevitable. IT is a double-edged sword. This technology has tremendous capabilities. No matter how it is applied, IT must be accompanied by a high concern for confidentiality and privacy.

## Category 8. Legislative Changes

### *Introduction*

All the authors incorporated significant federal legislation in their planned changes. Some proposals require repealing existing legislation, while other proposals only require amendments to existing laws. In some, the essential legislative and structural foundations are already in place, and relatively few legislative changes are necessary. Many establish commissions, bureaus, and departments, at federal, state, county, and local levels. These require legislative enactment followed by administrative decrees.

[It should be noted here that the proposals were submitted on July 1, 2003 and some legislative changes the contestants addressed may have been changed since that time, e.g., Health Savings Accounts and current Medicare reform.]

### *Specifics of Legislative Changes*

What follows is a closer look at the specific legislative change recommended by various proposals.

Benn proposes federal government establishment, funding, and oversight of a five-year pilot program for low-income families (Benn, 17-19). His proposal to expand the federal Medicare and Medicaid programs to the working poor requires federal legislation and ongoing regulation (Benn, 20). Benn also lists a package of other reform legislation that includes “drug price controls, demand management by patients rather than supply management by doctors, capitation rather than fee-for-service, self-care patient management, reduction of administration and for-profit costs, and malpractice litigation caps” (Benn, 20). The legislative and administrative locus of these reforms is not described.

Richardson proposes a variety of reform measures to be adopted at the Federal level. She quotes Paul Ellwood, father of the HMO concept, who recently proposed several areas of federal reform legislation:

1. Pass a bipartisan congressional resolution that calls for deployment of medical records and evidence-based clinical guidelines to all consumers;
2. Mandate the Drugs for Seniors Act written to anticipate changes outlined in [Ellwood’s] Pathways to Healthy Outcomes;
3. Establish an Institute for Medical Practice and Consumer Technology [IMPACT];
4. Institute within a few years Medicare requirements for doctors and patients to utilize electronic medical records and follow evidence-based guidelines (Richardson, 4-5).

Yuse’s Medicare For All program requires enabling legislation by the U.S. Congress. It will retain both the Social Security structure and the Medicare process, but both of these programs will need to be greatly expanded (Yuse, 16). A tax credit is given as an incentive to members who are able to pay or who already have health insurance, requiring a change to the federal IRS tax code (Yuse, 12).

Pavka and Shermis require federal and state legislation mandating universal access to basic and catastrophic care. Their implementation timeline begins in 2004. Their Sickness Treatment

Surcharge is passed in 2007. Federal enacting legislation is passed in 2008. The subsequent phase-out of Medicare and Medicaid and passage of related insurance reform legislation occurs in 2012 (Pavka and Shermis, 40-41). Five major changes in the USHeS include:

1. Creating a hybrid of single payer and free market;
2. Legislating basic coverage and catastrophic coverage for every American;
3. Phasing out Medicare and Medicaid;
4. Making all subsidies explicit;
5. Revamping health insurance (Pavka and Shermis, 23).

LLUSPH initiates their transition plan with establishment of a national health commissioner, implying that federal enacting legislation would be required (LLUSPH, 13). Full implementation of their three tier—federal, state, and county—governmental health boards would require extensive and carefully coordinated legislation on the federal, state and county levels (LLUSPH 10,13-15). LLUSPH recommends federal regulation of the insurance industry and establishment of governmental case management and ombudsman capabilities (LLUSPH, 14, 16).

Tracy and Clark’s proposal prescribes enactment of federal legislation that guarantees all citizens the right to basic health care services delivered through local community health systems in each state. This also requires enactment of state legislation to implement federal guarantees for citizens’ right to health care services and access to free or low cost public health care systems (Tracy and Clark, 21). These legislative enactments encompass the definition of funding, scope of services, distribution and organizational principles of new system. Federal Medicare and Medicaid funds will be transferred to the respective states (Tracy and Clark, 21). States will be responsible for legislation that will:

1. implement federal guarantees;
2. establish local/regional health boards;
3. establish taxation and funding mechanism;
4. modify state insurance systems;
5. establish no-fault systems modeled after state workers compensation systems for victims of medical error;
6. specify processes for transition planning (Tracy and Clark, 21).

They would also modify ERISA to prohibits employer-sponsorship of group health plans (Tracy and Clark, 21).

Anthony asserts that the ERISA laws, rules, and regulations for a VEBA Trust already exist. These VEBA portions of ERISA are essential to establishment of his Community and State Health Care Cooperatives. But Congress needs to pass several pieces of enabling legislation, which is essentially amendments to existing legislation, so it can: 1) allow anyone living in the same geographical area to participate in the VEBA Trust; 2) restrict the provision of wellness services to 501(C)(3) not-for-profit health care organizations; and 3) allow Health care Savings Accounts to be owned by anyone and to include a rollover and portability feature (Anthony, 32).

In what Miller calls “Theoretical Foundations for Balanced Choice”, he collapses 18 poorly articulated, and often competing systems into one more efficient program called Balanced Choice (Miller, 22-32). Employers will save on their combined tax and insurance expenses for health, and workers’ compensation, automobile, and liability insurance (Miller, 42). Because of the efficient

nature of his system, each employee's prepayments for health care, consisting of tax plus insurance, would decrease. Balanced Choice reorganizes the collection of money for health care, and combines it with gap payments that are made out of pocket (Miller, 32-35). Miller also requires federal legislation to enact the federally-mandated medical fees contained in his Standard Side proposal (Miller, 4).

Rollins discusses a number of legislative and regulatory changes. The portions of ERISA that enable employers to self-insure would be repealed and self-insurance is prohibited (Rollins, 24-27). Federal and state governments would require state residents to self-insure. Medicare and Medicaid populations and military personnel are slowly integrated into SRHI (Rollins, 24-27). An extensive educational program targeting Medicare patients and those individuals who between the ages of 19 to 34 is carried out (Rollins, 24-27). Hospitals and the general practice of medicine would not change significantly (Rollins, 24-27).

### *Summary*

The proposal authors are aware that their proposed changes will not magically appear. These changes require legislative enactments, varying from small to large in scale, and from incremental to rapid. The steps required to move a proposal from its present status of concepts, to projected strategies, and then to law are described in Category 11.

## Category 9. Political Changes

### *Introduction*

Most authors recognize that no proposal to improve the current health care system will reach fruition without careful attention to questions regarding the political status quo, entrenched economic interests, and ingrained attitudes. The authors have considered these matters and provided feasible strategies for change.

### *Strategies, Plans, and Tactics*

In the section titled “Who Will Provide the Leadership Needed to Enact Medicare For All?” Yuse states “Medicare For All cannot succeed without strong independent leaders to give voice to society’s needs and to counter big money pressure to maintain the current inequitable and inefficient system” (Yuse, 10). There is considerable need for leadership from the President, Congressional leaders, political parties, labor unions, and community groups.

Yuse argues that those who wish to implement his plan must consider America’s unique tripartite, checks-and-balances form of government. Americans must consider the media rejection of Clinton’s 1993 health care changes. We must find ways to develop counter strategies to the fear tactics created by stakeholders who are not amenable to change. (Yuse, 9-10). To do this, political strategies must avoid toxic terms such as “socialized medicine,” “single payer,” “revolutionary,” or “the government in your hospital room” and substitute terms such as “cooperation,” “individual choice,” and “public-private partnership” (Yuse, 10). Yuse posits that “a well-organized, sophisticated campaign can succeed because the health care crisis has the public’s attention this time” (Yuse, 10).

Political strategists must learn how to deal with the certain opposition of the insurance industry. Yuse also notes that private companies in the past have been powerful agents blocking changes in the health care industry (Yuse, 9). Efforts must be made to seek the cooperation of labor unions, which may oppose changes because they have negotiated health insurance plans with their members (Yuse, 11). The same point is made about those protected by Taft-Hartley Trust and ERISA of 1974. These objections “can be met legally and by means of logic” (Yuse, 11-12). “Market forces must be tempered with a responsibility for the common good” (Yuse, 10).

Anthony’s plan puts forth for the development of a not-for-profit Health Care Network, Inc., a network of people committed to health. While not required for the creation and implementation of the Community and State Health Care Cooperatives model, such a consumer network could benefit patients, relatives, providers, purchasers, payers, politicians, and regulators (Anthony, 25). All the stakeholders of health care are permitted and encouraged to participate; the network represents no particular stakeholder group, nor advocates for any single group of stakeholders (Anthony, 26). These stakeholders would access health care information as well as influence plan design, product development, service improvement, health promotion, and public policy.

Benn argues that “in general, large-scale organizations change in response to pressures in their environment” (Benn, 25). He notes that large numbers of people, companies, and organizations are presently dependent on the 14% of GDP that is spent annually on health care. Given the complexity

of health care reform issues, he is not optimistic about mounting a grassroots challenge. Indeed, due to rising costs and inefficiency driving doctors and hospitals out of business, he envisions the possibility of an outright collapse of high-technology medicine (Benn, 25).

Tracy and Clark believe significant coordinated federal, state, and local legislation would be required to implement their public utility health system model (Tracy and Clark, 22). The main beneficiaries of the new model, patients-consumers, are the least organized. Many powerful special interests would be threatened, especially those which profit most from the current system. Too much of the recent reform legislation adds minor system fixes which do not address fundamental problems of accountability, financing, or delivery system organization (Tracy and Clark, 22). The political impetus for the plan should come from a variety of unhappy stakeholders whom they describe in detail (Tracy and Clark, 22-23).

Pavka and Shermis insist that current political thinking must come into phase with the necessity of dealing with the changes now. "Politicians, organizations, and individuals will require courage to make the difficult choices resulting in the 'pain of change.' Reduced power, prestige, money, health insurance benefits, and constituencies will ensue" (Pavka and Shermis, 33).

Loma Linda University School of Public Health (LLUSPH) acknowledges that certain stakeholder groups, including insurance carriers and attorneys, would be threatened by their new system. Some stakeholders, including consumers and governments, would immediately benefit. Other groups like businesses would benefit in the long term (LLUSPH, 9).

Miller proposes that the entire health care system "needs to be implemented as a complete health care system change or free market dynamics would not be restored and the savings resulting from eliminating insurance would not be achieved" (Miller, 49).

### *Summary*

The attitudes around needed political change range from "there's not much we can do to create basic change" to "when things get bad enough, which they will very soon, the people will force politicians to make changes." In between these attitudes are a variety of strategies, proposals, plans, and analyses. We need to expect objections from insurance companies, unions, and other private sector organizations. But, there may be ways to reframe the issues and engage them in a problem-solving dialogue.

Some proposal authors suggest that once a critical mass of stakeholders engendered by their proposal materializes, they will function as change agents. Others maintain that there must be a gradual but purposeful design where particular changes are phased in at discrete intervals. Some authors argue for the necessity of widespread public debate to lead to clarified goals and desired models. One author discusses retraining and re-employment plans for those who will lose their jobs as a result of health system change.

In sum, these authors argue for sweeping health care system changes. They recognize the many obstacles standing in the way. They believe any health system change must be firmly founded on shared core values, and then we can proceed with the brass tacks of change.

## **Category 10. Medical Malpractice Changes**

### ***Introduction***

Some proposal authors address the problems in the medical malpractice system, including escalating costs, the difficulties certain specialties face in obtaining malpractice coverage, unfairness of compensation awards, and the misappropriation of malpractice system dollars to insurance companies and lawyers instead of patients. Anthony's statement is typical of a number of these proposals: "The high cost of legal services, excessive awards, and cost of liability insurance is a major factor in driving up the cost of health care and driving providers, payers, and purchasers out of business" (Anthony, 22).

### ***Malpractice Reforms***

Pavka and Shermis do not propose fundamental changes to the U.S. medical malpractice system. However, they posit that medical malpractice claims will reduce as relationships between care providers and patients become better aligned in a wellness-oriented system (Pavka and Shermis, 30).

LLUSPH authors advocate for the creation of specialized medical courts to adjudicate medical malpractice claims, so medical negligence can be determined by medical professionals rather than by the legal system. They also recommend development of special medical tribunals staffed with expert judges who will screen claims, determine liability, set economic damages, and apportion settlements based on an established standard schedule (LLUSPH, 14).

Tracy and Clark propose even more fundamental changes. They argue that both fault and negligence should be eliminated from determinations of malpractice liability, and that a no-fault medical malpractice system be established. "Individuals who are the victim of injury caused by medical error would be compensated for medical expenses, wage loss, disability, and other direct damages in a fair, efficient and timely manner, under a system that does not require proof of provider negligence or other fault. The current fault based malpractice system does not benefit the large majority of victims of medical error, and instead wastes billions of health care dollars on unproductive legal, insurance and defensive medicine costs" (Tracy and Clark, 16). In addition they note that our country has successfully employed no-fault principles in compensation of occupational injuries in our workers compensation system for many years (Tracy and Clark, 4).

### ***Damage Awards***

Some proposal authors focus on damage awards, which in our current malpractice system are often set unfairly high or low. Benn believes insurance companies are largely responsible for the current crisis, and recommends that states pass legislation capping medical malpractice liability claims at \$250,000 (Benn, 13, 23). LLUSPH also supports damage caps to ensure "all people involved in the process will receive fair and equitable reimbursements without threatening future sustainability of the health care system" (LLUSPH, 14).

Anthony discusses reform of damage awards in some detail, proposing that only those who are truly injured, or harmed by another be permitted to sue for economic damages. Economic damages would

include all past, present, and future diagnostics, treatments, and rehabilitation expenses, along with all ancillary expenses related to the injury, including compensation for lost income. Funds for such anticipated future expenses would be deposited in the individual's health savings account, accrue tax-free interest, and be earmarked solely for payment of such expenses (Anthony, 23). No separate compensatory damage payments for "pain and suffering" would be made, because future needs for pain treatment, pain management, and emotional distress would be anticipated, projected, and included in the financial settlement (Anthony, 23).

### ***Summary***

Most authors acknowledge many problems with medical malpractice in the current health system. One proposes complete replacement of the fault-based tort malpractice system with a no-fault system. Several advocate establishment of specialized courts so health care professionals rather than legal professionals can determine liability. The recommendations for unfair jury awards vary considerably, including caps on awards, standardized award schedules, and limitation of awards to economic damages, thereby eliminating damages for pain and suffering or punitive damages.

## Category 11. Transition and Implementation Plans

### *Introduction*

The current health care system must continue to provide services to people requiring them, even while it is implementing significant changes. This category looks at the implementation plan in eight proposals. Each plan is so unique that no groupings could be made. Please note that this Category overlaps considerably with Category Eight (legislative changes), because extensive legislation is required to enact the majority of the author's proposed reforms to the healthcare system.

Anthony proposes the following five-year implementation plan:

- 2004 – Legislation to enable Community or State Health Care Cooperatives is recommended to Congress and passed.
- 2005 – One to five alpha sites nationwide are designated as Community Health Care Cooperatives.
- 2006 – Community Health care Cooperatives expand to State Health Care Cooperatives
- 2007 – State Health Care Cooperatives expand to all 50 states.
- 2008 – State Health Care Cooperatives expand to include Medicaid-eligible participants.
- 2009 – State Health Care Cooperatives expand to include Medicare-eligible people. (Anthony, 27).

Benn also outlines a five-year implementation plan for both his vocational village and “expanded Medicare” programs (Benn, 19-21).

LLUSPH presents a detailed transition plan (LLUSPH 1, 5, 9,13-15). “The Health Commissioner will be appointed immediately and oversee the appointments of Health Care Directors for each state and county. With government support and backing, the proposed system can be successfully implemented in two years. Currently the federal government spends approximately 6% of the health care budget on program administration. These funds can be used to cover the cost of implementing and managing the proposed changes” (LLUSPH 13).

LLUSPH also proposes implementing pilot programs in the state with the largest number of uninsured over a six-month period when problems can be identified and corrected. After the pilot testing has been completed and corrections made, the new system will be phased in to remaining states over a two-year period. In this time period, individuals will have an opportunity to sign up with an insurance plan. After this two-year grace period, all individuals not already enrolled in a given plan, will automatically be enrolled in the government plan. The delivery of care will be simplified, enabling the individual easy access to current providers. The way that care is delivered will be transformed by the revised financing and regulations imposed by the new Health Commissioner, Directors of Health Services, and local boards (LLUSPH, 1, 5).

Miller proposes that “Balanced Choice, with the exception of the Balanced Choice Pharmacy Benefit System, needs to be implemented as a complete health care system change. . . .Transitional

[sic] can be accomplished by instituting the Balanced Choice Pharmacy Benefit System in Medicare in order to familiarize consumers and providers with the last dollar gap payments. . . . Within two years, a transition date would be established, and on this date the new Medicare tax would begin and insurance would be phased out. Insurance reserves would be used to pay outstanding debts. The insurance industry employees or health care system administrators, who lost positions as a result of the system transition, would be offered retraining. . . . All licensed providers would be eligible for participation in Balanced Choice. The two-year planning period would allow ample time to work out the details and educate consumers and providers. For the most part, the existing health care infrastructure would fit smoothly into Balanced Choice” (Miller, 49).

Pavka and Shermis suggest a gradual transition to prepare major stakeholders for their proposed changes to the U.S. health care system. They estimate an initial 5-10 years for preparation time, with full implementation taking 20-30 years (Pavka and Shermis, 36-41). Their implementation plan includes three major parts. First, providing answers to a series of questions developed by Leland Kaiser, a health care futurist; Second, creating a timeline that stretches from 2005-2030 and includes a task force timeline, political timeline, financial timeline, educational timeline, and pilot community timeline; Third, illustrating the evolution of their new system by recounting the life of a woman named Anne who is born in 2010 and lives through 100 years in their new system (Pavka and Shermis, 30-33).

Rollins’ implementation includes the following topics:

1. regulatory changes;
2. informational [educational] campaign;
3. absorption of Medicare, Medicaid, and military personnel populations;
4. graduate medical education;
5. hospital information computerization;
6. pharmaceuticals (Rollins, 24-27).

Rollins writes that “an agency under the federal government but independent of the Food and Drug Administration would be established to evaluate the effectiveness and cost-effectiveness of pharmaceuticals on the U.S. market” (Rollins, 26). The section “Impact on Stakeholders” contains scattered and fragmentary implications for the transition phase (Rollins, 34-36).

Tracy and Clark argue that we must “clearly articulate the health care system that we want” (Tracy and Clark 22). “The federal government would need to employ its considerable financial and regulatory powers to direct Medicare and Medicaid dollars to the states which is conditional on state establishment of regional and public medical care systems and would require a multi-year transition plan” (Tracy and Clark, 23). New federal laws will be especially critical in the transition phase in order to:

1. codify citizen rights to basic medical care and equal opportunity to access care;
2. require each state’s commitment to establish local public health care systems;
3. eliminate employer sponsorship of health plans;
4. maintain federal support for medical research, education and quality assurance;
5. transition Medicare and the federal portion of Medicaid into state systems.

State and local laws will be primary after implementation (Tracy and Clark, 3).

According to Yuse, all US residents will be members of his expanded Medicare For All system. National health insurance will follow the model and experience of the current [Medicare] program (Yuse, 7). Medicare For All will become a part of the federal Department of Health and Human Services and will rely on its experts and experience. The Social Security Administration will work with the Department of Health and Human Services to enroll all residents and collect contributions to the program. Enabling legislation will define responsibilities for these federal agencies (Yuse, 16).

### *Summary*

All the proposal authors are astute enough to recognize that planning changes in something as large, complex, and costly as the American health care system requires anticipating problems and identifying potential solutions. Knowing how the system needs to be changed was one thing; devising how to get there was another obstacle entirely. To this end, most have devised plans that range from slight modification of existing programs to sweeping change at all governmental levels. They have also formulated implementation timelines that range from two years to 30 years.

## Category 12. Strong and Unique Points

### *Introduction*

Each of the proposals to changes the U.S health care system include one or more strong and unique points. These are encapsulated below.

Benn identifies the core problem of the health care system as a failure to have effected disease prevention and health promotion, building a cogent case for his patient self-care model. He argues that socio-economic factors are *the* overlooked issues that underlie many of our serious public health problems. Benn offers a detailed plan to address the socio-economic needs of low-income families by providing housing, food, day care facilities, and training to parents that will allow them to become licensed practical nurses or nursing assistants.

Richardson conducts a detailed exploration of how the power of information technology can be effectively utilized in patient care, illness prevention, health education, clinical research, and administration. She cites recommendations from various Institute of Medicine studies of health care quality and the health professions, and makes innovative recommendations in these areas. She advocates expansion of the number and responsibilities of public health clinics. In addition, Richardson includes a listing the fifteen costliest treatments and number of people with diagnosis at [www.healthaffairs.org/1100\\_table\\_contents.php](http://www.healthaffairs.org/1100_table_contents.php).

Tracy and Clark's "New Paradigm for the Public's Health" places consumers at the center of the system, with direct control over the governance and financing of their health care. Their public utility based health care system is modeled after the American educational system, in which elected regional health boards operate community health care systems that provide essential health care services to all citizens. In their model all citizens financially support their community health care systems and for-profit health care providers and insurers move to the system's periphery. Tracy and Clark also provide a unique discussion of the history of the American health system, from its 19th century origins to its present profit-centered, employer-dominated status. They describe five design principles that have proven successful in other service businesses and government initiatives. In addition, they argue that recent threats to American security and the current crisis in American health may foster a new appreciation for public service and public employees, and attract health practitioners to work in community health centers.

LLUSPH discusses governance and management of their three tier governmental health care system. They provide a detailed analysis of the financial basis of their new system. LLUSPH is unique in describing the financial and administrative advantages to employers in discontinuing their sponsorship of employee health plans. They propose an innovative challenge to medical provider groups: capitation contracts to care for high health risk populations. In addition, LLUSPH recommends combining ombudsman and case management approaches to patient advocacy issues (Loma Linda, p.14).

In Miller's own words, his Balanced Choice Health Care System is an attempt "to restore normal economic principles to health care." Miller carefully designs a foundation of government mandated universal coverage with mandated basic fees. He then leaves providers and consumers free to negotiate alternative rates. Balanced Choice would pay the first dollar instead of the last dollar and

create a price list suitable for comparison shopping. Miller's asserts that the current system and other proposals create market forces that raise prices, lower quality, create accessibility problems and result in inefficiency. He advocates for a system that he believes will restore free-market economic forces that lower costs, raise quality and improve accessibility.

Pavka and Shermis apply social system design principles to the American health care system in a systematic manner. Their thoroughness of core assumptions, and development of their model based on those assumptions, provide a clear framework for their model. They outline the Eight Steps of a Social System Design Process (Pavka and Shermis, 10). In addition, Pavka and Shermis provide a detailed description of the biomedical model and holistic model of health paradigms, citing the work of Mark Woodhouse. Their new United States Health System integrates the biomedical and complementary-alternative medicine approaches. Their proposal includes a unique picture of their new system by presenting the 100-year life story of a woman named Anne, born in 2010, through her encounters with the by-then-established USHeS.

Anthony's Patient Driven Health Care System is unique in the group in basing health care reform on expansion of the federal ERISA legislation, essentially an "ERISA for all" solution. Anthony applies the buying power of ERISA-sponsored health plans to purchase cooperatives that will be available to all citizens whether they're employed or not. He utilizes existing provisions of ERISA, the Voluntary Employee Beneficiary Association, to create a state regulated system of purchasing cooperatives and participating health plans. Anthony suggests that the health care cooperatives present the most feasible and administratively practical approach to universal coverage. In addition, Anthony proposes creation of a health care consumer advocacy and oversight body utilizing existing local, state, and national organizations and associations. This organization, called the Health Care Network, Inc., would provide information about health, wellness, and medical treatment to consumers over the Internet and other media. (Anthony, 26).

Yuse argues that wholesale health care innovations have not been, nor are likely to be, politically feasible. He builds his case for the one meaningful and practical health care reform alternative: expansion of Medicare to all of the country's 280 million citizens. Yuse demonstrates Medicare is a practical, proven, and quite popular among the elderly. Politics is, to reiterate an old cliché, the art of what is possible. In addition, Yuse clearly and cogently presents the philosophical bases of his plan, demonstrating the morality and social utility of universal health care coverage.

Rollins' State Resident-Based Health Insurance program combines government mandated universal coverage with a regulated private insurance sector. They systematically describe the roles of federal and state government, insurers, employers, and consumers in detail. Regulation is needed to ensure universal coverage and community rating, and to prevent adverse selection, job lock, and exclusion based on economic status. They also provide a flow chart of a patient-consumer in their new system (Rollins, 23) and an extensive bibliography.

### ***Summary***

We are rapidly approaching a true crisis in our nation's health care system because neither the people nor the leaders perceive the severity of the national problem. But unless radical changes are made soon, we will be unable to fund our health care system in about ten years at our current rate of spending.

Recognizing this, CodeBlueNow! offered its Challenge to build an American health system. . These finalists had dedicated their knowledge, energies and talents to inventing solutions—each of which is unique. All these solutions—or perhaps combinations of them—are practical and workable. We need to acknowledge that we can no longer tinker at the edges and expect different results. We need fundamental change and the ideas herein are as good a place to start as any. What must happen is for our political leaders, foundation heads, administrators, physicians, researchers, universities and all those who are anxious about the future of health care in this country is to examine these fresh and innovative ideas. And then act.

All that is needed is the political will. Which is what CodeBlueNow! intends to create.

## APPENDIX A

### Contest Finalists Brief Biographies and Contact Information

**Wayne Anthony, BA, MDiv., MBA, SPHR** currently serves as the Director of the Business Resource Center of the Pastoral Institute, in Columbus, Georgia.

The Business Resource Center provides employee assistance services, financial counseling services, management training and development services, and organizational planning and development services to more than 125 organizations in Columbus. He helped create and direct the Center for Servant Leadership in Columbus and helped launch, House of Heroes, a joint initiative by US Congress, US Chamber of Commerce, The Society of Human Resource Management, Department of Defense, Department of Veterans Affairs and Hands On/City Cares of America. He is an ordained United Methodist minister serving a church in a transitional neighborhood in South Columbus. He is also a citywide elected member of the Columbus Consolidated Government City Council.

Prior to joining the Business Resource Center, Wayne was in corporate management for eight years with RJR Nabisco. He serves on the Society of Human Resource Management (SHRM) national legislative committee. He holds a B.A. in psychology from Asbury College, Kentucky; a Master of Divinity from Emory University, Georgia; and an M.B.A. from the University of Georgia. with an emphasis on strategic planning and human resource management. He also completed graduate studies in financial planning from Colorado's College of Financial Planning.

**Douglas Benn, DDS, PhD**, is Professor of Radiology and Director of Oral Diagnostic Systems in the Department of Oral Surgery and Diagnostic Sciences at the University of Florida in Gainesville.

Douglas notes that the views in his paper are his views and are not necessarily the views of the University of Florida.

Douglas is the author of 51 refereed papers (first author on 36), and was Editor of Dentomaxillofacial Radiology, the journal of the International Association of Dentomaxillofacial Radiology. In 1996, he founded the Alliance for Best Clinical Practices in Dentistry (ABCPD) to facilitate payment plans encouraging evidence-based dentistry. In 1996/97 he served on the Military Health Services System 2020, a Department of Defense Think Tank. His current research and teaching focus on Clinical Decision Support Systems and Health System Design.

Douglas was trained as a dentist at the University of London, United Kingdom (UK) and spent 10 years as a practicing dentist in London. He worked for four years as an Artificial Intelligence researcher of the Open University, Milton, Keynes, UK, and received a Master's Degree in Computer Science. He also served as a Research Fellow in the Department of Community Dentistry and General Practice at the University College London Dental School, University of London where he received his Ph.D. in developing oral diagnostics systems. He also worked in the Division of Maxillofacial Radiology and was awarded a Diploma in Dental Radiology from the Royal College of Radiologists, UK when he was working at the Guy Hospital, University of London.

**Ivan Miller, PhD.**, is a psychologist in private practice in Boulder, Colorado.

Prior to private practice, he spent 15 years working in the public mental health system. He is owner and President of the Psychotherapists Guild, Inc., an organization that promotes a group of 72 psychotherapists in Boulder. He has advocated for health care reform in his capacities as the former Executive Director, National Coalition of Mental Health Professionals and Consumers, Inc. in Commack, New York and Boulder, and in his current role as Chair of the Board of Colorado Patient Advocates, which helps consumers resolve problems with managed care. He also chairs the Interdivisional Task Force on Managed Care and Health Policy for the American Psychological Association (APA), in Washington DC. His work includes an analysis of health economics, and through the APA, assisting in the development of guidelines for evaluating evidence-based medicine.

Ivan holds a PhD in Counseling Psychology from the University of Colorado, Boulder, Colorado.

**Elizabeth A. Pavka, BS, MS, PhD, and S. Samuel Shermis BA, MSED, PhD**, are from Asheville, North Carolina.

**Elizabeth** has worked for 22 years as a holistic nutritionist in a variety of settings within the health care system. For nine years, she was the assistant director of the International and American Academy of Nutrition and Preventive Medicine and served as editor of its bi-monthly newsletter for 600 professional members worldwide. She is currently on the faculty of the American Academy of Nutrition. She offers presentations for professional and lay audiences, and has taught at the University of North Carolina, in Asheville and at Asheville-Buncombe Community College.

Elizabeth received her BS in biology, chemistry, and education and her MS in Nutritional Sciences from Cornell University. She received her PhD in social systems, with an emphasis on designing a new US Health System in 2002 from Saybrook Graduate School.

**Samuel** is a Professor Emeritus in Education from Purdue University. He currently teaches weekly at the Black Mountain Correctional Center for Women for women who wish to complete their high school diploma or need basic education. He also teaches at local colleges. He has written 11 book-length works, and has published about 200 articles, columns, papers, essays, editorials, and radio scripts. He is currently working on an article on the philosophy of Benedict Spinoza and a book on the historical, religious, and philosophical context of social justice. After he completed his PhD in 1961, he was on the faculty of Idaho State University. from 1961 to 1965, and at Purdue University from 1965 to 1995. He also taught high school in the San Joaquin Valley in California.

Samuel's BA is in history and social sciences with a minor in French Literature from Fresno State University. His MSED and PhD degrees are from the University of Kansas. His dissertation focused on the political and social philosophy of John Dewey.

**Joan Richardson, MD**, is a board-certified family practice physician in Miami, Florida.

Joan is active in the American Academy of Family Practice; Florida Academy of Family Practice; Managed Care Ombudsman Committee of the Agency for Health Care Administration (AHCA) in Florida. She is a member of the University of North Carolina Educational Foundation and the

General Alumni Association in Chapel Hill, North Carolina. Her past affiliations include being a member of the American Board of Quality Assurance and Utilization Review for Physicians; National Association of Managed Care Physicians; American Medical Women's Association; Florida Medical Association; Dade County Medical Association and the Special Olympics. She also served for three years as a board member and physician at the McLamore Children's Center of the Children's Home Society for foster care, and for Cedars Hospital Utilization Review Committee.

Joan received her BA in Chemistry and English and her MD from the University of North Carolina in Chapel Hill. She completed her residency at Georgetown University and Providence Hospital in Washington DC.

### **Rollins School of Public Health, Emory University, Atlanta, Georgia**

**Rollins School of Public Health, Emory University, Student Team formally entered the contest as a School of Public Health.** The students came together to begin work on this project shortly after matriculating in the Master's Public Health (MPH) Program of the Health Policy and Management (HPM) Department.

**Keri White** grew up near Orlando, Florida, and attended Winter Park High School. Prior to beginning work on her MPH, she earned a Bachelor's degree in Business Administration (Marketing) from the University of Central Florida in 1996 followed by a Master's degree in Exercise Physiology in 1998 from the same university. Her work in the health field during the past decade has been published in peer-reviewed journals and in a textbook. She was recently honored with an internship at the Centers for Disease Control and Prevention (CDC) sponsored by the Association of Schools of Public Health (ASPH). As she finishes her MPH, Keri is concurrently enrolled in the Georgia State School of Law in Atlanta, as part of the class of 2006.

**Bina Patel** was born in Zambia and lived there until she was ten, when her family moved to the US and settled in Florida. In 1997, Bina earned a Bachelor's degree in Health Science Education from the University of Florida. Before beginning her MPH, she did advocacy and program development for the Women's Center of Jacksonville. After graduation, Bina hopes to pursue her career in public health policy in Washington, D.C.

**Marissa Scalia, MPH,** grew up in Lakewood, New Jersey, and graduated from Lakewood High School. She earned a Bachelor's degree in Health and Society from the University of Rochester in 2001. She is a former Capitol Hill intern, having worked with both Ted Strickland (D-OH) and Anna Eshoo (D-CA) during 1999. Like Keri, Marissa was also recently selected for an ASPH internship at the CDC; where she will continue to work during the academic year. Marissa is the Health Policy and Management Department's Student/Faculty Representative. She volunteers weekly at the Children's Hospital of Atlanta.

**Erik Mettler** hails from Albuquerque, New Mexico, and graduated from the Albuquerque Academy. He attended the University of New Mexico, where he earned a dual Bachelor's degree in Psychology and Sociology in 2000 and a Master's degree in Public Administration in 2002. In addition to his position as President of the Rollins School of Public Health's chapter of the American College of Healthcare Executives (ACHE), Erik hold two jobs--graduate assistant for the Career MPH program at Rollins School of Public Health and had budgetary and administrative

duties at the Veterans Integrated Service Network Seven of the Veterans' Administration (VA) Hospital System.

### **School of Public Health, Loma Linda University, Loma Linda, California**

#### **The School of Public Health at Loma Linda University, also formally entered as a School of Public Health**

**Eric Andersson MHA, CHE** holds a Bachelors degree in Physiology from the University of California at Berkeley and a Masters degree in Health Care Administration from Washington University in St. Louis, Missouri. He is working towards a Masters degree in Finance. Eric has a twenty-three year career in health care. He has served as a senior executive in hospitals, medical groups and managed care. He is recognized as the founder of Mills-Peninsula Medical Group, one of the few National Committee for Quality Assurance (NCQA) accredited Independent Practice Associations. Eric's focal points have been to bring a demonstrable commitment to community health care access in the organizations he has served, to achieve market success and stability within volatile markets, and to develop self-directed healthcare teams.

**S. Eric Anderson, PhD, MBA**, is an international lecturer and consultant who has traveled to 118 countries. He presently serves as the MHA Program Director at Loma Linda University. He has written or been interviewed on several occasions for articles that have appeared in a variety of publications such as *Forbes*, *Your Money*, *Journal of Cost and Quality*, *Medical Tribune*, *USA Today*, *Los Angeles Times*, and *California Medicine*. He was also selected to serve on a nationally recognized task force mentioned in *Time*, *Newsweek* and *US News and World Report* that was established to improve the health care delivery process. Eric has been recognized on several occasions as he received the 1995 Business and Health Administration Top Research Award, the 1998 Reader's Digest Publishing Award and in 1998 received the P. William Dysinger Teaching Award. He served as advisor to the student team.

**Dora Barilla, MPH, CHES**, is a health care consultant working with hospitals and community based organizations. She has implemented innovative alternatives to traditional health care by using a collaborative and community-based approach. Dora has worked with hospitals, health maintenance organizations, and managed care companies. She is presently a doctoral student in public health at Loma Linda University. Her passion and dedication are maternal child health and reforming the current system of health care.

**Mary DeWalle, BSN, RN**, currently works as a quality management consultant for the state of California. Mary has over 32 years experience in health care with 14 years in managed care and 14 years of acute care nursing experience. Prior to being a consultant, Mary was the Director of Quality Management and Compliance, and developed and implemented quality and utilization processes in a mixed model health care delivery system for 22 IPAs with 650,000 managed care members and over 1,200 primary and specialty care physicians and integrated health delivery expectations and requirements. Mary developed all Policy and Procedures for HIPAA (Health Insurance Portability and Accountability Act), Quality, Risk, Utilization, Credentialing, Health Education and Preventive Care, and Disease Management utilizing standards set by NCQA, HMO, Centers for Medicare and Medicaid Services (CMS), and the DMHC, including maintenance of compliance with standards for Knox-Keene license.

**Brad Gilbert, MD, MPH**, is the Medical Director of Inland Empire Health Plan (IEHP), a non-profit HMO for Medi-Cal and Health Families beneficiaries. His responsibilities are the oversight of all medical aspects at IEHP. Under his leadership, IEHP was awarded a three year Commendable Accreditation by NCQA (2002), the first Medi-Cal only plan in California to achieve this distinction. In 2002, IEHP was awarded NCQA Full Disease Management Accreditation, the first full service health plan in the United States to achieve this status. Prior to IEHP, he also served as the Director of Public Health for both Riverside County and San Mateo County, California.

**Daniel Giang, MD**, graduated from Loma Linda University School of Medicine in 1983. He completed his neurology residency and a Behavioral Neurology Fellowship at the University of Rochester. He served as a professor of Neurology at the University of Rochester from 1990-1995. Daniel also served as an Assistant Residency Program Director and ran an offsite Neurology practice in addition to working with the Multiple Sclerosis Section. In 1996, he returned to Loma Linda University as Chair of the Department of Neurology, and is currently Vice President of Medical Education at Loma Linda University Medical Center and Associate Dean for Graduate Medical Education in the School of Medicine.

**Nancy Loomis, BSN, RN**, is currently a Nursing Director at a 329-bed full-service hospital with nearly 2,000 employees and a medical staff of over 500 physicians. Nancy has developed innovative programs for nursing care. She has been a leader in finding long-term solutions to the nursing shortage within her hospital that promote quality and nurse satisfaction.

**Jeff Mason, MD** has practiced medicine as a primary care physician and Endocrinologist for 18 years. He is board certified in Internal Medicine and Endocrinology and is a Fellow of the American College of Physicians. Jeff has served as a medical director for two IPAs and is currently a health plan medical director. His primary interests are in the management of chronic illness in a managed care environment, the economics of health care delivery, and in integrating physicians into a comprehensive health care delivery system.

**Monica McKenzie, MPH, RN, CHES, CLE**, has worked in health care settings on three continents and is presently enrolled as a doctoral student in Health Promotion and Education in the School of Public Health at Loma Linda University.

**Rhodes Rigsby, MD**, presently serves as Loma Linda University's Health care Executive Director for Medical Affairs, encompassing roles in managed care credentialing, quality management and utilization management. He is Special Assistant to the Dean, Loma Linda University School of Medicine. Rhodes chairs the Loma Linda University Medical Center's utilization management committee and institutional review board, and maintains an active primary care internal medicine practice. He has five years experience as a hospitalist, and in that role was recognized as the Internal Medicine Teacher of the year. He has serviced on multiple HMO advisory committees, and on the local and state boards of the American Lung Association.

**John Shaffer** is an insurance broker in Orange County, California.

**Bruce Smith, MD, MPH** is a family physician with training in public health, with interest in international health and preventive medicine. He currently serves as Medical Officer for Maternal

and Adolescent Health with the San Bernardino County, California, Department of Public Health. He has eight years of experience working with diverse health systems in Costa Rica, Guatemala and Nicaragua as well as the United States, and has served in policy shaping or advisory roles with MACH Action (California Association of Maternal Child Health professionals), committees of the California Conference of Local Health Officers, and the California State Breastfeeding Advisory Committee.

**Gerald Tracy, JD, and Terri Clark, CNM, MSN, PhD** are from Connecticut.

**Gerald** has a diverse 30 year background in the health care field: as a health care executive, an entrepreneur, and as a health care lawyer. He assumed management positions of increasing responsibility in hospitals, mental health organizations and managed care organizations, developing expertise in provider reimbursement, information systems, risk management, quality assurance, and new business development. He guided one company (Managed Health Benefits Corporation) from start-up to a successful public offering. He currently oversees the health law practice of the Hartford Fire Insurance Company, a national property, casualty and disability insurer in Hartford, Connecticut. His current practice concerns include privacy, ehealth, managed care, fraud, workers compensation, claims management, and anti-terrorism. He handles contract negotiations, regulatory compliance, litigation management, and lobbying support in each of these areas.

Gerald has a Bachelor of Arts from Wesleyan University and a Master's degree in Public Health from the Yale University School of Public Health, where he was awarded the Richard K. Weinerman Fellowship. He received his legal training and Juris Doctor from the University of Connecticut. He is a licensed attorney in Connecticut and a member of the American Bar Association and the American Health Lawyers Association.

**Terri** is a faculty member of the School of Nursing at Yale University in New Haven, Connecticut. She is a provider in the School's Faculty Midwifery Practice at the Yale-New Haven Hospital. Her areas of interest and research include maternal-fetal conflict of interest, access to care, nurse-midwifery perinatal outcomes, minority health outcomes disparities, preventing mother to baby transmission of HIV and increasing professional nursing, midwifery and maternal-child health care capacity in developing countries.

Terri has a BA in Philosophy from Yale University, and is a certified nurse-midwife with a Master's in nursing from Yale University's School of Nursing. Her PhD is in sociology from the University of California, San Diego. Her sociological research is in the areas of social control, sociolinguistics, and ethical problems in society.

**Frank Yuse, BA, MEdAdm** , is a retired teacher and principal from Spokane, Washington.

He taught English and Latin at Shadle Park High School in Spokane and was elected to the Inland Empire English Association. Frank directed a workshop in English Communications, and then was promoted to chair of the Shadle's English and Foreign Languages Department. He installed an interdisciplinary humanities studies program which became a model program for other schools. He also introduced the teaching of seven languages in the high school. Frank has also taught at

Gonzaga University and Eastern Washington University; he has received Gonzaga University's Distinguished Alumni Merit Award. He worked for one year at Catholic Charities in Spokane and oversaw the decentralization of their operations in twelve Eastern Washington Counties. Frank also served as President of the Washington State English Teachers, Eastern Washington Lay Council and as the 5<sup>th</sup> Legislative District Leader. He edited and published a 400 page book, *Honey in the Mouth*, on the daily meditations of Bernard of Clairvaux (1090-1153). His articles have been published in journals and newspapers on topics ranging from religion, politics, land use and health care.

Frank received his BA in education and his BA in liberal arts from Eastern Washington University in Spokane and his degree in Administration from Gonzaga University.

## **APPENDIX B**

### **CodeBlueNow! Summary Committee Template**

#### **Questions**

- 1) What does the writer define as the major problems with the current U.S. health system (e.g., availability, accessibility, affordability, quality; other problems)?
- 2) What governance model is proposed (e.g., level and extent of government control; role of federal/state/local governments; role of employers, insurers and other stakeholders)? How would the proposed new system be managed to improve service availability, affordability, and quality?
- 3) What rights and responsibilities does the patient-consumer have in the proposed system?
- 4) How does the writer address levels of care: prevention, primary care, secondary care and tertiary care?
- 5) What health care service delivery system(s) are proposed? (including impacts on various categories of health care providers practices and their relationships with patients).
- 6) How would the proposed new system be financed and by whom?
- 7) What is the role of information technology in the proposed system?
- 8) How does the writer address the legislative changes that would be necessary to establish the proposed system?
- 9) How does the writer address the political changes that would be necessary to establish the proposed system?
- 10) What changes, if any, does the writer propose to our medical malpractice system?
- 11) What is the writer's transition plan? How are obstacles and feasibility problems addressed?
- 12) What are the strongest points made by the proposal writer?
- 13) Add any important miscellaneous points that have not been captured in the other 12 questions.

## APPENDIX C

### Terms and Conditions of Build an American Health System Challenge

- 1) Must use the principles outlined in the [Health Care Magna Carta](#) (page )  
Others have created principles to organize the health care system. You may use those principles as well. See: [Institute of Medicine Crossing the Quality Chasm](#); [The Collaboration.org](#); and [the Belmont vision](#); You may change some principles and/or add others, but in all cases you will need to indicate why you are not using or changing some of the principles. What principles will drive your system and why?
- 2) Must take into account the interests of all stakeholders—businesses; individuals; government; and providers—how will their interests be met in your system?
- 3) Must demonstrate a sustainable financing mechanism. How will your plan be financed and who is going to pay for it and how?
- 4)..Must find a way to assure everyone has coverage and must describe each group’s expected financial contribution. How will your plan assure that everyone has health care coverage?
- 5)..Must demonstrate accountability and responsibility for all the participants in the health care system. What incentives will your plan create to assure all the participants are accountable for themselves and the system, and have responsibility for their actions?
- 6)..Must address the plurality of the current system. Would you keep the employer-based model? Why or why not? If not, how will you deal with an employer community that has significant tax advantages now?
- 7) Must address the regulatory challenges. What regulatory changes would you make for commercial insurance and public programs, such as Medicare and Medicaid and ERISA?
- 8) Must recommend a management structure. Who will manage your system and why did you choose this management model?
- 9) Must include a section on how we migrate from where we are to where you want us to be and the time that will be necessary to get there. How will we get from where we are now to your new vision of health care in America?
- 10) Must address on-going advocacy and oversight. What kinds of on-going advocacy and education, and by whom, would be necessary to keep your health care system both effective and humane?

## APPENDIX D

### Health Care Magna Carta

- 1) We believe we must all participate in health care decisions and that health care is too important to be left to someone else. Just as war is too important to be left to the generals, our health care is too important to be left to the industry and employers.
- 2) We believe everyone who participates in the health care system should pay for it—individuals, businesses and government. If we all benefit, we all must participate and support it. No one gets services without paying for them, at least in part.
- 3) We believe all people should have access to a common set of health care services that promote the health and well-being of our nation, including access to preventive services, full maternity and well-child care, childhood immunizations, and full dental and mental health services for children, as well as comprehensive health services for seniors. We believe that this includes culturally sensitive health care services that recognizes the diversity of our nation and that includes complementary and alternative therapies, as well.
- 4) We believe no person should face bankruptcy because of catastrophic health care costs and needs.
- 5) We believe in the freedom of employers to offer more than a common set of health care services; but in return, large employers should not oppose the needs of small businesses to offer at least a common set of benefits, so people don't live in fear of insufficient insurance.
- 6) We believe we should all be in the same risk pool rather than separate our society into smaller and smaller segments.
- 7) We believe we all need clear and succinct information about health care services and benefits, and that information about services and benefits should be written for the average reader, not just for lawyers, physicians and government employees.
- 8) We believe we need central standards and management of health care financing and services, just as we have central standards and management for the banking industry. We need an independent national board, but we also need local flexibility to meet the specific health care needs of our communities. We also need to define care standards for ourselves, our providers and our communities.
- 9) We believe funds for health care services should not be dictated by the specific health care categories as we now have, so we can be more flexible in meeting the wide range of needs of clients vs. the compartmentalized requirements of each separate system as we now have.
- 10) We believe we must all assume personal responsibility for our health and help our friends and family members so the same. We encourage individuals, employers and community groups to put efforts into health promotion and disease prevention and reduction.

## APPENDIX E

### Judge Biographies

#### **Thomas D. Aschenbrener, M. Ed., President, NW Health Foundation, Portland, OR**

Thomas has more than 25 years of experience with foundations and grant-making. He currently serves as president of the Northwest Health Foundation, which was organized under his leadership in 1998. Prior to joining the Foundation, he started a company that advised high-income individuals and families on charitable giving and consulted with corporations and organizations establishing philanthropic foundations.

Thomas has served in a variety of health education and management positions, including founder and director of the physician's assistant program at the University of Iowa School of Medicine; grants program officer in the federal government's Division of Medicine; director of the governor of Georgia's statewide health coordinating council; director of professional affairs at the American Podiatric Medical Association; and vice president for institutional advancement at the California College of Podiatric Medicine.

He holds a BA from the University of Iowa and an M.Ed. in medical education from the University of Illinois, where he was a Kellogg Foundation fellow. He is also a graduate of the Duke University physician's assistant training program.

#### **Clement Bezold, Ph.D., President of the Institute for Alternative Futures (IAF) and President of IAF's for-profit subsidiary, Alternative Futures Associates (AFA).**

Clement established IAF in 1977 with Dr. James Dator and Alvin Toffler, to encourage "Anticipatory Democracy." He started AFA in 1982 to assist corporations in their strategic planning. Trained as a political scientist, he has been a major developer of foresight techniques - applying futures research and strategic planning methods in both the public and private sectors. Clement has worked with a large variety of successful and growing corporations and designed numerous workshops and projects to study future environments for corporations, and he has also consulted on strategic processes for new product development.

Clement is a frequent speaker on the future for voluntary organizations, corporations, and health care and education groups. In the health area, Dr. Bezold has worked with groups to consider the future role of hospitals, pharmaceuticals, medical technology, and voluntary organizations.

In 1991, Clement co-founded and chaired the International Health Futures Network, at the request of WHO/Europe and the European Community. He is presently overseeing a major process for the Department of Defense on the future of military medicine. He is also consulting with both WHO/Geneva and the Pan American Health Organization (PAHO) on enhancing their ability to use health futures in their operations to support WHO's vision of health for all.

Clement is published extensively. His book, *The Future of Work and Health*, co-authored with Rick Carlson and Jonathan Peck, received the American Health magazine book award. Other works include *Horizons 2013—Longer, Better Life Without Cancer*, in collaboration with the American Cancer Society; *Future Care: Responding to the Demand for Change*; *Anticipatory Democracy*; *Health Care Information Standards and Technologies*; *Pharmaceuticals in the Year 2000*; *Nursing in the 21st Century*; *Judging the Future: Alternative Futures and the Legal System*; and *The Information Millennium: Alternative Futures*. His latest book, *The Future of Health in Latin America: The Prospects for Achieving Health For All* was released in April 1998.

Two major reports, *The Future of Complementary and Alternative Approaches (CAAs) in US Health Care* and *The Future of Chiropractic: Optimizing Health Gains*, were released in July 1998. Clement has published in magazines such as *The Futurist*, *Business and Health*, *Modern Healthcare*, *Quality Progress*, *Healthcare Forum Journal*, *Pharmaceutical Executive* and the *National Journal*. He is government editor of *The Futurist*, and is on the editorial board of *Futures Research Quarterly*.

Clement has a BA in International Affairs from Georgetown University's School of Foreign Service and he received a Ph.D. in Political Science from the University of Florida. He has also served as the Assistant Director of the Center for Governmental Responsibility, was a Visiting Scholar at the Brookings Institution, and a consultant to the Rockefeller Commission on Critical Choices for Americans, the Commission on the Operation of the Senate; and numerous state and local governments as well as several corporations.

#### **Gerald Coe, JD. Attorney at Law, Seattle, WA**

Gerald is an attorney in private practice, providing legal services to health insurers, self-funded health and welfare benefit plans and administrators, facilities and providers in matters relating to health insurance, regulatory compliance, health care reimbursement (including Medicare and Medicaid), non-judicial dispute resolution, and general business and administrative law. He has served as President of Sisters of Providence Health Plans in Washington and as Acting CEO and General Counsel for Group Health Cooperative of Puget Sound. He has also served on the boards of numerous national and local health care organizations, including the Group Health Association of America, the National Managed Health Care Congress, and the National Health Lawyers Association.

Gerald is a graduate of the University of Washington Law School and has served on the clinical faculties of both the University of Washington's Law School, and the School of Public Health's Masters in Health Administration program. He is not a lobbyist.

#### **Rheba de Tornay, Ed D., Professor and Dean Emeritus at the School of Nursing, University of Washington.**

Rheba has over fifty years of experience in health related institutions including experience in long term care, acute care, community health, and nursing education. She is a graduate of Mount Zion Medical Center School of Nursing in San Francisco, and she received her bachelor's degree in nursing and her master's degree in education from San Francisco State

University. In addition to her earned doctoral degree in education from Stanford University, she holds three honorary doctorates.

Her professional associations include being a member of the Institute of Medicine, National Academy of Sciences, and the American Academy of Nursing which designated her as a “Living Legend” for her lifetime achievement and contributions to the nursing profession. She is a trustee emeritus of the Robert Wood Johnson Foundation, having served for ten years as the first woman trustee.

Rheba’s primary interest is in aging and long term care. She was a member of the San Francisco Institute on Aging for many years, and currently serves on the Regional Advisory Board of the Northwest Geriatric Education Center. She served as the co-chair of the University of Washington Retirement Association Housing Facility Committee, to develop a residential retirement community for the retirees of the University of Washington. With Heather Young, a gerontology nurse practitioner, she co-authored Choices: Making a Good Move to a Retirement Community to help older adults decide whether or where to move.

### **Dave Garets, Executive Vice President, HealthLink, Houston, TX**

Dave has 25 years of experience in information technology. Prior to HealthLink, he served as Group Vice President, Healthcare Industry Research & Advisory Services for Gartner, Inc. and as Senior Manager for Emerging Practices with First Consulting Group. He has also served as the CIO of Magic Valley Regional Medical Center in Twin Falls, ID.

Prior to coming to the health care industry, Dave spent 13 years in various management capacities for AT&T. Since 1992, he has served as a Course Director and faculty member of the College of Healthcare Information Management Executives (CHIME) Information Management Executive Courses, held at the University of Michigan. He serves on the editorial advisory boards of six health care information technology journals and magazines. He is a Fellow, Board member and Chair-elect of HIMSS (Health Information Management Systems and Society), the healthcare IT industry professional society. He is an internationally known author and speaker on information technologies, strategies, benchmarking, and the future of healthcare.

### **Jose Gonzalez, MHA, Principal, CBA Business Advisors, Long Beach, CA**

Jose is a health care financing consultant in private practice and a Member of the CodeBlueNow! Board of Directors. He founded Latino Health Care in 1996 to create a network of Latino health care providers so he could provide access to quality health care services for the Latino community in Southern California. Latino Health Care now includes 25 hospitals, 2,300 doctors and 35,000 members and manages capitated revenues of \$25 million.

Prior to founding Latino Health Care, Jose had his own successful consulting business, served as President and CEO of Universal Medi-Co, which developed and managed ambulatory health care delivery networks, and was Director of Planning, Community Affairs and Development for St. Francis Medical Center in Lynnwood, California. He has also served as the Assistant Medical Director, University of California, Irvine Medical Center.

Jose was born in Mexico and immigrated to the U.S. in 1954. He holds a BA from California State University and an MHA from Pepperdine University. He was featured in “Ten Who Dared—Hispanic Entrepreneurs Who Have Succeeded Against the Odds” in 1996 Hispanic Business.

He was most recently appointed to serve on the California Commission on the Solvency of Health Plans.

**Andrew Holtz, Principal, The Holtz Report, Portland, OR and President, Association of Health Care Journalists**

Andrew is the former CNN Medical Correspondent, and an independent journalist covering health and medicine from Portland, Oregon. His work appears on the PBS television program HealthWeek, The Learning Channel's Medical Detectives, InTouch magazine, and websites including WebMD and Reuters Health Information.

Andrew is the host and co-producer of Taking the Pulse, a series of health policy programs that debuted on Oregon Public Broadcasting in June 2001. He was a 1998 Kaiser Media Fellow. The Kaiser Family Foundation grant supported research into tobacco control campaigns, in conjunction with Masters of Public Health studies at Portland State University and the Oregon Health Sciences University.

He also serves as President of the Association of Health Care Journalists. The Association of Health Care Journalists is an independent, non-profit organization dedicated to advancing public understanding of health care issues. Its mission is to improve the quality, accuracy and visibility of health care reporting, writing and editing.

**Edward F. Howard, JD, Executive Vice President, Alliance for Health Reform, Washington DC**

Edward has headed up the Alliance for Health Reform since its formation in 1991. Previously, he served as general counsel for the Pepper Commission, a bipartisan congressional panel convened to plan for providing health coverage to all Americans. Before that, he directed public policy at the Villers Foundation and at the National Council on the Aging, where he served as general counsel to the House Select Committee on Aging. He holds a juris doctor (JD) degree from Harvard University.

The Alliance is a non-partisan, non-profit organization that offers a full array of resources and viewpoints, in a number of formats, to elected officials and their staffs, journalists, policy analysts and advocates. The Alliance believes that all in the U.S. should have health coverage at a reasonable cost. But it does not lobby for any particular blueprint, nor does it take positions on legislation. Senator Jay Rockefeller of West Virginia, a national leader in health policy, chairs the Alliance's board of directors and Senator Bill Frist of Tennessee, a key policy maker and a heart and lung transplant surgeon, serves as the vice chairman. Since 1990, the Alliance has held over 200 forums in Washington DC and around the nation and has developed several different press resource guides and issue briefs.

**Sandra Hullett, MD, MPH**, Interim Executive Officer, Jefferson Health System, Birmingham, AL

Sandra is the newly appointed Interim Chief Executive Officer/Medical Director for the Jefferson Health System consisting of Cooper Green Hospital and Jefferson Outpatient Care. Jefferson Health System's primary focus is service to the underserved populations of Jefferson County. Most recently, Sandra was the Executive Director of Family HealthCare of Alabama, which provides services to patients of west central Alabama.

Sandra earned her undergraduate degree in biology at Alabama A&M University, her medical degree from the Medical College of Pennsylvania, and her Master's in Public Health from the University of Alabama at Birmingham (UAB). Since completing her residency in Family Practice and fulfilling a National Health Services Corporation obligation, she developed an interest in rural health care including health care planning and delivery to the underserved, underinsured, and poor of this area.

Sandra has extensive experience in research, clinical trials, community outreach and teaching direct care delivery. She serves as project director and principle investigator for several grants funded by the National Cancer Institute, the Robert Wood Johnson Foundation, the Kellogg Foundation, the National Heart, Lung, and Blood Institute, and the Ford Foundation.

She serves as a member of the Board of Trustees of the University of Alabama, and the Board of Directors of UAB Health System. She is active in local, state, and national organizations such as the Alabama Women Hall of Fame Board of Directors, Leadership of America, Family Practice Rural Health Board, Greene County Hospital, the Rural Coalition, the Rural Environmental Justice Board, and the Nursing Home Board. Dr. Hullett also serves as a member of the Practicing Physicians Advisory Council for the U. S. Department of Health and Human Services, the Institute of Medicine, the National Academy of Sciences, Intercultural Cancer Council, the Steering Committee for the Alabama Partnership for Cancer Control in Underserved Populations, the Advisory Committee for the Minority Medical Education Program, the Institute of Medicine Committee on Environmental Justice and the Institute of Medicine Committee on the Changing Market, Managed Care and the Future Viability of Safety Net Providers.

Sandra is the co-author of several nationally published articles on health care issues among rural primary care communities. For her efforts in rural health, Dr. Hullett's honors include the Rural Practitioner of the Year Award in 1988 by the National Rural Health Association, the Clinical Recognition Award for Education and Training in 1993 by the National Association of Community Health Center, the Distinguished Leadership Award in 1996 by Leadership of Alabama, Rural Leadership Image Award in 1998 by the National Black Churches Family Council, Public Health Hero Award for Year 2000 by the UAB School of Public Health, and for her years of dedication to improving and protecting the health of Alabamians, she was recognized and inducted in the Alabama Academy of Honor by the Alabama Department Achieves and History in August of 2000.

## **Appendix F**

### **Declaration for the Health of America**

#### **We believe**

Our health care system should support the health of all our people and the communities in which we live.

#### **Principles**

We believe the health care system should:

- Make our health the center of the system and build programs and services to promote our health
- Assure we all have the authority, resources and responsibility to make health care decisions about our own physical and mental well-being.
- Give us the tools and information to make these decisions

#### **Core Elements**

We believe the health care system ought to:

- Guarantee a core set of health care services
- Focus first on prevention and health promotion
- Assure access to all licensed health care professionals
- Be accountable to the people and their communities for quality, access and cost
- Improve care by constantly researching and adjusting health care practices
- Reduce the employers' role in health insurance
- Decrease administrative costs and waste
- Address ways in which poverty, the environment and behavior affect our health

Signed this day, April 30<sup>th</sup>, 2004