
IV. SOLUTIONS TO THE PROBLEMS IN THE U.S. HEALTH CARE SYSTEM

The Health Care Community Discussion groups did not pinpoint one specific problem with the American health care system, but rather described an array of cost, access, and other systematic problems. Each group also offered solutions in response to the central questions of health reform. In rebuilding this system, what values should be prioritized? What roles and responsibilities should each actor assume? What specific ideas should be tried or adopted? Finally, at the end of the day, what should this system look like? Health Care Community Discussion reports offered thousands of solutions, which were often similar, to these questions.

A. Principles for a Reformed U.S. Health Care System

Many of the Health Care Community Discussions focused on the aspirations for the health system, suggesting that its performance would improve if it adhered to guiding values and principles. Among reports discussing solutions, participants wanted a system that is fair (36%), patient-centered and choice-oriented (19%), simple and efficient (17%), and comprehensive (15%) (see Figure 8).

Fair

Fairness was a common theme among Health Care Community Discussions and motivated many to call for a health system that insures all Americans. A number of Health Care Community Discussion reports explained how the group came to this conclusion. For example, the moderator of a Health Care Community Discussion at the St. Louis University School of Medicine in St. Louis, Missouri, comprised of forty-five members of the community, noted, “One of the attendees stated strongly that health care should be a ‘right’ rather than a privilege. After a brief subsequent discussion, I asked for a show of hands. Virtually everyone present agreed that health care should be a right and equally available to all citizens of all ages.” A Health Care Community Discussion at a hospital in Asheville, North Carolina, took a theoretical approach, “The fundamental policy question to be addressed is, ‘Is health care a public right?’ If health care is a right, then solutions to paying for health care will require a public solution. If not, then the market will only allow those who can afford care to access

it as is the case with other commodities.” In Devon, Pennsylvania, “The group agreed unanimously that some type of a universal care model not only should be ‘on the table’ as a philosophical option, but should be the preferred model and starting point of discussion.”

A commonly expressed recommendation among Health Care Community Discussion participants was to make health insurance inclusive of people with health problems or risks. As a report from North Brunswick, New Jersey, explained, “People who have the pre-existing conditions are the ones who need the insurance the most yet most of their time is spent fighting with the insurance company on what is covered and what is not covered. Tests, which are recommended by doctors, are not covered by the insurance company. This kind of power in the hands of the insurance company should be taken away. Any insurance carrier which provides coverage in the US (travelers, third party insurance companies, or local insurance companies) should be mandated to cover every pre-existing condition at the same premium.”

For some participants, the principle of fairness was less about helping the uninsured than about preventing their own high costs or compromising their own health. A group of community leaders and non-profit workers from a Charleston, South Carolina Health Care Community Discussion explained how the uninsured affect health costs. They said, “The nation needs some form of universal health care. The failure to insure that every citizen has access to affordable health care is a major reason for the chaos and fragmentation of the delivery of health care in this country, and goes a long way towards explaining why our country ranks below many others in the overall health and longevity of its citizens.” One parent who attended a meeting hosted by a health organization in Arlington, Texas, explained, “If someone is sick, they should receive medical care, regardless of whether or not they can pay. If my daughter is in school and she’s sitting next to someone who is ill, but whose parents don’t have insurance so she’s not receiving the care she needs, then my daughter could contract her illness. I don’t want that. It’s not the kids’ fault. Everyone should be afforded health care.”

Participants in Health Care Community Discussions had different interpretations of what “covering” all Americans means. Some reports advocated that everyone should have minimum catastrophic insurance to prevent bankruptcy related to unexpected health events. As a group of diverse community members who met at a home in Albany, Georgia, stated, “There should be basic universal coverage

for all or at least catastrophic coverage for all or a national pool.” In San Jose, California, a group of friends and neighbors echoed this suggestion, “The delivery of that system should be through a universal health care baseline insurance program with options for individuals and/or employers to add increased benefits or lower deductibles at an additional affordable cost. Those who have existing coverage through employment or retirement should not be forced into the universal system. The coverage should be transportable and without regard to pre-existing conditions.” Participants at a Health Care Community Discussion group in New York, New York, urged looking less at insurance when contemplating a fair and inclusive system and more at the content and quality of care. They advocated, “Insurance should not only be about getting access to treatment, but equally good treatment for all...In other words, it is not about minimum care but excellent care.”

Patient-Centered and Choice-Oriented

Numerous Health Care Community Discussion groups believed that any reformed or new health care system should have the patients’ needs as a central focus. A small group from North Scituate, Rhode Island, met at a home and described this demand, saying, “We want a system that encourages engagement between people and their primary care practices and other health providers; that is patient centered, which means meeting people where they are, as they are, and giving them services that actually improve their health.” A group of community members who met in Pittsburgh, Pennsylvania, on a Saturday morning conveyed a similar sentiment. They noted, “The consensus was that the definition of ‘preventive care’ must be expanded to include not just routine medical screenings such as mammograms, but also, more broadly, a model of patient-centered care in which primary care and people’s personal relationships with caregivers are encouraged and incentivized, as opposed to the current system that most profitably rewards specialized and catastrophic care.”

Choice emerged as a strongly held value in the Health Care Community Discussion reports. For example, many participants wanted the ability to choose their own provider and felt current insurance networks forced them to choose providers in-network regardless of quality or personal preferences. A group that met at a library in Richmond, Virginia, explained, “In terms of public policy, we want the flexibility to choose physicians (including specialists) outside of our insurance plan or networks without paying a high cost. It was a unanimous decision that we should not continue to allow

health insurance companies to select our doctors.” A gathering at a small apartment in New York City advocated a similar position, “People, the general public, does not want a choice of insurers, we want a choice of providers.”

Groups also expressed that they wanted the option to upgrade from a basic plan to one that covers additional care. For instance, a group from rural Kunkletown, Pennsylvania, noted, “A choice of policies, and upgrades to the basic policy should be available so that individuals or employers who want more than the basic policy may purchase it at additional cost. Most people want a choice, and allowing insurers to offer different policies will cause them to compete, which should be beneficial. Upgrades and alternatives to a basic policy might include such things as lower co-pays, coverage of procedures not covered in the basic policy, access to a greater choice of providers, and/or extra services such as dental and vision.”

Simple and Efficient

Many Health Care Community Discussion participants felt that a more user-friendly private and public health care delivery system would yield to greater efficiency. At a meeting at the Saint Louis University Medical School in St. Louis, Missouri, the participants agreed, “People need a few choices they can understand....” Local physicians gathered at a Huntsville, Alabama medical center for a Health Care Community Discussion reiterated this sentiment, “The system should be made less complex so that less educated patients are able to understand how to access good health care/benefits.” A participant from Trenton, New Jersey, relayed her father’s experience to emphasize the importance of an easy-to-navigate system. She said, “We need to make the health care system more user-friendly. The health system is very difficult to navigate. Recently, my father (a retiree...) was informed that [his employer] was canceling health care benefits for retirees. It was very stressful for him to figure out what he needed to do in order to purchase health care insurance for himself and my mother. He talked to friends, health insurance salespeople, etc. and everyone told him something different. This is a lot to ask a 75-year-old person to do!”

Participants from a Health Care Community Discussion at a Baptist church in Sterling, Virginia, concurred that simplifying health care options improves outcomes. They concluded, “Looking at

the number of options health care plans offer, this group suggested that the plans be streamlined so that the everyday consumer can better understand the language, reduce the number of redundant options, and be held accountable to pay for services they have initially contracted to pay.” In Merrick, New York, a group concluded, “The amount of increased paperwork and need for doctors to hire people to take care of it was cited as wasteful, a result of our present insurance environment, and the feeling that the money spent on that be put where it can increase the quality of care for everyone. Paperwork needs to be streamlined because it becomes the focus of care instead of the patient.”

Comprehensive

Numerous reports urged policy makers to ensure that insurance is comprehensive enough to protect against catastrophic health care costs. A mix of health care professionals, health care technology employees, and health care consumers at a Health Care Community Discussion in Madison, Wisconsin, reported, “The middle class, however, often has insufficient coverage, high deductibles, high co-pays, and/or limited catastrophic coverage, leading to years of harassment by collection agencies and, in many cases, personal bankruptcy.” A conversation in Longmont, Colorado, pointed out, “Medical savings accounts sound like a good idea, but with very high deductibles and still high premiums, they can only serve the wealthy.”

About 11 percent of groups recommended improving the comprehensiveness of benefits covered by health insurance plans to include, for example, mental health coverage, dental care, alternative medicine, and vision care. A group of community members in Springfield, Virginia, elaborated on the need to cover mental health services, noting, “The medical community recognizes that mental health is largely dependent on biological processes. It is abhorrent that the United States stigmatizes and leaves out the mentally ill. Due to their conditions, the mentally ill find it difficult to maintain regular employment. It is time to stop making these people fend for themselves, often in the frigid doorways of inner cities, and to provide the medical treatment they need and deserve. With treatment, the mentally ill are more likely to end up working and paying taxes, as opposed to ending up in shelters and jails.” Some participants, such as those at a Health Care Community Discussion in Stafford County, Virginia, recommended, “Alternative treatments (massage, acupuncture, chiropractic/body work, naturopathy, nutrition services) need to become part of [the] mainstream

medical community, and more of their costs covered by insurance” and urged that any health system should “include dental and vision care as part of basic coverage.” In Southwest Durham, North Carolina, a group spoke about the potential impact of covering alternative medicine, saying that it “would drive costs down by allowing people to choose care that was not as intrusive as traditional western.” Another group in Fairbanks, Alaska, also voiced their frustration over the inadequate coverage with alternative medicines by stating, “We want the freedom to continue to choose what alternative modalities we wish including naturopathic medicine, auryurvedic medicine, homeopathy, herbology, Chinese medicine.”

B. Roles in a Reformed U.S. Health Care System

Participants discussed and reported on the roles different actors should play in a reformed health system. Groups recommended collaboration as a way to both improve patient care and achieve reform, and the theme of “shared responsibility” was common. However, groups had differing views on whether the roles of the main actors in the health system – the government, private sector, businesses, and individuals – should expand or contract in a reformed health system.

Role of Government v. Market

The Health Care Community Discussions were designed to solicit ideas for policy makers; therefore, it is not surprising that virtually all participants believed that policy makers and government should have a role in shaping, financing, and delivering health care. Specific suggestions from Health Care Community Discussion reports primarily focused on how to change Federal programs to make the health care system more affordable, accessible, and high-quality (detailed in the next section). There were some skeptics. A group in Middletown, Virginia, reported, “The consensus of the group of 27 neighbors who attended the forum was that most of the problems with the health care system is a result of the complex tangle of Federal government regulations already on the books and that any additional interference would only make matters worse.” This opinion was in the distinct minority.

The real debate was over the balance of government versus the market in insuring Americans. Supporters of a single-payer system submitted numerous reports, in part due to the encouragement by advocacy groups to participate in Health Care Community Discussions. Under most versions of a single-payer system, the government would replace private insurers in organizing, financing, and paying for health care. Its specifics, and arguments for and against it, are described below (see Single-Payer System box).

Some participants who did not fully embrace a single-payer system nevertheless expressed concern about the current and potentially expanded role of private insurers. In Emeryville, California, a group comprised of health care professionals and consumers agreed, “Insurance companies should not ‘dictate’ nor be the final say on medical procedures and treatment.” A group in Bend, Oregon, stated, “Insurance companies must not be allowed to insure people capitalizing on health problems to reap enormous profits.”

Conversely, a small number of participants expressed concern that a public plan without private insurers would reduce the quality provided by private plans. Participants who met at a Baptist church in St. Louis, Missouri, felt, “[A] major concern with [a] public v. private plan was the quality of care received with a public plan. Private [plan holders] all felt [they] received excellent care. With Private plans there is more to take advantage of for the costs you are paying.” A group of health care professionals in Waco, Georgia, explained, “On the whole it was felt that market based forces, rather than government involvement, was the key to the best overall outcome. The idea of a menu driven selection offered through a coordinated commercial effort of several different entities, perhaps under the auspices of the federal government, allowing people to pick and choose the coverage they needed and could afford, taking advantage of the economies of scale to be provided by such a cafeteria style mechanism, might be a viable alternative.”

Some groups were divided in their opinions about the role of government relative to the private market. On a Monday afternoon in Bristol, Virginia, “many argued that the insurance industry should be completely removed from the health care delivery system, but others saw how they acted as ‘gatekeepers’ to control costs, and to offer affordable coverage to some employers.”

Other participants spoke about a system with roles for both public and private actors. Some saw the private market's role as an addition to a new public insurance plan. A small and "enthusiastic" group in New York City talked about a two-tiered system over a light supper. They noted, "In addition to this basic system, additional health care products and services (including private insurance) could be purchased by those who have the means and desire for such things. This would allow a free market health care system to exist alongside the basic federal program, as, in fact, exists in many countries which have national health care." A group in Eureka, California, elaborated, "A hybrid system, with single-payer for basic health care and private insurance for catastrophic coverage and those wanting 'Cadillac' coverage (e.g., no requirement for referrals to specialists) might assuage some of the 'free market' advocates as well as address some of the reported shortcomings of pure single-payer systems with respect to rare or very expensive conditions." A group of health care consumers and providers in Springfield, Missouri, suggested that public and private insurers operate side by side, saying, "Private insurance should continue to play a role as an alternative to federally financed or managed insurance programs. Some consumers will opt to pay more for more coverage." Some participants raised policy concerns about public and private plans being offered side-by-side, without more regulation of the private plans. They feared unfavorable risk selection, where the sickest would choose a public plan, making it more costly than the private plan.

A few Health Care Community Discussion participants believed state government should play a larger role in a future health care system by either supplementing or entirely replacing the federal system. Groups implied that this sentiment resulted from a distrust of national solutions and the success of the Children's Health Insurance Program (CHIP) and other state programs. For instance, one participant in Gurnee, Illinois, stated, "I'm much more in favor of health care being addressed at a state or local level (or even a regional level) than a national health care initiative. I'm skeptical of the federal government handling this in an efficient or cost effective manner." Other groups recommended a federal and state partnership and explained, "There was general agreement that health care reform needs to take place at the local level along with whatever programs, policies and funding mechanisms are implemented by the federal government." In Washington, D.C., a group that met with just a few days notice wrote, "First and foremost, participants believe the...Children's Health Insurance Program...works and should be preserved, fully funded, expanded, and indexed to inflation." Participants also recommended a number of other state programs as reform models.

Other Health Care Community Discussion groups praised certain aspects of the Department of Veterans' Affairs (VA) system as a model for the larger health care system. A Health Care Community Discussion held by the Commission on Aging in Ridgefield, Connecticut praised the VA's coverage of hearing aids, dentures, and eyeglasses and suggested using "the VA model to obtain national discounts and supply these appliances." A Redway, California group recommended that America should enact a "public health insurance/health care program similar to Medicare and Veterans Administration programs we already have." However, not all comments were positive. A veteran at an Apollo Beach, Florida Health Care Community Discussion "complained about the decreased access to the VA system at a time when many can no longer afford private health insurance."

Single-Payer System

Over one-quarter (27%) of the groups discussed the merits of a single-payer system, and the majority of those groups supported this idea. These groups argued that this radical change was a necessary step for reform. On a rainy Thursday night before Christmas, a group of over 50 consumers and health care providers met in Del Rey Oaks, California, and stated, "Most attendees agreed that single-payer universal health care would be the preferred delivery system, and many even offered to pay additional taxes to support a government-run health care program."

Some groups believed that Medicare should serve as the model for a single-payer system. For example, one group of retirees from New York, New York, wrote, "The group felt unanimously that U.S. citizens should be on Medicare from birth; and were in favor of single-payer insurance." Others referenced other countries' models, such as those in Canada, France, and the United Kingdom. As a Health Care Community Discussion group from Livermore, California, stated, "This group was almost strident in its belief that we should simply adopt a single-payer system similar to what is enjoyed in Canada and much of Europe and take the burden off of individual employers and corporations altogether." A number of participants voiced their support for H.R. 676, a single-payer health care bill sponsored by U.S. Representative John Conyers (D-MI). For example, the League of Women Voters in Ithaca, New York, reported, "The group unanimously agreed that John Conyers' H.R. 676, the single-payer legislation, was the appropriate solution to support at this time, not alternatives that fine-tune existing employer-based coverage."

On the other hand, a number of groups opposed the idea of a single-payer system, concerned that it would lower the quality of service and eliminate competition. A provider in Maquoketa, Iowa, wrote, “I don’t think that a single-payer plan would be a good idea. I think some standardization is necessary, but I worry that a single-payer plan would eliminate competition.” A small group in Welaka, Florida, discussed this debate, saying, “All did not agree about a single-payer Medicaid/Medicare model for health care. Objections centered [on the] inability to get care when needed and rationing of access to tests, medical procedures and qualified doctors.”

Role of Businesses

As discussed earlier in this report, Health Care Community Discussion participants expressed varying views on the role of employers in a reformed system.

Many groups articulated support and even expansion of the current employer-based health insurance system. A group that met in an apartment in Staten Island, New York, reported that, “All feel that all employers should be required to offer some health care plan to employees, that business incentives be given, and that tax free ‘Flex Spending’ should be available to everyone. There should also be open forums of employees to be able to give input and make decisions regarding their health care plans.”

Other groups envisioned employers continuing to help finance health care coverage but playing less of a role in actually providing that coverage. A doctor in Hillsborough, California, hosted a group that argued, “Employers should be involved in paying for health care, but not providing coverage; health care itself should not be linked to employment; [there should be] seamless ‘portability’ of health coverage.” Members of a book group in Seattle, Washington, turned their normal gathering into a Health Care Community Discussion. They envisioned employers still playing a financial role, even in a single-payer system, suggesting “Unlink health care insurance from employers. We shouldn’t have to change our insurance and our doctors when we change jobs. But employers could be a source of funding for a single-payer system.”

Still others envisioned employers playing a role in improving the health status and wellness of their workers. At a coffee shop Health Care Community Discussion in Baton Rouge, Louisiana, participants expressed, “Employers should promote a healthy work environment and preventive care.” A participant at an El Sobrante, California Health Care Community Discussion expanded upon that idea and specifically suggested that public policy should “encourage more companies to incorporate a gym into their facilities so that employees may work out during lunch breaks or before/after work for minimal or no cost.”

Role of Individuals

Health Care Community Discussions placed a strong emphasis on the role of average Americans in improving their own health and the health system at large. A significant portion of reports advocated for greater individual responsibility in eating right, exercising, and adopting other behaviors that prevent the onset of disease. Many Health Care Community Discussion participants suggested that education should always be a priority. As a group in Leesburg, Florida, explained, “Educate and prepare people, particularly youth, to take responsibility for their own health thereby empowering them to make healthy choices in areas such as nutrition, sexuality, use of substances including tobacco and alcohol, as well as emotional health. This also needs to include funding for educating parents on how to help their children set boundaries and make healthy choices from infants through the teen years.”

A number of participants felt Americans should share the responsibility for healthy living, and this responsibility has been underemphasized. Members of a family medicine residency program in Washington, Pennsylvania, discussed the need for Americans to start practicing healthier behaviors by pressing that, “Individuals need to take more personal responsibility for their health. The health care system is being bankrupted by many things, but one of them is the fact that people are making daily choices that are poor for their health and then expect medical care to make everything all better. You cannot smoke or eat a poor diet or not exercise or abuse substances and expect to have good health.” An Indiana group echoed these same thoughts, “Many Americans do not take great enough responsibility for their own health. There is a cultural expectation of medicine to be the ‘quick fix.’”

Other groups talked about the role of individuals in financing the health care system. One suggestion was to calibrate individuals' financing of health care with an income-based sliding scale contribution structure. In Kissimmee, Florida, the Health Care Community Discussion host commented, "Everyone in my group voiced they did not want something for nothing but they wanted to be able to pay the cost based on their financial situation." Another group met in the rural town of Saylorsburg, Pennsylvania, and discussed the "overuse" of health care. They suggested, "Co-pays and other charges to individuals should be used to deter individuals from insisting on tests and other procedures which are not medically necessary." Still others discussed the need for individuals who can afford health insurance to purchase it.

C. Specific Suggestions

The Health Care Community Discussion groups provided a wealth of specific ideas in their reports. These ideas encompassed a wide range of topics including establishing health insurance exchanges, decreasing the cost of prescription drugs, developing methods to enhance and promote high-value health care, developing ways to upgrade and simplify information technology, improving health and wellness through education, encouraging healthy lifestyles, and expanding the health system's capacity.

Health Insurance Exchange

Some Health Care Community Discussions focused on how people access health insurance and supported the "establishment of a Federally-sponsored health insurance cooperative or insurance exchange that allows individuals to purchase affordable group coverage." A group from Redondo Beach, California, discussed health insurance exchanges and felt, "All individuals with employer based packages seemed to like the idea of options to utilize insurance exchange[s] or public insurance, depending on the cost of the program(s)." Participants in a Health Care Community Discussion in Potomac, Maryland, agreed, "The group seemed receptive to the idea of something like the Federal Government negotiating for rates and policy qualifications as it does within OPM [Office of Personnel Management] for Federal employees and offering the choice of those plans universally at cost."

Similarly, Health Care Community Discussion participants discussed the potential for small businesses to form coalitions to obtain purchasing power and reduce the cost of health care insurance for their employees. At a home gathering in Saylorsburg, Pennsylvania, the group reported, “There were a number of thoughts about what might be done to help contain costs. For one thing, small employers and individuals must be able to buy as part of a larger group and benefit from that group’s purchasing power. A woman who is a realtor noted that she must pay a particularly high price for insurance because she has no large group in which to buy.” Other groups found the complexity of insurance exchanges undesirable. As a group of consumers from Ithaca, New York, noted, “Getting health care through an insurance exchange would be too complicated; we want a simple system.”

Reducing Prescription Drug Costs

As noted earlier, many Health Care Community Discussion participants viewed the high cost of prescription drugs as a major problem. A group in Pennsylvania, comprised of a broad cross-section of the community, wanted the government to more actively negotiate prices: “We recommend using the vast purchasing power of the Federal government to negotiate with pharmaceutical companies and with lobbyists over fee schedules to lower costs on drugs and tests and raise reimbursement for people-driven care.” Attendees at a gathering in Sebastopol, California, stated that “pharmaceutical costs are too high and do not appear to be associated with reasonable research and development costs. Pharmaceutical costs should be standardized and decreased through a government acquisition program. Pharmaceutical companies have become too involved in directing health care.”

Participants in a Health Care Community Discussion in South Trail, Florida, recommended reimportation of prescription drugs from other nations. They explained, “There is something wrong with a system that requires a prescription for a drug that costs upwards of \$100 for a one-month supply that can be obtained from Canada for pennies on the dollar. The citizens of America are fed up with the exorbitant cost of purchasing drugs in the very same country where the research, development and manufacture of these medications occurs.”

In debating other ways to reduce the cost of prescription drugs, many groups suggested that the government regulate the amount of pharmaceutical company advertisements. A Health Care

Community Discussion in Kent, Washington, argued the need to “stop advertising by drug companies [and] [u]se the savings to lower the cost of drugs. Participants agreed advertising incentives increased the cost of medicine.” Another group in Welaka, Florida, echoed these thoughts, saying, “Most STRONGLY felt commercial advertising of most prescription drugs should be stopped. All strongly felt that there is a serious lack of ethics in the way drugs are pushed at Doctors. All feel there must be an overhaul of drug company marketing techniques and drugs from other countries should be easier to obtain.” Some groups suggested limiting pharmaceutical representatives’ influence as a way to control costs. In Millerton, Pennsylvania, participants agreed that “pharmaceutical companies should not be allowed to wine and dine the medical offices. Many medical offices have lunch brought in (paid by a pharmaceutical company) every day. Are the doctors prescribing medication because it is the best for the patient or because they are getting incentives from these companies?”

Research, Standards, and Promoting High-Value Health Care

Several Health Care Community Discussion reports discussed the importance of research, standards, and promoting high-value health care. Some groups discussed specific research programs that should be enhanced. A university health council in Wisconsin urged the “[i]nfusion of major research dollars into the National Institutes of Health, Centers for Disease Control, and the Environmental Protection Agency to understand the relationship between disease, environment, and behavior and develop/implement effective strategies to achieve healthy people in healthy communities.”

Some Health Care Community Discussion groups discussed how high quality care requires better quality measures and more accountability from providers. A Chesapeake, Virginia group, who gathered to talk about improving care for individuals with intellectual disabilities, suggested, “A quality scorecard should be designed to measure: quality of service, timeliness of service, ability to listen to patient, knowledge of medical condition, pain management and cleanliness of medical facility and staff. The scorecard should be submitted to a neutral agency.” In Del Mar, California, a group of both providers and consumers concurred, “...that it would be helpful if the government could figure out a way to provide some sort of rating system with objective information available that would aid consumers in determining the quality of a physician.” In Mesa, Arizona, “A majority of [graduate health] students supported the idea of a public rating system for providers to promote

improved quality and efficiency in the system.” A group meeting in Rutland, Vermont, commented favorably on Pennsylvania’s rating system, saying, “In Pennsylvania, doctors are rated and that information is available for public consumption.”

In addition to quality reporting, Health Care Community Discussions also recommended cost reporting. At a Colorado Discussion, participants stated, “[P]ublic policy can create a data base to compare providers and their costs for basic services. In this database can be a listing of their filed complaints or some type of review (maybe similar to the Better Business Bureau) where consumers can know if they are seeing a quality provider or not (rather than relying on the insurance company to tell them who they get the best rates from). Providers would ultimately benefit because patients would migrate to those more efficient/better outcome providers.”

Other Health Care Community Discussions recommended going a step further by having a public or independent organization produce such information and recommend what works best in health care. A Health Care Community Discussion in Harrisburg, Pennsylvania, sponsored by a Pennsylvania underwriting organization, suggested implementing a national cost containment council as a way to rate and better manage the health care system. Describing a similar initiative in Pennsylvania, the group explained, “It compares procedure frequency, cost, etc at most of the state’s hospitals. It also lists general cost.” A forum in Binghamton, New York, focused on disseminating best practices. This would, in their assessment, “Standardize care delivery from state to state and county to county... [e]specially interpretation of regulations and definitions of terminology. That being said, there must be some appreciation for local differences in terms of availability of service and allowance for creative ways to build long term care plans that include local services.” A group in Solana Beach, California, declared, “We should consider taking health care out of politics by having the details of the system controlled by a National Health Care Board with Regional Health Care Boards in various parts of the country, similar to the Federal Reserve Board.”

Some Health Care Community Discussion participants also thought that scaling back coverage of expensive procedures with limited benefits could be one avenue to pursue high-value care. A group in Sherman Village, California, met on a Saturday morning and highlighted, “While the concept of ‘rationing’ is anathema to most Americans, there nevertheless needs to be discussion around

and decisions about cost-benefit analysis: if an expensive procedure is likely to prolong life only for a short time, then perhaps the same health care dollars should be used on a patient who has a reasonable expectation of improvement or at least longevity.” A group that met in Silver City, New Mexico, suggested, “[A] 600-gram preemie would receive all appropriate care whereas a 90-year-old cancer patient would receive appropriate palliative care but would likely not receive a bone marrow transplant.”

According to roughly 11 percent of Health Care Community Discussion groups, reforming the medical malpractice system would promote high-value care and reduce costs. Some groups suggested tort reform to standardize award regulations and “no fault” compensation. At a meeting in Arlington Heights, Illinois, the group concluded, “Medical mal-practice should be managed like workman’s compensation, i.e., fixed payment schedules for bad outcomes. Medical professionals, hospitals and pharmaceutical companies would contribute to a workers’ compensation type system. Payouts would be based on fixed schedules.” A participant at a meeting in Bellaire, Texas, felt that “the legal punishment system for suing doctors/hospitals needs to be overhauled, perhaps putting variable monetary caps on liability. Too many doctors are quitting because of insurance/litigation issues. An issue of ‘fairness’ needs to be established.”

Simplification and Information Technology

As described in a previous section, Health Care Community Discussion participants felt that the current health care system is antiquated, which raises costs and lowers the quality of care. Many of the reports (15%) named information technology as a solution and some offered specific suggestions to address this issue. Participants who attended a forum in Prior Lake, Minnesota, recommended that the government: “Simplify medical records. Pass transactional regulations at the federal level to decrease records keeping and billing costs and develop a national standard for billing, coding and record keeping. Make medical records truly portable for patients. Make a national medical database available to providers to identify ‘best practices’ and ‘medical trends.’”

Several forums supported national disease registries and electronic medical records. The attendees at a meeting in Visalia, California, felt a need to “establish a universal health care data base for

sharing of medical information between doctors. The group discussed how pharmacists have a similar system and that it is important for doctors to be able to pull up a name and see where, why and how a patient has been treated.” Group reports suggested that this would ensure higher quality care by synthesizing patient medical history and prior testing, but cautioned that sufficient privacy measures must be undertaken. In Springfield, Missouri, a diverse gathering of health care providers and several uninsured individuals agreed, “Health records should be standardized, made electronic and secure. This will promote coordination of care, enhanced quality, and create a safer patient environment.” In Aptos, California, a registered nurses’ family gathering discussed how, “[r]equiring the use of electronic medical records should also do a great deal to promote quality health care, as long as confidentiality is protected.” Another group from Lexington, Mississippi, agreed with the idea that “all clinics, hospitals, doctor offices, pharmacies and specialty centers” should be required to have electronic medical records. EMRs [electronic medical records] can prevent duplication of services and prescriptions for conflicting medications.” A group in New Jersey suggested a “Smart Card” to “track use of medical care ... (similar to today’s Veteran’s Administration system).” Another group in Colorado Springs, Colorado, expressed, “We were impressed by the way the Veteran’s Administration already serves as a successful model, by sharing a patient’s medical information between its facilities all across the country. For example, an older veteran we know recently was given a CD of all his current VA medical records that he was able to take with him when he moved to another state and applied there for medical care. The VA is a system already in place that could show us how this sharing can work successfully.”

Participants also suggested that an online and standardized billing system would help alleviate high health care costs by eliminating unnecessary variation and confusion. At a gathering in Cheyenne, Wyoming, a group of health care providers, consumers, and community leaders agreed that there is a need to “reduce the cost of health care administration [and create a] uniform billing system; electronic claims processing; standardized health insurance industry forms and physician credential; [and] smart card technology.”

Education on Health and Wellness

Many Health Care Community Discussions emphasized the importance of education on health and wellness. Discussants believed that health reform should raise awareness about health and the health care system, support media campaigns, and train people with chronic illnesses to better manage their own care. Over one-quarter of the 3,276 reports (27%) suggested education as a health reform priority.

Roughly 12 percent of Health Care Community Discussion group reports suggested enlisting the public education system to help with disease prevention and promote healthier lifestyles. Comments centered on an underlying assumption that if people have the tools to live a healthy life, they will utilize costly medical care more appropriately. A group of 45 attendees at a Saint Louis University gathering in St. Louis, Missouri, emphasized preventive health care in schools. The group concluded, “Education about the benefits of diet, lifestyle and related approaches needs to start early – as early as grade school. Following this comment, several people spoke about the importance of the public school system as a place where such education should begin and where good habits should be formed.” A meeting moderated by a physician and attended by 150 Tallahassee, Florida residents also reported, “The participants suggested promoting healthier lifestyles by stressing this subject in the public school system, including teaching healthy eating habits, exercise, encouraging walking/ biking and consuming healthy foods.”

Health Care Community Discussion groups also suggested that education on health and wellness should not be limited to children. A pharmacist in Pinole, California, strongly advocated, “Public policy can promote healthier lifestyles by educating the public on disease prevention by providing workshops and seminars on health-related issues, promoting proper diet and exercise, and alerting the public on the health risks involved with obesity, smoking, alcohol-consumption, and other disease-causing factors.” Discussants at a home in New York, New York, also felt as though this was an important aspect to health care reform, noting: “We further believe that meaningful health care reform must include an emphasis on health education – throughout the life course – focusing on prevention and wellness. The goal is to teach people what they need to know to stay healthy and give them enough knowledge to make informed choices when they need medical care.”

In addition to school- and workshop-based education, various groups advocated for promoting healthier lifestyles through public ad campaigns and bans on “unhealthy” habits. A group of health care consumers in Arlington, Virginia, felt a need to “develop an effective health literacy campaign aimed at all segments of the population, especially parents and children. Obesity and diabetes are major areas of concern.” Likewise, in Glenwood, Colorado, participants sought to “make available free of charge to all parents information, in many formats and easily accessible, on the effects of poor lifestyle choices in food, thought and exercise and how they control what they bring into the house and what their children watch on TV.”

Several Health Care Community Discussion groups recommended targeting education on health and wellness where it may be especially beneficial. In Geneva, Illinois, a group of friends recommended implementing one Illinois program on a national scale: “Healthy Families Illinois and similar home-visiting programs...provide voluntary ‘parent-coaching’ to moms and dads of very young, at-risk kids – everything from helping parents learn how to better foster their children’s optimum growth and development, to helping them track down community-based health services they might not know about otherwise.” A Health Care Community Discussion group in Napa, California, felt as though “every hospital should have community outreach teams that teach chronically ill patients how to self manage to avoid future emergency room trips.”

Other Policies to Promote Healthy Lifestyles

Numerous Health Care Community Discussion participants recommended reaching beyond education to use policy tools to promote healthy lifestyles. In particular, groups focused on the role of healthy food and exercise in reducing obesity and preventable chronic diseases. Suggestions included providing healthier food in institutions, improving the clarity of nutrition labels, eliminating agriculture tax subsidies for unhealthy products, taxing unhealthy products, and promoting physical fitness.

Health Care Community Discussion participants frequently recommended promoting access to healthy food; it was a topic of discussion in 13 percent of groups. A group of 31 people in York, Pennsylvania, elaborated, “We discussed the school lunch program and agreed that it fails miserably in providing nutrition and instilling proper eating habits. School lunches should be part of the learning curriculum, and not for profit.” Similarly, Americans meeting in Oaxaca, Mexico, agreed,

“Unhealthy foods should be removed from institutions such as schools, prisons, medical facilities, etc.” A home gathering in Larchmont, New York, reported, “The group agrees that the country needs to treat obesity as an epidemic taking over the nation. Every dollar we spend putting apples in the hands of our youth will translate into hundreds of dollars saved in diabetes treatments, etc.” In addition to schools, discussants suggested that faith-based and social service organizations need to play a role in reforming health care. A group from Long Beach, California, stated, “Food Pantries/Food Banks - churches can provide healthy food to communities that need fresh produce and other dietary needs in place of cheap fast food.”

Some participants also provided national-level food policy recommendations. At a meeting in Boston, Massachusetts, a group of co-workers felt a need to “mandate transparent and simple-to-read and understand food labeling (include visual health rating on each product label, include markings of organic and genetically modified foods, include listing of all artificial ingredients, etc.).” Targeting agriculture subsidies was raised at a Health Care Community Discussion held in a St. Louis, Missouri restaurant: “Public policy can promote healthier lifestyles by eliminating agricultural subsidies to unhealthy crops (such as tobacco, sugar and starchy grains), increasing agricultural subsidies to healthy food crops (such as vegetables and fruits), taxing unhealthy food ingredients (such as sugar and high fructose corn syrup), promote the practice of eating unprocessed foods, promote healthy nutrition beyond the standard food pyramid, promote exercise in the workplace and homes and schools, and promote the idea that people are responsible for their health.”

Numerous Health Care Community Discussion reports suggested financial incentives for healthy behaviors and for the use of proven prevention methods. Although there was no consensus on who should receive incentives (such as employers, employees, providers, or consumers) or the type of incentive (such as tax breaks, payment incentives, lower insurance premiums/deductibles, gifts, or awards), the Health Care Community Discussions addressing this point believed that groups and individuals should be rewarded for promoting health and preventing disease. A group from Warrenton, Virginia, suggested, “The Government can offer tax deductions for healthy lifestyle choices such as health club memberships. The tax laws could be changed to ‘help’ health clubs and employer benefits such as sick days with pay and relaxation and recreation days off with pay. Employers could be offered incentives to create offices close to employees’ homes. This promotes more healthy lifestyles.”

Participants at a home in Glastonbury, Connecticut, considered changes to the health insurance system, recommending, “the new financing system will need to build in incentives that promote prevention for people across the lifespan: e.g., no co pays for preventive services; premium or co pay discounts for consumers who get the required screenings, vaccinations, and other preventive services.”

Some Health Care Community Discussions recommended financial disincentives for unhealthy behaviors. In particular, some of these groups noted that since we already have “sin taxes,” such as taxes on cigarettes, policy makers could simply make these financial disincentives greater or applicable to more areas, such as unhealthy foods. Participants at a meeting in a café in Staten Island, New York, suggested that “taxes could be raised on certain items like tobacco and sugar saturated items. The revenue raised should be used exclusively to combat these addictions, as well as to prevent, intervene, and treat the diseases they cause.” A similar idea was proposed at the Health Care Community Discussion held at a home in Lenoir City, Tennessee, where participants stated that we “need to consider taxation on unhealthy foods as well as tobacco, alcohol. Consider a ‘medical’ tax on foods and substances that are known to impair health or are known carcinogens. Proceeds could be targeted for associated treatments or research efforts.”

However, other groups expressed concern about the use of financial disincentives. A group in Grand Rapids, Michigan, noted that “Good health should be rewarded, but poor health should not be punished by health cost or discrimination.” Participants at a Topeka, Kansas, Health Care Community Discussion held at a local public library thought that: “The poor often have diet and stress they cannot control... [and] should not be punished for what they cannot control” and were also concerned about “possible discrimination against individuals with special health care needs and disabilities that cannot be address[ed] through prevention activities.” A Governor’s Island, New York, Health Care Community Discussion attended by health care and pharmaceutical consultants acknowledged the possible criticisms of financial disincentives and recommended that “Rewarding patients who lead healthier lives is more effective than punishing patients who engage in unhealthy habits (ie, healthier people pay lower premiums will be more effective v. making smokers pay higher premiums).” Others cautioned against penalizing people for problems out of their control (e.g., triggered by genetics or the environment).

A number of Health Care Community Discussion groups encouraged the promotion of physical fitness. A group of friends in Salt Lake City, Utah, suggested, “Require mandatory physical education in schools. Physical education and health classes should be required beginning in preschool and continuing through high school and perhaps college.” Participants at a health care brunch in Rockaway, New York, supported “[requiring] physical education 5 days a week in the public schools.” Recommendations extended to communities as well. In Fort Worth, Texas, discussants agreed that we need to “make neighborhoods safer so people can get out and walk; put in sidewalks in all communities; have community facilities aimed at teaching healthy behaviors.”

Expanding Health System Capacity

Delivering high-quality, affordable care to all Americans requires new insurance options, financing, and – as many Health Care Community Discussion participants noted – greater health system capacity. Reports suggested shortages in the number and types of our nation’s health care providers. Groups recommended finding ways to train more providers, to encourage them to practice in underserved areas, to expand the roles of existing providers, and to support additional community-based services.

A number of groups suggested making professional training more affordable. At a Health Care Community Discussion in Cary, Illinois, participants urged policy makers to, “Improve access to medical schools. Medical schools are so expensive that our group believes that only those in middle/upper middle class families actually aspire, and become doctors. Thus the pool of competition is decreased. Also people from more depressed areas who might be happy to work in their childhood neighborhoods, are not as likely to become doctors.” A Health Care Community Discussion in Sacramento, California, with participants of all ages, commented, “One solution would be for the government to pay for medical school, as they do in France, so that more doctors will choose Family Practice.”

Some groups suggested that a program should be established to provide tuition reimbursement for community service work. A Health Care Community Discussion held by a long-term care county agency in Binghamton, New York, favored this idea, “[Creating] a ‘Teach for America’ in the health professions. College graduates could work in community health programs to pay back loans. They

could work as aides in nursing homes and home care.” A group in the San Fernando Valley, California, also advocated this approach: “Create a ‘Health Corps’ or ‘AmeriCare’ (along the lines of the Peace Corps) not only providing new jobs but also creating a network of health care providers across the country that can deliver affordable care, conduct community outreach for education, prevention, and wellness, and flag emerging health problems as they arise.” A state psychological association held a Health Care Community Discussion in Albany, New York, and suggested, “[o]rganizing psychologists for pro bono mental health services, such as the ‘Give an Hour’ program for members of the military and their families.”

Nurses, pharmacists, and other providers who participated in the Health Care Community Discussions advocated for expanding their roles to expand primary care capacity. As articulated by a Health Care Community Discussion hosted by a chronically ill nurse in South Pasadena, California, “While doctors are a critical part of the health care system, and provide the diagnosis, treatment, and specialized knowledge that helps save lives, nurses are at the backbone of the broader health care safety net. Nurses carry their skills and knowledge wherever they go – whether into the schools, libraries, churches, mosques, parks, or neighborhoods. While there is a shortage of nurses in the country, we are a powerful enough force to effect change for the public good in a cost-effective way.” A pharmacist from El Sobrante, California, pleaded, “Please, please, as a pharmacist I ask you to engage the profession of pharmacy more in helping to promote safe, effective use of medications and minimize over-spending on medications for the entire health care system. Please use pharmacists as a very accessible entry point for many patients.” A Health Care Community Discussion group comprised of providers in Santa Fe, New Mexico, agreed with this sentiment, “Remove barriers to practice for professional providers, such as CNMs, NPs, PAs [Certified Nurse Midwives, Nurse Practitioners, and Physician Assistants], nutritionists, dental hygienists, and acupuncturists.”

Other methods of increasing capacity suggested by the Health Care Community Discussion groups included providing additional free or low-cost clinics and increasing funding for social services that target underserved areas. At a meeting in Kirksville, Missouri, participants suggested building on existing clinics, noting: “Currently one of the most effective approaches to providing universal care is that of community health centers designed to provide care for the underserved. Many of these, including our Northeast Community Health Council, are delivering quality services in a highly cost

effective manner. Rather than attempting to shift the underserved en bloc into other systems, it would be more effective to selectively build on what is already in place.” A group in Valley Village, California, favored the “Creation of a widespread network of free or low-cost community clinics staffed by paid professionals and volunteers and funded by government funds, employer contributions, and private donations.” A group in Wailuku, Hawaii, also advocated for “more community health clinics.” Participants in Bethesda, Maryland, recommended a similar idea, saying, “Hospitals should have clinics attached to them or there should be free-standing clinics (e.g., there are currently such clinics in Boston and elsewhere that are available on a walk-in basis to diagnose minor illnesses at a low cost and either treat or recommend specialty or hospital services if necessary).”

D. Relationships between Concerns and Solutions

One of the most striking results from the analysis described in this report was the lack of differences in the concerns and solutions across the country: Americans who participated in Health Care Community Discussions were generally united in what they felt was wrong with the system and the general direction on how to fix it. No significant differences were found in the results when looking at the groups’ locations by rurality, region, average income, and unemployment. As such, the information from the Health Care Community Discussions is relevant to policy makers at the local, state, and national level.

That said, some patterns emerged in the detailed analysis of the Health Care Community Discussion reports. The analysis team separately analyzed reports that were from Health Care Community Discussions where a majority of attendees were from provider groups or advocacy groups, and compared them to groups where a majority of attendees were interested citizens. Provider groups were more likely to express concerns on a number of topics. Specifically, they were more concerned about provider shortages, the lack of a “system,” inadequate research, payment rates, medical malpractice, the inefficiency of the system, and the inadequate treatment of mental health (see Figure 9).

A different pattern emerged in the comparison of topics of interest to advocacy groups and typical Americans. Health Care Community Discussions where the majority of attendees were from advocacy groups were more interested in access than average Americans and much more interested in women’s

health and comprehensive coverage. (Planned Parenthood, among other advocacy groups, recommended that its members participate in Health Care Community Discussions.) (see Figure 10).

Relationships also emerged between perceived problems of Health Care Community Discussion participants and their solutions. For example, groups that expressed concern about accessing health insurance due to pre-existing conditions, the cost of prescription drugs, and the uninsured were also concerned that a health system includes for-profit providers and insurers. Health Care Community Discussion groups that raised problems with the employer-based health care system were more likely to support a single-payer system than others. And, those groups where the cost of the entire health system was at issue were significantly more likely to support education and prevention as solutions.

E. Suggestions for Future Engagement

The Health Care Community Discussion Participant Survey solicited more than just concerns and policy solutions: it asked how policy makers should reach out to them, and what they need to do to remain involved in health reform. To help summarize the participants' thoughts on the "next steps" of the health care reform process, the Participant Survey asked, "What do you think is the best way for policy makers to develop a plan to address the health system problems?" The possible responses were:

- Community meetings like these;
- Traditional town hall meetings;
- Surveys that solicit ideas on reform;
- A White House Summit on Health Reform; and
- Congressional hearings on C-SPAN.

Among participants, the most popular way to develop a plan for health care reform is more community meetings similar to the Health Care Community Discussions. Thirty-seven percent of respondents named this as the best way for policy makers to develop a reform plan, and at over 90 percent of meetings at least one person supported this idea (see Figure 11). Participants in rural communities were slightly less likely to prefer this approach (34% support), probably due to the physical challenge of convening Health Care Community Discussion groups (Map 4). These survey results are a promising indication that participants had positive experiences at the Health Care Community Discussions.

Over one in five (21%) of the 30,603 survey respondents supported the idea of a White House Summit on Health Reform. This idea was more popular in the Midwest and the West (22%) compared to those in the Northeast (17%). Surveys to solicit ideas on health reform were supported by 18 percent of respondents. Participants in rural communities (22%) and the Northeast (20%) were more likely than other participants to prefer surveys. One in ten participants chose C-SPAN hearings as the best way to develop a plan for health care reform.

Comments on how policy makers should develop health reform plans included:

- In Gardiner, New York, a dinner gathering among friends and family concluded, “Most felt that the best way for policy makers to develop a plan to address the health system problems is through traditional town hall meetings and communications campaigns targeted to people who are uneducated about health, wellness and prevention.”
- In Tallahassee, Florida, a Prison Reform/Human Rights/Family Support advocacy group encouraged “traditional town hall meetings” and “community meetings like these whereby our government involves its people in discussions about what is best for our country.”
- At a local restaurant in Aurora, Illinois, one group felt that “community meetings, town hall meetings [and] keeping in touch with the people, the average citizens, will give the people cause for hope. Each person will begin to believe that they can help make a difference.”
- In Syracuse, New York, at a town hall meeting in a local church, participants agreed: “Local citizen participation in health planning is very important.”

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- Groups in San Bernardino, California and Watkinsville, Georgia advocated for “seeking grassroots input” and “keep[ing] the general public involved.”

Many groups provided additional comments on having the opportunity to share their thoughts and concerns with the Obama health policy team.

- In Green Acres, Washington, participants reported, “We are extremely encouraged that President-elect Obama is reaching out to all Americans rather than special interest groups to come up with a solution. More than ever, we are optimistic that this solution will be reached.”
- In Aurora, Colorado, participants at a Health Care Community Discussion organized by a community based organization “had a wonderful and meaningful discussion on health care. Everyone was engaged and appreciative to be part of the global discussions being held across the nation.”
- One group, led by a pediatrician in Tampa, Florida, said, “Thank you very much for giving us the opportunity to let our voices be heard. We are hopeful things really are going to be done differently in Washington D.C. and America from now on.”
- In Riverhead, New York, a Health Care Community Discussion host shared that participants “were all engaged and encouraged by the fact that this team actually solicited input from the populace.”

In addition to asking about what policy makers should do, the Participant Survey asked, “After this discussion, what additional input and information would best help you to continue to participate in this great debate?” The possible answers were:

- More background information on problems in the health system;
- More information on solutions for health reform;
- More stories on how the system affects real people; and

- More opportunities to discuss the issues.

Most participants (38%) wanted more information on health reform solutions as a means for continuing participation and 31 percent of respondents wanted more opportunities to discuss the issues (see Figure 12). Those in Health Care Community Discussion groups in the West (40%), rural areas (41%), and areas with per-capita income above \$45,000 (41%) were particularly interested in information about solutions (Map 5). The level of interest in opportunities to discuss the issues was constant across different types of communities. More background information on problems and more stories about how the system affects real people were selected by 18 percent and 13 percent of respondents, respectively.

Lastly, Health Care Community Discussion participants' recommendations on how to proceed with health reform related to their own concerns and interests. Among the 30,603 survey respondents, participants more interested in quality than cost were more interested in Congressional hearings and stories and less interested in community discussions like the ones that they had participated in. People who were most interested in receiving more information on solutions were less interested in opportunities to discuss the issues. Those who most wanted a White House Summit on Health Reform were the least interested in C-SPAN hearings.



Overland Park, Kansas



Pompano Beach, Florida



San Jose, California