



**Access to Health Care  
for All Vermonters**



*Beginning the  
Dialogue  
and Action*



*A Study Circles Project  
of the Vermont Ethics Network*



## VERMONT ETHICS NETWORK

The Vermont Ethics Network (VEN) is a nonprofit, educational organization working to increase public understanding of ethical issues in modern health care. It began in 1986 with a project called “Taking Steps.” For that project, forty-five diverse volunteers from all over Vermont brought a discussion on ethical issues in critical and terminal care to 4,500 Vermonters in 200 community forums. Since then, dozens of additional volunteers have participated in planning and leading VEN projects. They are the network.

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Additional copies of *Access to Health Care, Beginning the Dialogue and Action* or its companion publication *Access to Health Care, A Workbook for Community Discussion and Problem Solving* may be purchased from: Vermont Ethics Network, 89 Main Street, Drawer 20, Montpelier, VT 05620-3601 / 802-828-2909 / ven@bishca.state.vt.us / www.vtethicsnetwork.org

# Access to Health Care for All Vermonters



## *Beginning the Dialogue and Action*

What Is Access to Health Care?  
Is Health Care a Right, Responsibility or Privilege?  
Establishing Priorities, Making a Difference

A Report of the Vermont Ethics Network's  
Study Circles Project on Access to Health Care for All Vermonters  
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## Introduction and Overview

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Access to health care is at its core a medical ethics dilemma believes James Bernat, MD, a medical ethicist and former member of the Vermont Ethics Network's board of directors. This realization led him and the VEN board to pursue a project to help Vermont citizens engage in the deliberations on health care access. The Vermont Ethics Network's mission is to promote better understanding of the ethical issues, dilemmas, and choices in modern health care.

Vermont has tried to address the problem of access to health care for all Vermonters for over a decade. Ideas have emerged, been developed, and put out to the public for consideration. Some progress has occurred, yet the issues are far from resolved. Many groups — advocacy, special interest, government, business, and think tanks — have sought to define it and solve it. Providing citizens (including members of the above groups) safe, impartial, independent settings in which to come together to listen, learn, and labor as equals brings a fresh approach to the process and movement toward the goal. Study circles are designed for that purpose.

This report first explains what study circles are and how they engender deliberative conversations. Then it conveys the essence of those discussions. Participants knew their work would be featured in the report, with less emphasis on quantifying and interpreting the data. As people registered, many wanted to know that their concerns would be heard, that this project would focus on making a difference. They did not want to come just to complain; they wanted to know they were not alone in their concerns, that they were valued, and that there was real hope for change. They did not want to waste their time.

The layout of the report reflects both the process and the content of the study circles. It outlines each session, describing each session's purpose and approach and summarizing conclusions, interspersed with quotes from participants. It shows how each meeting built on previous ones to move participants forward, gain trust and respect for one another, elicit thoughtful responses, think openly, and engage group members in the problem-solving process.

## Project Background

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### Purpose

VEN undertook this study circle project to educate Vermont citizens and involve them in access to health care issues. Directors on VEN's board indicated three goals they wished to pursue. These were:

1. to **raise the public consciousness** about the many dimensions and ethical implications involved in access and choice at the societal level;
2. to develop a consensus among a broadly diverse and representative group of citizens which will **feed into the development of public policy**, and
3. to stimulate citizen input and participation to **create initiatives for action** at the local and regional level. VEN brings these discussions to the public because it believes solutions must come from informed citizens, via a democratic process.

### Rationale and Conduct

To accomplish the above goals, VEN felt it important to use a participatory process. The study circles model provided that process. Often people come to understand the ethical choices and dilemmas best when they have the opportunity to examine the issues on a personal level, hear other people's ideas, and struggle with case scenarios together in small, private, nonjudgmental groups. Once people have an understanding of the issues, they tend to be motivated to work on solutions, whether those solutions are making personal changes, working locally to improve a service, or getting involved in the political process. This project then, was a nonpartisan, open sharing among equals about matters that affect us all. Its deliberative process gets at the **broadest range of access issues**, not just the cost of health care and whether people have adequate insurance coverage. Though the cost of health care will be among many people's concerns, "it's not just about money."

Initially the project hoped to offer 40 study circles across the state to get a broad representation of Vermonters. Over the summer of 2001, a discussion workbook was developed and two pilot study circles were held. Facilitators were recruited from VEN's network of volunteers, professional social workers, and graduates of the Snelling Center for Government's Leadership Institute. They received a day and a half orientation and training for this project. Each facilitator had leeway to use the discussion guide as a starting point and to deviate from it as long as the conversations stayed productive.

A kickoff news conference, designed to be the cornerstone of the participant recruitment process, was scheduled for September 11, 2001. Because of the tragic events of that day, and the following weeks and months of societal grief, confusion, and readjustment, the project was revised. A much subdued recruitment process was developed and implemented, focusing on reaching out to groups more individually, such as business and professional groups, public health providers, and advocacy groups. Originally, all groups were to be held in the fall, as that was identified as the most opportune time for people to participate. Instead, five groups met then, and the remainder held their sessions in 2002.

After all the groups ended, an Action Forum convened on March 19, 2002 to bring together representatives from all the study circles. VEN board members, political and governmental leaders, and interested advocacy and health groups attended, as well.

### **Scope of the Information**

Because this project employed a citizen education and involvement model, and not a research model, the questions posed prompted an open-ended discussion, not concrete data or a specific prioritized plan. VEN hoped to capture the breadth and quality of people's ideas, experiences, wants, and potential directions for future solutions. Though there was no attempt to quantify people's comments, the report will show what common themes emerged and what types of action citizens wish to see happen and in which they are willing to be involved.

Many who participated work in the health care field. While this may influence their views, the emphasis was on their personal experience and ideas, not their professional work. Some participants were not associated with health care professions, and no matter what the professional background, there were diverse ideas about what makes good health care, who is responsible for it, and how we should strive to achieve it.

## What Are Study Circles?

Study circles are small group, democratic discussions that involve community members in dialogue and action on important social and political issues. They usually have 8 to 12 participants, meet over a period of weeks, are led by impartial facilitators who help manage the deliberation process, but are not experts or teachers in the traditional sense, and look at issues from many points of view. They do not require consensus, but they do uncover areas of agreement and common concern. A culminating event generally is held to bring together all participants, facilitators, and recorders, as well as staff and community people, to look at common themes and directions for action.

The key concept of study circles is to promote dialogue, not debate. Several comparisons below illustrate the difference.

In dialogue, one listens to the other side(s) in order to understand, find meaning, and find agreement.	In debate, one listens to the other side in order to find flaws and to counter its arguments.
Dialogue opens the possibility of reaching a better solution than any of the original solutions.	Debate defends one's own positions as the best solution and excludes other solutions.
Dialogue creates an open-minded attitude: an openness to being wrong and an openness to change.	Debate creates a closed-minded attitude, a determination to be right.
Dialogue assumes that many people have pieces of the answer and that together they can put them into a workable solution.	Debate assumes that there is a right answer and that someone has it.
Dialogue remains open-ended.	Debate implies a conclusion.

## The Study Circles Project: Process and Content

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During the four sessions of each study circle, group members examined their own concerns and experiences, looked at the issues from a broader, policy perspective, and discussed how they thought our health care system should be designed. They struggled with a case study, established their priorities for action, and took steps toward those priorities. In using a model that allows and supports “cordial disagreement,” people found it is possible to move beyond politics and rancor to realize that all perspectives and efforts are needed to progress toward an improved health care system. They also realized that, as individuals and small groups, they can and must be engaged in action on the individual, community, system, and societal levels.





## Session One: How have you been affected by health care in Vermont?

At this first session, participants had a chance to get to know one another, learn about study circles and this specific project, agree on some ground rules on how to talk about the issues, and start to get comfortable with participatory discussions on public issues. They shared personal experiences they had had in the health care system.

Each group suggested modifying the ground rules, which gave participants the opportunity to make the group safe and respectful for themselves, and to emphasize the importance of the upcoming conversations, to test out speaking up, and to determine whether or not the facilitator would stay out of content areas and let the group take responsibility for itself.

They considered what experiences they had had — what made them good or bad and how they influenced their general opinions about Vermont’s health care. This allowed participants to see where they had common perceptions, and what they thought were some of the serious challenges Vermonters face with access to health care. They did not mince words.

Many of the negative experiences were related to impersonal treatment, due to not enough time in a doctor’s day, being short staffed, or lack of insurance. Participants reported being yelled at by a nurse, or having a doctor be rude or use a paternalistic “doctor knows best” attitude. Some people noted that their level of care was directly related to whether or not they had insurance and what that insurance covered.

***The hospital was short staffed and I became a ‘thing.’***

***You have to advocate for yourself.***

***You need to know the tricks, how to play the game.***

Dealing with bureaucracy was a common theme. Whether it was a voice-mail service that never allowed conversation with a human, or being denied care and having to appeal, or bills not being paid in a timely manner by the insurance company, frustration with “the system” ranked high among many people’s concerns.

***I did medical billing. If I put a dot in the wrong place,  
they'd send paperwork back to me.***

***Billing is a secret code that no one understands.***

***Administrative bloat sucks up dollars.***

***Even insiders have to advocate for themselves.***

Participants related positive experiences as well.

***The VA staff is committed to serving you, honoring your service to the country.***

***My son got bitten by a dog. The owner walked away, the police weren't  
responsive. The doctor from urgent care called to see how he was.***

Being treated professionally, with kindness and sensitivity, as a partner in health care made a big difference. Having a professional available to advocate was seen as a plus. Quite a few people also cited having choices for preventive and complementary care, as well as conventional or Western treatments, as a positive experience.

***Home health nurses are like a second family. They were very responsible —  
acted as though they couldn't do enough for me. They respect people, no matter  
what their circumstances***

***The genetics/cancer center in Burlington gave very  
conscientious care and followed up with me***

Interestingly, most of the noted experiences, good or bad, concerned how people were treated. Some “good” experiences also included actual health care services or outcomes; whereas only a few of the “bad” category did so. Those few, however, presented quite serious problems. In one case, doctors disregarded a living will and advance directives; in another, minor topical surgery with aftercare for 3 weeks became 2 years of painful treatment with the patient addicted to pain killers because of bad care; and in a third case, procedures were administered insensitively. Affordability and availability of insurance concerned many. By the end of the session, participants were genuinely interested in each other's stories and had formed a common bond and purpose.

***I am deaf, without a hearing aid, and couldn't get it taken care of while  
I was in a hospital. There was no one to tell. I was afraid and I won't go back  
to [that facility] — I would die first.***

Doctors who participated acknowledged that their degrees opened doors. Others noted that because they had good insurance or not many health problems, they were unaware of the problems others encounter. One participant noted a paradox: We spend a million dollars on treatment for complex health care when death is inevitable and natural.

***I've witnessed a peaceful death at the hands of the system,  
and a violent death in the system.***

***It is an illness treatment system, not a health care system.***

***It is a group of fiefdoms, not a system.***

When participants were asked to identify what they thought of as the most serious concerns we face in the health care system, the following items were mentioned: capital expense for new technology, general overall costs, prescription costs, bureaucracy, dental care, staff shortages, finite resources, follow-up care, changing public perception of rights and responsibilities — the need for a culture shift, long-term care for catastrophic injury and illness, and the need to broaden health care to include holistic, preventive, home care, and patient education.

***One size does not fit all — for care, for outreach, for health promotion.***



## Session Two: Core questions about health care and access

In session two, participants moved from personal experiences to the challenge of examining complex policy issues and tolerating differing opinions. Drawing on their common bonds and expanded awareness, they struggled to decide if health care is a right, responsibility, or privilege, to define health, health care, and access, and to look at what reali-

ties exist in their communities. The questions promoted critical thinking, consideration of difficult issues beyond the personal level, and how to minimize political “hot button” terms.

### **Is health care a right, responsibility, or privilege?**

*It's all three.*

*It's a right that needs stewardship.*

*A privilege is something you can live without. If I'm having a heart attack, it's not a privilege to have health care.*

*It's a responsibility, and people need to maintain a healthy lifestyle.*

*They are interconnected.*

*Health care is a right and society has to find a way to provide it.*

*Personal responsibility is essential.*

This last comment illustrates how important many participants felt it was to link rights and responsibilities.

Discussion included the following points: health care should be a right without discrimination; several people felt it should be

*“like Act 60,” where everyone has some basic level of care provided by state funding and should pay for anything above that.*

Analogies also were drawn to other societal infrastructures such as highways. Others were not so sure:

***Universal access is an extraordinary goal —  
there needs to be continued discussion and debate.***

Some people felt that the responsibility belongs to the community and to society. Schools were seen as a place where health education and preventive care could be provided.

***Does a healthy democracy require enhanced health care?***

***Communities, regions, states, the country have a responsibility to take care of their citizens so as to not be a drain on the system.***

Other participants focused on the individual responsibilities each member of society has to take care of him- or herself. Though people acknowledged that it would be difficult to monitor, evaluate, and judge people's right to access based on personal behavior, they did feel emphasis should be placed on this aspect. Concern was expressed especially around drinking, drugging, nutrition, and exercise. A few people mentioned physically risky activities, such as riding a motorcycle without a helmet, skydiving, and dangerous sports.

***Some limits help me take responsibility. For example, if I know bypass surgery will be available, I might not eat as healthily.***

Many of the study circles looked at rationing — that is, making rational, thoughtful decisions about where society's health care dollars should be spent, both in a general and specific sense. This applied to many areas such as hospital expenditures, preventive care, research, unproven or new treatments, and end-of-life care. Preventive care and primary care should be accessible to all; beyond that, there was no consensus concerning allocation of health care dollars.

***Where do we cut back?***

***We have to accept that we can't get everything we want.***

Other factors affect access, as well. The more common barriers participants identified included transportation, lack of doctors (and other providers) in their area, providers who did not take their insurance or Dr. Dynasaur (a Vermont health insurance for children), lack of interpreters for people who use sign language or speak another language, and cultural practices, such as the stoic New England attitude of not seeking help until a major problem has developed

Knowledge of available services, programs and health care information, of how things work now, and of government processes varied among people. All felt it was useful to share what they knew, and several people found ways to meet their needs as a result of the discussions. Participants in some groups disagreed about what was the correct information, and in most groups, participants did not know where to get information.



## **Session Three:** What structures, principles, and values does our health care system need?

During the third session, participants worked to identify structures, principles, and values needed in our health care system through two activities. First, they discussed a case study crafted to touch on many of the ethical dilemmas facing us individually and as a society. Then they articulated what features the “ideal” health care system would have. These opportunities not only allowed them to voice their wishes, but to experience the difficulties in planning for health care needs.

### **We asked about an ideal health care system:**

- What services and facilities should be in it?
- Where should they be located?
- What hours should they be open?
- Why should the services be part of the system?
- What organizations should administer the system?
- How should the services be paid for?
- Who gets to use the services?
- How do you actually move through the system?
- How should the parts be connected?
- How would someone know how to use it?
- How do you resolve conflicting values?
- Given realities of choice, limits, and cost, what would the best possible health care system look like?

A common theme was that a broad spectrum of preventive and primary care and health education services should be available to all. Some believe it is especially important to include dental, vision and eye care, hearing, mental health, and substance abuse treatment among these core services. Most people mentioned that some sort of an advocate, or case manager or primary care provider, whose responsibility was to the consumer, and not the organization providing or paying for the service — was very important, as was consumer autonomy in choosing providers and making health care decisions.

A variety of specific ideas came up that would provide topics for further discussion.

### **Several dilemmas arose:**

- Some people are forced to choose between health care or heat or food.
- How do we, as a society, deal with young people who feel invincible? They won't purchase insurance, and they engage in risky behaviors.
- Most people felt health care should not be tied to employment, yet it is not clear how to fund, manage, and provide it..
- How much should we focus on life-saving, versus life-enhancing, care and services?

### **A broad spectrum of ideas emerged regarding an improved health care system:**

- Provide health care choices for Western, Eastern, and alternative or complementary medicine.
- Subsidize schooling for providers (medical/nursing school education) so they aren't burdened with debt.
- Model a new system after the original health maintenance organizations (HMO) of the 1940s and 1950s.
- Establish statewide standards of care.
- Reach out more to men.
- Provide more hospice and long-term care services.
- Provide family lodging and other services on site, especially for hospital care.
- Establish a health care bill of rights and responsibilities.
- Locate primary care services in or near shopping areas, and be open more hours.
- Assign everyone a case manager or advocate for their needs.
- Use more telemedicine.

- Educate people better about health care costs and other factors involved in policy development.
- Streamline the bureaucracy.
- Provide a warm, sensitive environment for care settings.
- Make second opinions more readily available.
- Have a single point of intake, information, and referral.
- Promote more neighbors helping neighbors.
- Use the existing public health system structures; improve and expand them.
- Use schools for prevention, screening, education; have healthy food in schools.

Conflicting ideas about how to pay for and ration care were suggested.

**Principles and values people wanted to see reflected included the following:**

- Prevention, wellness promotion, and primary care available to all.
- Everyone needs to help pay for the system.
- The system should be citizen controlled; there should be a statewide public process that includes a vote, to set health care priorities.
- Support patient decision making.
- Research should be guided by other than market value.
- Death is a natural part of life, not something to be avoided at all costs.
- Each person needs to make a difference; for example, taking responsibility for behavior, practitioner accountability.
- Privacy and confidentiality protected.



## Session Four: Establishing priorities and making a difference

For the final session, questions led participants to think about and own what **they** would like to do to move the issue forward. Because this project is based on citizen involvement, it needed to end in a way that “left the ball in their court.” While VEN can help communicate the results of the project to government officials and health care organizations,

ultimately citizens must become more involved. Focusing on citizen action, therefore, was the most important aspect of this meeting. We asked:

- Who would you want to talk to about improving access to health care and what would you want to say?
- Of all the concerns raised in your study circle, what would you most like to work on?
- What can you do as an individual to make a difference? Why is this important to you?
- What can you do if you work together as a group?
- How can you build on existing efforts to make health care accessible to all Vermonters? Who is involved? Who else should be involved?
- What knowledge and information do you want to have? How might you go about getting that? What help do you need to get it?
- What two or three ideas for addressing access to health care for all Vermonters does your group want taken forward to the forums, to policy makers, and to be included in the final report?

*Facilitators, recorders, and participants  
at the training on September 6-7, 2001,  
and the Action Forum on March 19, 2002.*



## Summaries from Each Study Circle

Each study circle was asked to come up with a few main points to be included in the final report and brought to the Action Forum. Participants were assured their reports would be reproduced here as closely as possible to the original they supplied.

### Barre

1. Start with a truly universal health system.
2. Establish a single-payer, tax-supported system.
3. Emphasize prevention and health promotion.
4. Develop a public process for setting health care priorities.
5. Disentangle employment and health care, business and health care.

### Bellows Falls

1. There is a need for concrete information in all aspects of health care: services in area, choices in treatment, health education, insurance.
2. People should have access to a spectrum of health care — complementary, preventive, urgent care, etc.
3. Communication needs to be improved, especially between consumer and provider. A concern is arising about ethical conflicts between communicating information quickly and globally to the benefit of health care consumers and providers on the one hand, and right to privacy and confidentiality on the other.

### Bennington

1. There needs to be access, education and cooperation among all providers so people can have choices including Western and complementary options.
2. Case management /advocate/resource educator who is on the consumer's side, not a bureaucrat or gatekeeper, who can bring information to the consumer and provide guidance and individualized support to the consumer so he or she may make informed decisions and get the care needed.
3. Increased funding to provide adequate reimbursement to providers to cover costs for everyone including the general population, the untended population, and marginalized folks no matter the source of payment.

## **Brandon**

1. Strongly support universal health care — see it as a federal issue though: Vermont is a small state, and if we try to tackle it ourselves may have too many problems, such as providers leaving.
2. Pharmaceutical expense makes medication not accessible due to insurance not covering it, especially for the elderly and people with mental health difficulties.
3. Concerned about health care for prisoners: Do they get adequate care, especially for mental health needs and substance abuse problems?
4. Limited access to and choice of doctors in small communities.
5. Access to dental care is a concern — don't have insurance, can't afford out of pocket.

## **Brattleboro**

1. Influence policy makers: invite politicians to meetings of concerned citizens and businesspeople. Pressure, education, information dissemination, and accountability are key efforts in this area
2. Personal action plans:
  - a. Create a local newspaper column devoted to the real-life stories of folks struggling with the current system. This has been implemented and is happening with two group members.
  - b. Mobilize people to engage in the efforts toward health care improvement before it affects them personally.
  - c. Mobilize members of the nursing profession to advocate for change.
3. Create a viable mechanism to reach out to nonengaged groups.

## **Burlington (summer)**

1. Action after the study circle can take many forms. For some it means volunteering in agencies. Others want more time to ponder the questions raised in the discussions, especially, what is the value of life? Political activities — serving in the legislature, lobbying the legislature — are important to a few.
2. Communication among and education of patients and providers, especially, but also insurance companies needs to improve.

## **Burlington (fall)**

What do we want?

Health care in Vermont will be provided as universal comprehensive coverage, probably through a state government-administered single-payer method that coordinates care utilizing a network of primary care practices. Personal decision-making will be preserved in the health care process. Dignity and respect will be key values in the delivery of quality services. A successful health care system will include a strong prevention and education focus. Pharmaceutical, mental health, chiropractic, and nontraditional options for care need to be elements of comprehensive coverage in one way or another. Long-term care must be an element of comprehensive coverage. It is a key health care challenge both for quality and cost. Ongoing administration of a Vermont health care plan needs to provide for a clear avenue of public assessment and citizen participation in the process. Vermont health care cannot be second rate. First-rate health care will measure success by the quality of care for the majority of people and not by an assessment of the pinnacle of care possible in a few cases or specific medical procedures.

### **Burlington (winter)**

1. A statewide, comprehensive, long term process needs to be designed and implemented to educate citizens and have them come to a consensus about what the health care system should be in Vermont.
2. Our group thinks there should be a real system that provides health care for all that maintains quality and has economic efficiency.
3. There needs to be public accountability of health care in Vermont.
4. Consumers need better information/education and advocacy.
5. The “industry” of health care and pharmaceuticals gets in the way of sound decision making.
6. Alternatives to treating people with pharmaceuticals should be emphasized and covered.
7. Resources need to be shared and we all need to make sacrifices.

### **Essex Jct.**

Every person in Vermont should have an individualized health plan.

1. Characteristics:
  - a. focus on building health
  - b. identify risk factors
  - c. identify wellness goals
  - d. screen for pathology as well as strengths
  - e. the plan moves people toward optimal functioning (physical, mental, spiritual)

- f. the plan is not static: “continuous quality improvement”
- g. the plan develops in partnership with individuals and experts
- h. personal ownership of the plan is vital

2. How to implement:

- a. should be multiple ways to access/develop a personal wellness plan
- b. most people develop these plans with their primary care providers
- c. other ways to develop a wellness plan could be through the Internet and other computer technology/resource center at libraries/informal support groups
- d. wellness model currently being developed by Vermont pediatricians could be expanded to include adult patients
- e. pilot this approach to study the effects on a small population
- f. medical leadership needs to endorse idea of an individualized health plan and organize providers
- g. the concept probably requires a cultural change (beginning with children)
- h. can build on self-help models and computer/Internet technology for some adults.

**Fairlee**

1. Our current system focuses on providing insurance, not providing health care.
2. Legislators are a weak link and yet they control the decision making.
3. Need easier public access to data – not buried in agency “protection.”
4. Need further information (in a matrix) to compare various health care systems around the world.

	<i>UK</i>	<i>Canada</i>	<i>Sweden</i>	<i>Norway</i>
Issues of care				
Self-employed				
Long-term care				
Funding: percent of health care of GNP				
Drug addiction				
Public/private funding				
Hospice: end-of-life care				
Taxation: gas, tobacco, alcohol, etc.				

## Irasburg

Problems with the health care system are numerous and diverse; ideas to address these problems are likewise. The task at hand – generating ideas to improve access to health care – requires an understanding of the fundamental features of the health system that leads to these problems and not responding to each problem, one at a time, without an awareness of the fundamental causal relationships.

1. The goal of the health care system should be optimal health for all citizens. The current health system is primarily focused on responding to disease and important factors that promote health extend well beyond the domain of the health system.
2. Everyone will need the health system at some time so there must be universal access.
3. Moving beyond the current system and its numerous limitations requires change and change requires leadership.
4. Leadership should have face-to-face accountability to its citizens.
5. We would like to see the following three structural changes:
  - a. An accountable leader, a *physician general*, to steward the changes necessary to pursue optimal health for all citizens.
  - b. A health care information system that will provide accurate and relevant information to all decision makers: providers, patients, policy makers, managers.
  - c. A health policy council to weight the costs, risks, and benefits of health policy decisions in pursuit of the goal of accessible health care for all citizens.

## Montpelier

1. Our society needs to adopt a more expansive view of what constitutes health care.
  - a. Current system focuses too heavily on treatment of disease.
  - b. We need to individualize care and increase prevention, maintenance, complementary services, and education.
2. We need to view health care as both a collective and an individual responsibility.
  - a. Collective Responsibility
    - i. We need to recognize that, in the end, we all pay for the health care of each other either through increased insurance premiums, out-of-pocket expenses and/or taxes.

ii. The public good is served by having all individuals covered with, at the least, a catastrophic policy with a substantial deductible (e.g., \$2000), with a share of the premium paid with state funds. An individual or family's ability to pay would form the basis for the amount of the state subsidy.

iii. In concert with that, we need to have a public discussion regarding what we, as a society, can afford to pay for health care for our citizens. That discussion should not be any different than the discussions we have at town meetings about town and school budgets. Some members expressed a willingness to adopt explicit rationing of health care, similar to Oregon, but that did not target the poor only.

iv. The group felt that consumers, employers, hospitals, and providers could probably agree on 80 percent of what needs to happen to fix the system if they put aside their various fears and competition and focus on their common needs and goals.

b. Individual Responsibility

i. There needs to be more emphasis placed on health care education, prevention, and maintenance.

ii. Consumers also need to be more informed about the costs and quality of a particular procedure, medicine, or practitioner in order to fulfill their fair share of responsibility.

## Randolph

1. In a rural state, transportation needs must be addressed as part of access to health care.
2. Prescriptions are not affordable.
3. We believe the system is reaching a breaking point.
4. A grassroots process needs to happen to bring about change.
5. Real planning for funding needs to be done.
6. The public needs better education about healthy choices.

## Rutland (fall)

1. Universal coverage is a priority.
2. Work on a benefits package allowed by available funds. Assumption that savings are available if we move to single payer and if Vermont covers basic package. Expenses over and above will be covered by insurance. Unresolved: whether there should be a gradual or radical approach in implementing the change.
3. Concern about the overlap among nonprofit and other service providers

## Rutland (winter)

1. There should be basic care for everyone, based on medical needs, especially routine and preventive health services, regardless of ability to pay.
2. Intake should be centralized: one stop shopping for any medical or related need from which assessment and appropriate and timely referral would be made.
3. Education should be offered at all levels to emphasize personal responsibility about health care and insurance or coverage.
4. Health care should be acknowledged as a major economic component of our society without judgment as to whether that is bad, good, or indifferent.

## Shelburne

1. Everyone get access to some basic level of care with some cap; people should be able to buy any higher level they wish to and can afford.
2. People need to be responsible for their care and healthy behaviors. People should be screened very thoroughly before granting transplants.
3. Health education should be emphasized (and providers need more education on this themselves)
4. We are concerned about lack of choice in a system similar to Canada or the United Kingdom
5. Everyone needs to pay into the health care system, similar to social security.
6. Reinstigate physical education as it was taught in the 1960s in schools.

## Stowe

The Stowe study circle sent a letter to their local hospital. The following points were in it.

1. Care:
  - a. The process the patient goes through is as important as the outcome.
  - b. Patients want the system to treat the whole person; a more holistic approach.
  - c. A warmer, more patient- and family-centered environment is needed.
  - d. There is a feeling that care out of state is a higher quality.
2. Access:
  - a. More convenient clinic hours.
  - b. Option of affordable clinics for the uninsured.

3. Education:
  - a. More public awareness of available social services programs.
  - b. Support of nursing programs (to help offset the low enrollments).
  - c. Physician and Hospital waiting rooms should display patient bill of rights.
  - d. Health education/prevention brought into schools earlier.
4. Cost:
  - a. Though this was seen as one of the largest problems, it was difficult to pinpoint due to the complexities of today's systems.
  - b. Current cost is prohibitive for small employers and therefore a large percentage of Vermonters.
  - c. Growing legal issues and high cost of liability insurance seen as a large part of the cost problem.
5. Process:
  - a. Health care has become a service industry.
  - b. Both patients and providers overwhelmed with paperwork: Where can it be streamlined and made more efficient?
  - c. The need to maintain more privacy and confidentiality (especially given the small community environment).

## **Swanton**

(No written report submitted.)

## **White River Jct.**

1. We would like to speak to the Vermont Association of Health Care Systems, the Vermont Medical Society, academic institutions, and consumers of health care. We need to ask candidates for state offices and the legislature to be explicit about what they will do to change health care systems.
2. Public health education at an early age should be part of the school curriculum. Laura Bush needs to lead the new Public Health curriculum.
3. School should model health behavior and bring this education to families. We should try to impact the critical decision-making skills to affect lifestyle choices: target media by reducing media's ability to stimulate unhealthy behaviors by manipulating children's choices and reduce direct-marketing of pharmaceuticals to consumers.
4. Get fresh ideas from younger and newer health care professionals. Stimulate them to think about changes needed to the health care system and the effects on their careers.

5. Staff community health care centers with physician assistants, nurse practitioners, and nurses for primary care services.

## Wilmington

1. We want a ***universal, single-payer, primary health care system*** to be established.
2. We will achieve this through ground-level lobbying to our neighbors and friends in terms that can be understood fully by all.
3. We want there to be education for the public about preventive health care, and for our community through public forums.
4. We are embarrassed at the alarmingly high number of Vermonters who do not have health care coverage.

# Action Forum

*Vermont Technical College, Old Dorm Conference Room  
Randolph, Vermont  
March 19, 2002*

Approximately 100 participants, facilitators, recorders and invited guests came together in Randolph, the geographic center of Vermont, to share their points from their final sessions, to network, and to identify what common themes they found among their groups.

Several issues emerged as important to the participants:

- 1. Need to increase citizen participation;**
- 2. The lack of a true health care system;**
- 3. Some basic coverage for everyone; and**
- 4. Prevention services and a focus on health and well-being.**

Smaller breakout groups met to discuss ideas for action in these four areas.

## I. CITIZEN PARTICIPATION INCREASED

*Is the goal to engage the public or to pick a goal to advance?*

Citizen participation focused on two areas: having more study circles-type meetings around the state where people can become more informed and discuss ideas and having people work toward specific goals through political action. Some people know already what they'd like to see and want to work for, while others believe more discussion and education about access to health care is needed.

*When is it time to have a single voice?*

For those who did have specific ideas and solutions to promote, ideas for action centered around communicating with legislators, working on political campaigns, forming a citizens' lobby, and sending letters to local health care institutions stating values and concerns

People who wished to see increased public dialogue want a formal, comprehensive process created that gives citizens an ongoing voice. People want to have a say in deciding priorities, examining issues, and holding the system

accountable. *They want an informed dialogue with hard data.* Some of the questions they'd like discussed are: What do we wish for in a health care system with no limitations? What don't we like? What are the real costs? What is working in the health care system? Many participants felt the study circles model should be used. They also want to hear candidates discuss the *Lewin Report* (about the feasibility and cost savings of a single-payer health system) and debate it from either side to show they understand the complexities.

***Why engage more people?***

***How should we get more people involved?***

Study circle participants believe a greater number of people should be involved because the larger the public voice, the greater the impact on policy and legislation. They want politicians to get their information from citizens, not lobbyists. They agreed with the saying, *"A leader is someone who finds a parade and goes to the head of it,"* and felt it was important to have many citizens in the parade so politicians would want to lead it. Some suggested that a variety of methods be used to get people interested. Though the study circles model was seen as a good one, not everyone wants to come to a structured discussion. *Preventing the marginalization of certain voices was important.* People felt whatever the methods, a long period of time would be required to promote more in-depth thinking and to get people connected to one another. In pursuing something over time, however, people still felt the discussions should be focused and time limited. Finally, they wanted *a way for all groups interested in access to health care to stay connected in some sort of a collaborative consortium.*

***With greater numbers, we can discover what our shared goals are,  
and we can shift the balance of power.***

## II. PREVENTION — EMPHASIS ON HEALTH

- Create a comprehensive health information system.
- Use schools as focal points for health education/information.
- Expand public nutrition programs through schools.
- Educate public re: healthy lifestyles.
- Place more emphasis on holistic health.

### III. CREATING AND MAINTAINING WELL-BEING

Participants in this group discussion focused on actions they could take individually and locally. They suggested the following :

1. Go back to communities and get dialogue started.
2. Go to groups we belong to.
3. Go to places of employment.
4. Go to schools and school boards.
5. Go to the health department.
6. Involve youth.

#### **Accomplishments they would strive for included:**

- Dissemination of information to general public (Healthy Vermonters 2010).
- Feedback: follow-up longitudinal study.
- Influence fast food places to offer more healthy choices.
- Begin good health education at early age.
- Offer incentives.
- Understand diverse belief systems and cultural differences.
- Identify target populations and develop messages and approaches specifically for them.
- Support groups .
- Improve quality of school lunches: get junk-food vending machines out of schools.
- Collect data on each issue: knowledge, attitude, practice.
- Encourage local dialogue.
- Encourage a community approach: community-run services.
- Get involved in environmental improvement issues (individuals and communities).
- Support movement for preventive approach and alternative approaches to medical treatment via medical school curricula.
- Open up dialogue about death and quality of life.
- Education support: durable power of attorney and living will.
- Re-educate physicians to address sensitive issues.

## IV. LACK OF A SYSTEM – EVERYONE COVERED

Many participants at the Action Forum noted that health care currently is not organized in a system. From the different groups, the following concepts and questions emerged.

### Specific features a system might have:

- Create a personal health plan for every Vermonter.
- Have a case manager for every person.
- Elect a *physician general* for state of Vermont.
- Set targets and goals for the health care system.
- Establish communication access for all Vermonters.
- Create a plan to reduce administrative cost.
- Set up drop-in centers for non-emergency care.
- Separate insurance and health care from employment.
- Create a single-payer system. (H.54 would establish a 3-person panel to design a system.)

### Questions to answer:

- Who is everyone?
- What are health services?
- What is the system?
- Service provided how?
- Single payer?
- What are core services?
- Should core-services decisions be evidence-based, focused on prevention and early life, and consider the total burden of an illness?
- Who decides?
- What are the criteria?
- Rationing: How are priorities set? Age? Risk?

### Information needed:

- Priority List — Oregon
- Use for selection of service
- Primary care needs
- Standards of care vary

### **Processes:**

- Decisions
- Commission
- Elective process
- Public needs ability to inform the legislature

### **Next steps:**

- Small group to determine priority list of core benefits. Group should represent a cross-section: doctors, senior citizens, people with disabilities, etc.
- Establish a time limit to small group process.
- From small group move to legislature, public forums.

This small group should propose highest priority service (2 to 3) to be implemented by legislature within 2 years.

- Call for a formally recognized major statewide study circle project, perhaps by the legislature, to provide support and visibility.
- Agree to process before discussion begins.
- Recruit leadership.
- Invite candidates for governor into the discussion.

The final exercise in the Action Forum was to look to the future. Participants decided what actions made sense for each of them to take and shared those decisions with someone else in the room. They then reviewed the various areas in which people could make a difference – individual, community, systems, and societal levels – and were asked to indicate which areas they were going to work within. All sectors were indicated. The point was made that it takes action at all levels to make changes.

***Just because action starts doesn't mean dialogue should stop.***

## Discussion and Conclusion

Accomplishing the three goals identified by the Vermont Ethics Network comprehensively across the state is an ambitious project. VEN sought to:

**1. Raise public consciousness** about the many dimensions and ethical implications involved in access and choices made at the societal level.

Participants delved into the subject matter, had respectful disagreements, and came to appreciate the complexities of and difference of opinions on access to health care issues. Many felt that this project should serve as a beginning and that much more conversation, information, and movement are needed for themselves as well as the rest of their fellow Vermonters.

**2. Develop a consensus** among a broadly diverse and representative group of citizens which will *feed into the development of public policy*.

There were several factors on which many participants were able to reach general agreement. Access to some basic level of care (though they could not come to a common definition) they accepted almost unanimously. Realizing that access is connected to employment troubled most people. That health care is both a right and a responsibility made sense to just about everyone. Paperwork, bureaucratic processes, and difficulty in navigating the system vexed and angered people.

**3. Stimulate citizen input** and participation to *create initiatives for action at the local and regional level*.

As evidenced by (1) serious conversations that took place in the groups, (2) over one third of the participants taking a full day to attend the Action Forum, and (3) 10 percent (who could not attend the action forum) writing out detailed comments to contribute to it, the project did inspire participants to become more active. In addition to the efforts during the study circles project, several groups decided to meet at least once, and one on an ongoing basis, after the formal study circle ended. Several people wrote up their thoughts into essays and formal statements to share with others. During the Action Forum, quite a few of the participants connected with other organizations to join their efforts. Some participants agreed to stay in touch with each other.

Thematically, addressing issues of **respectful treatment**, providing **opportunities for participation** in ongoing system reform, and **developing objectives for basic universal health care** appeared to be what most study circles participants want to see happen.

The challenge for policy makers will be to articulate strategies to help address these thematic concerns. Ongoing dialogues, such as study circles, can help bring people together in nonjudgmental and nonadversarial ways to craft solutions together.

If some form of rationing or limit-setting is required, the public clearly wants a deliberative, participatory role in the process that goes beyond incremental reform or subtle shifts in priorities at the legislative level alone.

If there is no other message readers of this report receive, we hope they will come to appreciate and respect how important this type of project is as opposed to scientific surveys that catch people one moment in time and do not ask them to make educated, deliberative responses or participate in a democratic process. This study circles project helped everyday people examine the health care problem, begin to understand the many aspects of the issue, and find out how they can have a constructive impact on addressing the problems as well as understand the realities, the imperfections, the joys, and the incredible power of participatory democracy.

## Acknowledgments

The Study Circles Project of the Vermont Ethics Network (VEN) would not have been possible without the commitment and enthusiasm of so many people, including the 142 participants. To them, especially, we dedicate this report and say thank you!

VEN thanks the volunteer facilitators and recorders who agreed to give of their time and skills for this study circle project. They were a resource and inspiration. Recorders and facilitators are listed in Appendix A.

We thank the many Vermont facilities and organizations that allowed us to use their spaces at little or no charge for our community study circles. All locations are noted in Appendix B.

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Much appreciation is due the current and former VEN board members involved in the project for their inspiration, participation and support.

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We thank Andrea S. McAuslan, who served as Project Director and collaborated with VEN Executive Director John Campbell, and Jim Mullally, VEN Staff Assistant, for his many extra hours of administrative support.

APPENDIX A

## Facilitators and Recorders

Gloria Alexander  
Robert Atherton  
Lori Baker  
Mary Belenky  
Carol Bennett  
John Campbell  
Michelle Champoux  
Laurie Crosby  
Erin Dean  
Jim Dean  
Judy Edwards  
Joanne Fedele  
Jennifer Fitzgerald  
Stuart Friedman  
Eddie Gale  
Larry Goetschius

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Mary Mazzariello  
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Patrick McKee  
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Margaret Miller  
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Eric T. Osgood  
Gayle Ottmann  
Anne Peyton  
Donna Reback  
Mel Richardson  
Steve Schapiro  
Robert Swartz  
Maureen Tremblay  
Kevin Veller  
Maureen Wilson

## APPENDIX B

# Locations and Facilities

### Study Circles

Barre — Aldrich Public Library  
Bellows Falls — Parks Place  
Bennington — Second Congregational Church  
Brandon — Neshobe Family Network and Brandon Public Library  
Brattleboro — Brattleboro Senior Center and Brooks Memorial Library  
Burlington (summer) — United Way of Chittenden County  
Burlington (fall) — Lake Champlain Chamber of Commerce  
Burlington (winter) — Fletcher Free Library  
Essex Junction — Essex Junction Recreation Center  
Fairlee — Upper Valley Ambulance (Fire Department)  
Irasburg — Office of Robert R. Holland, MD  
Montpelier — Vermont Center for Independent Living  
Randolph — Clara Martin Center  
Rutland (fall) — Rutland Senior Center  
Rutland (winter) — Community College of Vermont  
Shelburne — Trinity Episcopal Church  
Stowe — Stowe Elementary School  
Swanton — Abenaki Learning Center  
White River Junction — Bugbee Senior Center  
Wilmington — Pettee Memorial Library

### Planning and Other Meetings

Berlin — Central Vermont Medical Center  
Essex Junction — Village of Essex Junction Offices  
Montpelier — University of Vermont  
Randolph — Vermont Technical College

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