

Vermonters Working Together and Speaking Out on Health Care Reform



A report from a public engagement process
on behalf of the Vermont legislature
Fall 2005

&

A guide to continuing the conversation
so that citizens and stakeholders stay
constructively engaged in the future



In arguing about the meaning of ideals, we're required to talk about what we mean by these vague words . . . we're required to justify our own political wishes as something more than self-interest, and we must be open to seeing alternative points of view if we hope to persuade those who disagree.

Deborah Stone, *Policy Paradox* (2002)

This publication aims to further the process of civic dialogue, sharing information, listening and asking for clarification in a search for shared understanding, and reflection on the potential of any specific health care reform proposal to create a new system that meets the needs of Vermonters. Transforming the system so that it can best serve the citizens of this state will not happen in one or even two easy steps. It will be the result of continuing the work and conversation of many Vermonters, over a number of years.

The Snelling Center would like to thank the many courageous Vermonters who participated in the public engagement process during the fall of 2005, who have attended the numerous public hearings over the years, who have come to Montpelier to meet with policy makers and legislative committees, who have written letters and notes, who have sent faxes and emails, who have shared their personal stories and experiences, and who all believe that we, as Vermonters, can collectively strive to do better to provide for the health and general welfare of our fellow citizens.

This report was produced by The Snelling Center for Government. Primary authors are Heidi Klein, Glenn McRae and Jan Eastman. The findings, quotations and messages were derived from the public engagement process designed and carried out by The Snelling Center on behalf of the legislature in October and November 2005. The complete report of those findings is available at <http://www.snellingcenter.org/ppol.html>. The statements and opinions expressed (other than those directly attributed to participants in the process) are solely those of the authors and do not intend to represent those of any other group or of the Vermont legislature. Funding for this publication was provided by private donations.

INTRODUCTION

This publication offers a summary of the public engagement process organized by The Snelling Center for Government on behalf of the Vermont legislature during the fall of 2005. The goal was to create opportunities for legislators and a wide group of Vermonters to work together to understand the current health care delivery and financing system, to grapple with the complexity and contradictions in providing health care, and to share their values and opinions related to system reform. The process included six regional sessions involving more than 800 Vermonters.

The pages that follow include a description of the process used to move conversation outside the statehouse; the information shared about the critical “drivers” behind health care reform; what was heard from participants — the urgency for reform and openness for change; and what was learned about the importance of perspective, shared language and shared understanding. Most importantly, this publication offers principles to consider in moving forward and proposes questions to ask as the conversation on health care reform continues.

What We Learned: Perhaps our greatest learning through this process is that while Vermonters share a sense of urgency for change we do not share a language for talking about the reasons for change or potential solutions. Some terms — access, choice, responsibility — mean very different things to different people and create confusion. Other terms — universal access, single payer — have become so highly charged, or laden with assumption, that they immediately stop any discussion or dialogue. We must be careful to define our terms, explain our assumptions, and listen openly if we are to be able to continue a dialogue that moves us towards identifying acceptable changes in our health care system. As citizens, legislators and policy makers we need to be dedicated to building a common language and understanding.

What We Heard: There was less agreement on the specifics, but there was a strong sense that Vermonters by and large agree that:

- *No Vermonters should be denied access to health care and health care should be more than basic or emergency care.*
- *Everyone should participate in the system.*
- *Everyone should contribute financially in some way.*
- *Rising costs jeopardize access and quality for all and specific actions need to be taken to reduce cost increases.*
- *The quality of health care in the state is basically good and system reform should not jeopardize that quality.*
- *Keep the network of community hospitals strong.*

Our job as citizens, collectively and individually, is to stay informed and engaged. No matter what changes and progress are made in 2006, it will be just a step forward, not a final solution. Your voice needs to continue to be heard and there are many vehicles for that to happen.

- Stay in touch with your legislator.
- Attend community forums on health care.
- Join an appropriate citizens, business or professional organization and be part of the process working with your peers.
- Ask questions of candidates in the fall elections.

Glossary

Common terms in health care reform

access An individual's ability to obtain appropriate health care services.

benefits The health care services provided under terms of a contract

capitation A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is most often associated with health maintenance organizations.

care management A process to improve the quality of care by studying variations in and outcomes for current practice in the care of specific health conditions. Changes in care are designed to reduce the variations, optimize the use of generalists and specialists, and to measure and improve the outcome.

case management The monitoring and coordination of treatment rendered to patients.

catastrophic health insurance Health insurance that provides protection against the high cost of treating severe or lengthy illnesses or disability.

chronic care Care and treatment rendered to individuals whose health problems are of a long-term and enduring nature.

chronic disease A disease that has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation or care.

BACKGROUND

Vermont legislators have spent an enormous amount of time learning and analyzing issues in an attempt to design a new health care system. The Principles of Health Care Reform, established by Coalition 21—a broad-based group with participants from advocacy organizations, service providers and private business — served as a foundation for the proposed changes.

Principles of Health Care Reform in Vermont Established by Coalition 21 (January 2005)

Principle I: It is the policy of the State of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.

Principle II: Health care coverage needs to be comprehensive and continuous.

Principle III: Vermont's health delivery system will model continuous improvement of health care quality and safety.

Principle IV: The financing of health care in Vermont will be sufficient, equitable, fair and sustainable.

Principle V: Built-in accountability for quality, cost, access and participation will be the hallmarks of Vermont's health care system.

Principle VI: Vermonters will be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and make informed use of all health care services throughout their lives.

<http://www.snellingcenter.org/coalition21/>

To move forward from their efforts in 2005, legislators needed to move outside the halls of the legislature and connect directly with Vermonters who are ordinarily not present in Montpelier during legislative sessions and whose voices may not otherwise be heard.

EXPANDING THE CONVERSATION AND CIVIC DIALOGUE

To expand the conversation, The Snelling Center for Government worked with members of the legislature to organize sessions in six different regions: Springfield, Rutland, Lyndonville/St. Johnsbury, Bennington, Chittenden County and Barre. Each day offered legislators and the public a chance to work together to understand the issues, grapple with the complexity and contradictions in providing health care, and share their values and opinions.

The process was based on the principle of legislators listening and citizens dialoguing. The underlying belief is that people who participate in the development of proposed changes are more likely to support the changes. Each day included multiple options for engaging a variety of people in conversation with one another and with state legislators. The goal was to expand the conversation in two ways: deepening the interchange and broadening the number and type of participants.

A Day of Conversation

12:00 **Lunch** discussion among community members and legislative members.

2:00 **Focused conversations**, facilitated by The Snelling Center, to identify groups' perspective (e.g., employers, providers). Participants conversed, legislators listened.

6:00 **Informational kiosks**, hosted by legislative members, on the key drivers (access, cost, financing, quality) and the principles of health care reform.

7:00 **Open Meetings** where citizens shared their thoughts using a public hearing format.

The flow of this publication mirrors the process used in the six days of engagement and the principles of civic dialogue: sharing information, listening, reflecting, staying informed and continuing the dialogue.

Core Questions from the Kiosks

- If there are to be changes in our health care system, what needs to be maintained in order for you to feel confident that a new system will meet your needs?
- If the system is to change, what might work better for you?
- What are the assurances you would need to support any proposed changes in our statewide health care system?
- How might you propose we measure success? If you had to draft a list of measures of success of a health care system in meeting your needs and concerns, what would be on that list?
- If a health care system DOES NOT INCLUDE _____ I would not be able to support it because _____. Meaning, any system must have it in order for it to be acceptable.

Glossary

community rating A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups of subscribers on the basis of their specific claims experience.

continuum of care The availability of a broad range of treatment services so that care can be flexible and customized to meet a consumer's needs.

cost containment Control or reduction of inefficiencies in the consumption, allocation or production of health care services that contribute to higher than necessary costs.

cost shifting The condition that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased.

deductible The expense that must be paid by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services.

fee-for-service Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered.

"global" budgeting A method of hospital cost containment in which participating hospitals must share a prospectively set budget. Method for allocating funds among hospitals may vary but the key is that the participating hospitals agree to an aggregate cap on revenues that they will receive each year.

health The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

SHARING INFORMATION

Vermont, like the rest of the country, faces three critical and interconnected issues:

- Health care costs are continuing to rise at a pace that is causing hardships to individuals and families, businesses, public institutions and the health care system itself.
- There are serious concerns about the quality and safety of health care.
- There is a large and increasing number of people who have no health insurance or who are under-insured.

While work by agencies and institutions has addressed each of these, the gains have been limited and fragmented. Public and political momentum for large scale change is growing. Change needs to be based on an understanding of the best available information about the current system and options. The following is some of the key information, evaluated over the 2005 legislative session, on the "drivers" behind the need for health care reform: rising costs, lack of access to health care services, concerns about quality of care, and equity in financing (or simply put, "who pays").

Quality

There is a need to improve quality, efficiency, and safety.

Improvements in health care quality result in improved health and reduced costs.

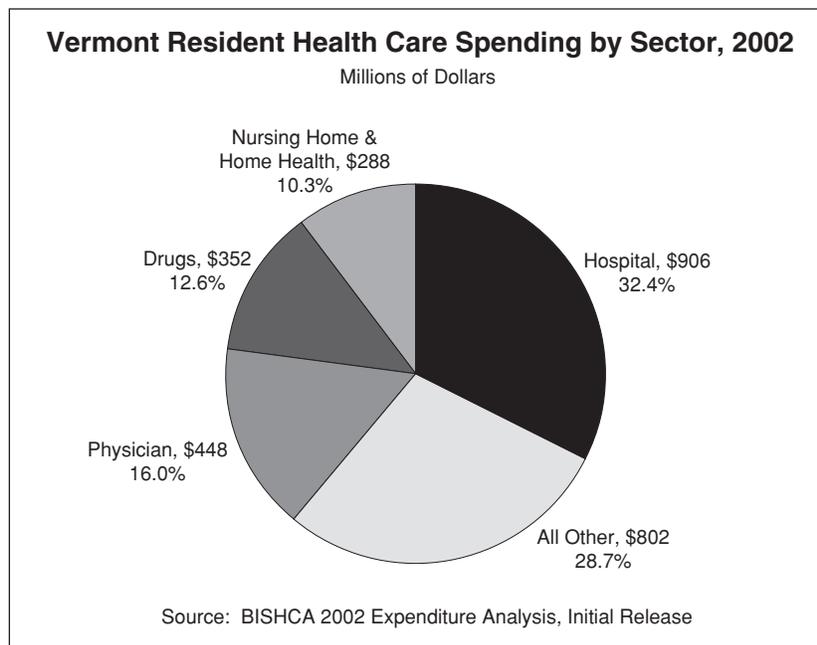
- The existing payment system does not tie reimbursement to improved health.
- Our health care infrastructure and services tend to be "disease-focused" rather than "health-focused," resulting in missed opportunities for less costly and more effective forms of care.
- Medical errors are costly. They result in the loss of human lives and increase the costs of providing health care.
- Poor quality care costs employers \$1,900-\$2,250 per covered employee each year. (Midwest Business Group on Health)
- Thirty percent of all direct health care outlays today are the result of overuse, misuse, and waste. (RAND study published in NEJM)

How can we maintain and improve quality in the health care delivery system so that Vermonters get the right care at the right time?

Cost

- Costs have grown from \$1.7 billion in 1996 to \$3.2 billion in 2004 (an 88 percent increase in eight years).
- Cost increases nearly \$1 million a day, or \$350 million a year, to support our current health care system.
- In 2003, Vermont's health care spending was 14.7 percent of the gross state product.
- Health care costs have risen an average of 9-10 percent per year over the past 30-40 years, with the rate rising to 10-11 percent in more recent years. These figures are well above the Consumer Price Index and exceed the state's capacity to pay for health care costs as measured against our gross state product.

How do we control costs? How do we stop rising costs?



Access

- In 2001, 43,000 Vermonters were uninsured; the number rose to approximately 71,000 in 2005, more than 10 percent of all Vermonters.
- Projections increase the uninsured to 80,000 in 2010.
- Lack of insurance is associated with an increased rate of illness and a shorter life expectancy.
- The costs of health services provided to individuals who are unable to pay are shifted to others. (Of the \$2.1 billion charged by hospitals in 2005, \$88 million was not collected, \$37 million was allocated as charity care and \$51 million was attributed to bad debt.)

How can we achieve universal access so that all Vermonters, regardless of income and employment, have equitable access to health care services?

Glossary

health insurance Financial protection against the medical care costs arising from disease or accidental bodily injury.

health savings account (HSA) A tax advantaged savings plan (a financial account with various restrictions) available to taxpayers in the United States to cover current and future medical expenses. It allows money to be put in before tax is paid on it and then to withdraw the money tax free for qualified medical expenses.

long-term care A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled) in an institution or at home, on a long-term basis.

managed care Health care financing/delivery systems that coordinate the use of services by its members to contain costs and improve quality. These systems have arrangements (employment or contractual) with selected physicians, hospitals and others to provide services and include incentives for members to use network providers.

Medicaid (Title XIX) A federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

medical savings account (MSA) An account in which individuals can accumulate contributions to pay for medical care or insurance. Some states give tax-preferred status to MSA contributions, but such contributions are still subject to federal income taxation.

Financing

Healthcare financing is accomplished through a patchwork of public programs, private sector employer-sponsored self-insurance, commercial insurance, and individual payers.

Under the current insurance-based financing system:

- Premiums are not based on the ability to pay.
- Deductibles and coinsurance place a financial burden on those with serious illness.

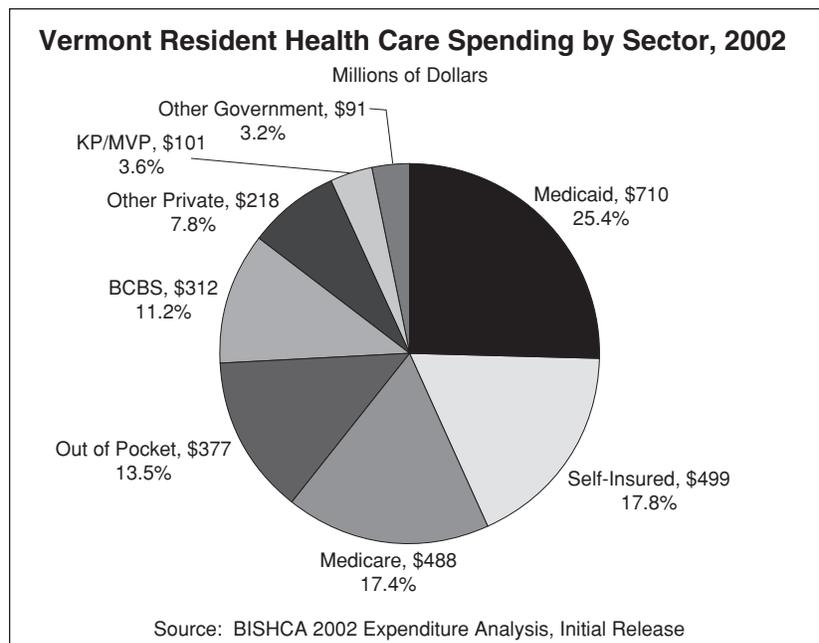
There are 130,000 Vermonters enrolled in Medicaid, 90,000 in Medicare, and 150,000 in private sector employer-sponsored self-insured plans. Combined, it is projected that these individuals will account for nearly \$2.3 billion of the \$3.8 billion Vermont will spend on health care in 2006.

Employment based healthcare premiums are growing faster than wages.

How do we pay for the health care system we all want? How do we create a "fair share" system where everyone contributes and shares the cost?

Tax dollars pay for much of healthcare spending:

- Property taxes support health benefits for municipal and school system workers and teachers.
- Payroll taxes support Medicaid and Medicare.
- State income taxes support state employee health benefits.
- State income taxes also support a number of health programs through the Agency of Human Services.
- Federal income taxes support federal employee health benefits and fund a variety of other federal health programs.



LISTENING

The six days of conversations were structured to move beyond the scripted advocacy agendas of the few to the personal values, experiences and understanding of the many. Themes of connection and of disagreement within and among groups filled the conversation. The conversations were also marked by contradiction, assumption and confusion. Health care reform measures must address this mix if they are to be acceptable to the diversity of people who call Vermont home.

Whenever we have these conversations we hit a wall — that this is really complicated. (We) can't let it stop us. (Springfield)

Common Themes

To begin, there are themes that were heard in most of the discussions and with most stakeholder groups about the key drivers — access, financing, cost and quality.

There is a **sense of “urgency”** to move ahead and impatience with the lack of significant change and the fact that we keep returning to the same issues year after year.



The time is now, the crisis is real; people can't wait any longer, they are in desperate shape. (Burlington)

Why are we still talking about this and not moving ahead? We want and the system needs us to have everyone covered and participating, why isn't it happening — this is not a new conversation, let's move on and deal with the other issues that we need to address .

There was less agreement on the specifics of what different aspects of reform should look like, but there was a strong sense that Vermonters by and large agree that **no Vermonter should be denied access to health care** and that **health care should be more than basic or emergency care.**

Many called for a **focus on wellness and the inclusion of preventive services** both to keep people healthier and health care costs down.

Health care is cheap, sick care is expensive (Rutland)

There was general agreement that **everyone should participate in the system** and that **everyone should also contribute financially in some way.**

There is universal concern that **rising costs jeopardize access and quality for all and specific actions need to be taken to reduce cost increases.**

Glossary

Medicare (Title XVIII) A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation and dialysis.

portability Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans.

primary care Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems. Such care has generally been provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

reimbursement The process by which health care providers receive payment for their services. Providers are often reimbursed by third parties who insure and represent patients.

underinsured People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

uninsured People who lack public or private health insurance.

wellness A dynamic state of physical, mental and social well-being; a lifestyle that recognizes the importance of nutrition, physical fitness, stress reduction and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system) and lifestyle.

Too many people hesitate to seek the right kind of care when they need it, and when it would make a difference, as they are concerned about cost. They wait too long and either they do not need the care because they die, or they need even more and more expensive care. (Lyndonville)

Because of high deductibles we avoid regularly scheduled appointments, "saving up our hurts" till something big hits. This is the best we can do with the present system. It's wrong. (Springfield)

There was near universal agreement that **the quality of health care in the state is basically good and that system reform should not jeopardize that quality.**

Vermonters want to build on the existing quality, which was largely identified as having a network of community hospitals and wanting to preserve their relationship with their primary care provider. Increasing quality was connected to adding other services to make sure that people have access to appropriate services at appropriate times and places.

(We need to) provide low cost alternatives to care through clinics or other methods — sometimes emergency care is sought due to lack of alternative (Bennington)

Finally, citizens called on legislators to **be bold.** There was a desire to step out in front of this problem in a big way.

We need bold and decisive leadership in Vermont. We can't keep reorganizing deck chairs on the Titanic. (St. Johnsbury)

Resist temptation to fly band-aids and splints — take a wholistic approach. (Bennington Employer)

Citizens also called on legislators to **be cautious.**

Don't do it unless it fixes the problem. (Rutland Employer)

Cautious action can be a process of careful and strategic experimentation to pilot test the major system reforms so that change would not lead to medical providers leaving, businesses closing or moving out of Vermont, or rationing of health care services. There was also concern that care should be taken not to undo those aspects of the system that work and are valued.



New Themes

As expected, Vermonters spoke about the “drivers” of health care reform — access, cost, quality and equity in financing. Vermonters also shared a number of stories describing why the current system is not working for them and what they want from a reformed health care system. Future discussions will need to address the themes expressed in these stories: simplicity, choice, responsibility, and continuity.

Simplicity: Citizens want more direct access and fewer barriers to getting care and having that care paid for. Employers, administrators and providers want less paperwork.

(I want a) streamlined administrative and access process—dealing with insurance companies is very complicated.



Choice: Insurance plans, doctors, and type of care, are important to individuals, families and employers. Choice was connected to other important issues:

- Choice of health insurance plan—flexibility in balancing costs and services.
- Choice of health care providers — trust, quality, meeting individual needs.
- Choice in type of care — many Vermonters spoke of their use of non-traditional providers (chiropractors, acupuncturists, etc.) as prevention.

Individual choice of provider and hospital. To be treated as a person with a health problem, not a number or statistic. (St. Johnsbury)

I want to see the system changed to be “patient centered” and offer choices and incentives for making decisions that lower costs. (Rutland)

Personal Responsibility: A new dialogue or debate seems to be emerging on the link between individual choices, personal responsibility for health outcomes and ultimately costs. We heard some strong — and differing — opinions and assumptions.

The entire culture of American health needs to have a drastic shift towards being much more responsible for one’s own health. That is the only way to ultimately drive costs down. (Burlington)

(We need) financial incentives to encourage consumers to practice healthy behaviors, use least cost alternative therapy, price shop and comply with physicians care plans...because this is necessary to achieve affordable premiums. (Bennington)

As a practitioner, I am appalled when I have a patient who wants to do the right thing in terms of lifestyle and care, but cannot access the resources of the system to support those right decisions. (St. Johnsbury)

We also need to remember that even making good decisions, people do get sick, some people are genetically or otherwise oriented to certain conditions or diseases (e.g., obesity). (St. Johnsbury provider)

Health Care Reform in Perspective

*We have been in this conversation
for a long time.*

1923 - Vermont Department of Health established

1930 - 121 Vermont towns without doctor in residence

1944 - Blue Cross/Blue Shield formed in Vermont - New Hampshire

1945 - Governor Proctor established Advisory Health Committee to write state health plan

1948 - First of annual state health plans for hospitals and health centers

1960 - 169 Vermont towns with doctor in residence - described as “shortage”

1965 - Governor Hoff appoints Advisory Board on Health Programs

1967 - Vermont House forms Health and Welfare Committee

1967 - Committee on Comprehensive Health Planning established by Governor Hoff

1968 - Vermont Comprehensive health planning agency established in the Governor’s office

1968 - Federal mandate establishes a Vermont state-wide comprehensive Health Planning Agency

1969 - Vermont Senate forms Health and Welfare Committee

1970 - Cooperative health information center of Vermont opened

Collective responsibility: Similarly there were differing opinions regarding collective responsibility. Some participants spoke of responsibility as assuming one’s “fair share” in paying for services while others spoke passionately about health care as a human right and moral imperative — providing health care services for all is our collective responsibility.

Continuity: People spoke of the need for a system that better reflects changes in life circumstances — children are born and grow up, individuals lose or change jobs, serious illnesses or injuries happen — and people need continuity of coverage through these life changes.

I want to be able to change jobs without being afraid that I might lose my health care. (Springfield)

Do not punish people by separating them from health care when going to college or taking a job. (Burlington)

VHAP does not work to provide a continuum of insurance to people who cannot afford commercial insurance. Income limits are too low. People cannot progressively move to better paying jobs and afford insurance. (St. Johnsbury)

Connected to the theme of continuity were the many voices calling for insurance to be connected to the individual and not the employer. Interestingly, this theme was heard in the public meetings as well as in discussions among employers and labor representatives.

That payment is not linked to a job — it should be linked to a person. That will allow workers to get portable coverage and get coverage even if they only work part-time. (Burlington)

Insurance should be disconnected from employment. Healthy employees are important for economy and business. (Rutland Employer)



A Closer Look: It Depends on Who is Talking

The themes noted so far were common to the many different discussions that took place with a variety of people throughout the state. Other themes were unique to discussions among specific groups representing different sectors of Vermont. As the following compilation of themes demonstrates, one's view of health care reform and of which issues are of greatest importance depends on one's primary responsibilities.

Employers (in private, public and nonprofit sectors)

The primary responsibilities/concerns of employers are: meeting their business objectives, keeping costs — financial and administrative — down, accurately predicting expenses, and recruiting and retaining high quality employees.

Businesses understand that there is a need and there will be compromise. Everybody should be talking more. We all have an investment in this system and the outcomes. We should be talking together. (Springfield business owner)

“Current cost increases are unsustainable for employers.” (Barre employer)

Current costs and rates of increase are unsustainable putting existing companies out of business or forcing them to relocate and preventing future entrepreneurship. **Employers want predictability in costs** so they can plan for the future.

Employers who pay for benefits universally feel that they are picking up an **unfair share** of health care costs both for their employees with benefits and for the employees of other companies that do not offer benefits. **Fair share should replace cost-shifting.**

Choice — in plans and providers — should be maintained in order to control business costs and enhance employee satisfaction.

Employers want **simplicity in administration**, less paperwork and reduced complexity. They want to reduce the amount of time spent dealing with health benefits and negotiating with insurers and employees, so they can focus on their business objectives.

Business should focus on what it is supposed to do, not on figuring out health benefits and managing them. (St. Johnsbury)



Employers want insurance attached to the individual rather than the employer. **Continuity and portability in health insurance** would reduce administrative burden to employers. **Disconnecting/decoupling employment and insurance** would reduce cost shifting, reduce the competitive edge for employers, and stop employees from staying in or leaving a job based on the need for benefits

Timeline

- 1973** - Governor Salmon appoints Daniels Commission on Health Care in Vermont
- 1975** - Daniels Commission report issued and Health Care Cost Commission established
- 1976** - Health Policy Council established
- 1977** - Governor Snelling establishes Health Policy Corporation
- 1980** - Governor Snelling establishes Kitchell Commission on Hospital Costs
- 1983** - Report on Health Care Costs in Vermont published by Agency of Human Services
- 1984** - Windham Foundation Conference on Future of Health Care in Vermont
- 1987** - Vermont maintains Health Policy and Data Councils without federal mandates
- 1987** - Governor Kunin initiates state-wide health planning by Health Policy Council and Health Data Council
- 1988** - Study of uninsured in Vermont
- 1988** - Vermont Program for Quality in Health Care established
- 1991** - Windham Foundation Conference on Vermont Health Care for the 1990s
- 1991** - 45,000 uninsured Vermonters identified
- 1991** - Governor Snelling appoints the Gibb Commission on Hospital Costs

Labor

The primary responsibilities/concerns of labor are: labor rights and responsibilities, employer/employee relationships, and fair contracts.

Labor advocates spoke of the need for access to health care for all. The unique themes for labor representatives were similar to those heard in the employer discussions.

Labor advocates urged change to **decouple employment and health care (insurance) and get it off the bargaining table** where it is one of the most contentious issues in negotiating contracts with both public and private sector employers.

If insurance remains connected to employers, then **everyone should pay and play**. All employers should have to provide it and all should pay. Not offering health insurance should not be a competitive business advantage.

Labor advocates recognize the need for **fair share of costs**. Employers should pay their fair share toward health benefits for workers, and workers should contribute fairly.

Providers (MD's, RN's, dentists, optometrists, chiropractors, mental health providers and others, including some medical and nursing students)

The primary responsibilities/concerns of providers are relationships with patients and providing the most effective and timely care.

*We do a lot of good for people.
Change the system to enhance our work. Don't put new impediments in the way of us providing good care to people.*



Providers were unanimous in their focus on the quality of care. **High quality depends on delivering the best care at the most appropriate time and place.**

Providing the right care at the right time means **preventive care must be central** to prevent more serious outcomes and reduce costs. Preventive care includes early childhood immunizations, wellness care, health education and public health models for addressing nutrition, exercise, screening and early detection.

Providers support access to primary preventive care, end of life care, complementary care and dental and mental health services as they believe **comprehensive care is economically and clinically prudent.**

Providers must be paid for the “right” care at a sustainable rate. Reimbursement should include time with patients and patient education. Low reimbursement rates overall are a serious threat to being able to do “business.”

Administrative requirements must be minimized so that time is spent providing care instead of processing paperwork. **Simplicity** would be achieved through **an integrated system** for sharing patient records, referrals and authorization of care.

*I spend an inordinate amount of time documenting and reporting to Medicare, Medicaid, BCBS, etc. It is all different and all very demanding and takes away from time for delivering care.
(St. Johnsbury care provider)*

Mixed Groups (Governing members of health care organizations, health care office administrators, and social service workers)

The primary responsibilities/concerns of these groups are: interfacing with the financial system, navigating the health care services delivery system, and accessing services for most in need/at-risk.



This group expressed concern that **rising costs to institutions are not sustainable** and that **reimbursement rates should reflect the actual costs** of delivering services which include time for regulatory and reporting compliance

Care management requires time to interact with patients and to provide education. A reformed system must include adequate **payment for care management activities.**

Care should include **public education** on **how to be healthy** and **how to use the system** to obtain best results. These reflect the themes of prevention, responsibility and choice.

Last, this group connected high quality **to local control and local presence of health institutions.** They urged that new networks of care be centered in the community and built off the existing system of regional hospitals, free clinics, health centers, etc.

Timeline

1992 - Health Department publishes “Healthy Vermonters 2000”

1992 - Health Care Authority replaces the Policy Council, Data Council and C.O.N. Review Board

1993 - Governor Dean establishes the Commission on Public Health Care Values and Priorities

1993 - Vermont House Speaker Ralph Wright appoints special Legislative Health Committee

1994 - Health Care Authority presents report on two Universal Access Plans for Vermonters

1995 - Office of Vermont Health Access is formed

1995 - Health Care Authority publishes “Guide to Health Care Reform”

1997 - Commission on Public’s Health Care Values & Priorities issues first report

1997 - Office of Health Ombudsman authorized

1998 - Medicaid eligibility for children expanded

1999 - Independent assessment of Vermont health care system authorized

2000 - Governor Dean appoints “Hogan” commission

2000 - Vermont Health Department publishes “Healthy Vermonters 2010”

2001 - Lewin report on extending health insurance to Vermont’s uninsured published

Perspectives, Assumptions and Values

For each of the groups work responsibilities shape the ways in which they interact with and understand the health care system. Ultimately this creates the lens through which they view the current health care system and proposed solutions.

Primary Concerns

Employers—rising cost to business, administrative burden, level playing field

Labor—rising cost to individuals and families, level playing field for benefits

Providers—providing the right care at the right time, including prevention, education and comprehensive services

Mixed—providing service to as many possible as cost effectively as possible

Public—getting the kind of care they want when they need it, and being able to afford it

For example, while almost everyone agrees that rising costs is one of the most critical issues, there is little agreement on what to do. Some disagreements about solutions are based on assumptions about what is driving high costs. These assumptions must be verified or shown to be unfounded.

Assumed cause

insurance companies single payer or free market

medical malpractice tort reform

overuse of emergency rooms create clinics as an alternative

poor health choices reward good behavior

overuse of medical services make everyone pay so they recognize the cost of their choices

Proposed solution

Other disagreements stem from fundamental differences in values.

For example, for some, health care reform is a financial issue:

No where in H524 do we explicitly state that our overall public policy goal is to provide good quality care to all Vermonters at the least overall total system cost (i.e. getting the best bang for our total money) in a way that is sustainable over time. (Burlington)

Which approach provides best health care for most Vermonters for least money and is sustainable for the long term? (Burlington)

For others, it is an ethical or moral issue:

Health care should be seen as a public good, like the roads. We spend billions of dollars on building and maintaining roads and bridges. No one looks at the per-capita costs, and in few cases do we even question how much it costs. However, when we think of health care we begrudge the dollars spent. (St. Johnsbury)

Future health care reform discussions and proposals must directly address fundamental differences in values.

The Importance and Power of Language

Language can clarify or confuse; it can help to unite us or divide us. For example, the terms “universal access” and “single payer” are used as shorthand descriptors in state-wide discussions on health care reform. These terms have become so highly charged and politically loaded that they do not help us to understand nor connect with one another.

Access: what do we mean? Competent care in all emergency rooms at any time? Any doctor at any time (abuse of access)? (Rutland)

Access means “affordable”- what is affordable? (Rutland)

Universal Access is a term interpreted in many different ways. For some, universal access means no one will be turned away from emergency care even if they cannot pay. For others, it means access to the right care at the right time. Still others believe universal access means access to care for every health need at anytime for everyone. “Access” also has additional meanings, such as providing transportation or portable health care for certain populations (e.g. persons with physical disabilities for whom mobility is difficult).

Universal access is not a good place. When government is involved — people will suffer, physicians will leave if fees slashed and people will be told what they can and cannot do. (I am) concerned about doctors leaving and not coming. Universal health care is not the course. Physicians will leave if government is involved. (Rutland)

And then, there are assumptions linking “universal access” to “single payer.”

- Universal access means a government run, government controlled system.
- Universal access means “single payer.”
- Single payer means a government takeover of health care services and decision-making.

State finance is different than state controlled. (Rutland)

(I) hear opponents of “single payer” say government messes up but we do have Medicare and people are liking it. Medicare is basically good- no one wants it to go away. (Springfield)

Single Payer is a volatile term which immediately stops discussion and dialogue. For some it means one publicly administered trust fund that replaces the current multi-payer system and eliminates the role of insurance companies but maintains private medical practice. Others equate “single payer” with “socialized medicine” where a central government agency not only sets prices and pays for services but also employs and regulates doctors and providers.

The language of moving ahead is a shared language. The first charge to those who lead and facilitate those conversations is to find that shared language.

Timeline

- 2001** - Hogan Commission issues report on Health Care Availability and Affordability
- 2001** - Commission on Public's Health Care Values & Priorities issues second report
- 2001** - Health Access Oversight Committee forecasts growing Medicaid shortfall
- 2004** - "Blueprint for Health" report is issued with emphasis on chronic care
- 2004** - Act 53 calls for new Health Resource Allocation Plan and State Health Plan
- 2004** - Broad-based "Coalition 21" begins work toward establishing principles of reform
- 2005** - Vermont House establishes Health Care Committee
- 2005** - Vermont Legislature develops public engagement process on health care reform, and Governor Douglas hosts a series of hearings around the state
- 2006** - "How will Vermonters remain engaged and part of making reform happen in Vermont?"

It is your choice to take this into the future. It is up to you to stay informed and engaged so that reform that happens is what best serves Vermonters and matches our values.

CONTINUING THE CONVERSATION

What if we stopped using these terms? What if, instead, health care reform discussions focused on the shared principles and values of **fair-share, simplicity, responsibility, and continuity?**

How do we move the conversation forward? Future conversations need to highlight the shared themes — old and new.

In any reform process differences in perspectives, assumptions, and values must be addressed in order to bring the largest group of people forward to support system reform. We must be careful to define our terms, explain our assumptions, and listen openly if we are to be able to continue a dialogue that moves us towards identifying acceptable changes in our health care system. The process of education and conversation must continue with the many publics of Vermont. It is not what we take ahead, but how we take it ahead that will prove most important in designing the approach to reforming Vermont's health care system.



More information from the legislature's public engagement process can be found at:
<http://www.leg.state.vt.us/Public%20Engagement%20Forums/PUBEngDates.htm>

STAYING INFORMED

Executive Branch websites

Vermont Health Care Authority (at BISHCA)

<http://www.bishca.state.vt.us/HcaDiv/hcdefault.htm>

Department of Health - Vermont Blueprint for Health

<http://www.healthyvermonters.info/hi/chronic/chroniccare.shtml>

Office of Vermont Health Access

<http://www.ovha.state.vt.us/>

Legislative website

<http://www.leg.state.vt.us/healthcare/>

The Snelling Center website

<http://www.snellingcenter.org/healthcarelinks.html>

Contact the **Governor**: 802 828-3333

(toll-free in VT only: 800 649-6825) TTY: 800 649-6825

<http://www.vermont.gov/governor/contact.html>

Contact your **legislators**:

Find your legislator: <http://www.leg.state.vt.us/legdir/legdir2.htm>

Or contact the Speaker of the House - (802) 828-2245

www.leg.state.vt.us/speaker

speaker@leg.state.vt.us

Questions for the continuing conversation

Any plan to reform or transform the health care system in Vermont is not a short term endeavor. It is in fact a continuing conversation that goes beyond legislative sessions and election cycles. Some of the key questions to ask about proposals and actions in the years to come include:

- Does the proposal or program eliminate barriers to care? Provide health care for all Vermonters or clearly move in that direction? Facilitate full participation by all Vermonters?
- Will it ensure access to essential health care services irrespective of age, income, employment or health status?
- Does it support the development of an integrated system of care and administration and facilitate continuous measurement of and feedback on quality and health outcomes?
- Is what we will contribute financially based on ability to pay? Does it eliminate financial barriers to essential health care services? Is it sustainable?
- Will the funding of the system encourage the outcomes we want (e.g., will we pay for health or sickness)?
- Are there clear partnerships between the health care system and individuals that promote good health, emphasize prevention and wellness, and focus on good management of chronic conditions?



www.snellingcenter.org
The Snelling Center for Government
130 So. Willard Street
Burlington, Vermont 05401

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