Citizens' Health Care Working Group Meeting
Courtyard Marriot, Washington, DC
Sunday-Monday, April 30-May 1, 2006

Meeting Minutes

Working Group Members Present:
Randy Johnson, Chair
Frank Baumeister
Dotty Bazos
Montye Conlan
Richard Frank
Therese Hughes
Brent James
Pat Maryland
Catherine McLaughlin
Deborah Stehr
Chris Wright

Working Group Staff Present:
George Grob, Executive Director
Jill Bernstein
Craig Caplan
Carolyn Dell
Jessica Federer
Lisa Goodnight
Margretta Kennedy
Andy Rock
Connie Smith
Caroline Taplin

Other Participants and Attendees:
Jon Comola, Wye River
Marcia Comstock, Wye River
Mary Giffin, GAO
Barbara Gilbert-Chen, UFCW
Cynthia Haney, American Nurses Association
Hala Harik Hayes, America*Speaks*
Carolyn Lukensmeyer, America*Speaks*
Mark Marich, PFI
Jonathan Ortmans, PFI
Mary Ella Payne, UFCW
Carol Reagan, UFCW

Randy Johnson began the meeting at 8:40 a.m., Sunday, April 30. The meeting was moderated by Jon Comola and Jonathan Ortmans on Sunday and by Jon Comola on Monday.

These minutes generally do not contain verbatim quotations of Members or even the specific exchanges among them. Because their discussions were exploratory and highly interactive, the Executive Director decided that it would be more useful to summarize the results of the discussions rather than seek to represent detailed exchanges.

Working Group Members discussed how most efficiently to move forward on recommendations. Some Members (Dotty Bazos, Montye Conlan, Joe Hansen, and Catherine McLaughlin) and the Executive Director provided proposals in advance of or at the meeting to assist the Working Group.

Members discussed what their recommendation objectives and level of detail should be. Broad points made by the members included:

- Keep the emphasis on what had been heard (both qualitatively and quantitatively) and include stories to illustrate and back up the data;
- Speak in a "voice" that resonates with the American public, not a bureaucratic voice;
- The recommendations should be simple and straight-forward and able to stand alone (be "dramatic" and attention-getting);
- Flesh out the bones with cross-tabs, stories, qualitative summaries (all pulled from the data);
- Write as citizens, not experts, who share the concerns and reflect the perspectives of a wide number of Americans; and
- Cross-walk results that are presented with other national surveys to underscore consistency and reliability even though the Working Group's activities were not based on random assignment surveys.

Members agreed to frame the debate, and their Interim Recommendations, by identifying values and principles and concluded that they would have a limited number of major proposals. Then the Members, with the assistance of the moderator, jointly edited a statement of values and principles and asked the staff to refine language overnight. The following day Members agreed to the following:

- Emphasis on a shared social value;
- Seek universal coverage and access rather than rely on categorical coverage;
- Access by all Americans to a set of core health cares services;
- Selection of benefits to be included in a core benefits package by an independent organization;
- Role of personal responsibility
- Importance of dignified, respectful, humane treatment;
- Efficient and effective use of resources;
- Value of wellness and prevention;

- Need for community-based systems; and
- Simplicity, cultural sensitivity, education, availability.

Regarding financing, points Members made included:

- Everyone must participate;
- System should be fair/equitable;
- Affordability was essential; and
- Government should help those in need.

Concerns expressed by the Members regarding the need for trade-offs included:

- Importance of eliminating waste in the system;
- Value of a national health information infrastructure;
- Elimination of free riders; and
- Patient-centered care.

A broad philosophical point (with practical implications) that was made was that the health care system should focus on and provide **services** that support individual *and* population **health**, not just on providing services to treat illness.

Regarding specific development of recommendations, Members observed that they could distinguish between recommendations on which there was general agreement and consensus and recommendations where significant differences among themselves (and the public) might exist. The recommendations should generally focus on areas of consensus and acknowledge where there were areas of disagreement.

Members discussed whether they had heard from all Americans, from a fairly representative cross section, or whether some groups were left out of the debate, and how perspectives from these other groups might best be reflected or included. Individual members indicated: *"We have heard health care stories that literally break your heart." and "We also heard eye-opening personal stories of waste and poor quality."*

Staff expressed the optimistic hope that the Working Group would achieve community meeting- and online-participation of a total of 20,000 individuals, or more. Some Members expressed a strong desire that Americans would recognize--in the documents and recommendations that the Working Group issued as the Interim Recommendations—that their ideas and concerns had been heard. Another objective that stated was to come up with practical recommendations upon which the President and the Congress could act.

Some Members of the Working Group did not believe that they had heard from a representative cross-section of Americans in the community meetings and on-line questionnaires. For example, Randy Johnson commented that in the meetings he attended, the majority of the audience seemed to consist of medical professionals, health system change advocates, and folks who are under-privileged in one respect or another. At one point, Catherine McLaughlin stated that he was frustrating the Working Group's

attempts to make progress on the recommendations by incorrectly and publicly asserting that "only advocates attend the community meetings," thus devaluing the comments of citizen input through the community meetings and online polls. The Chair responded that he was in fact speaking his mind frankly and would not be intimidated by the Members in doing so.

Several Members expressed support for reflecting, in the recommendations, issues or concerns expressed during the hearings in order to supplement what was heard at community meetings and on the web. Members generally agreed that they had heard from a diverse group of citizens who were interested in and knowledgeable about the health care system. Some Members believed that the voices heard represented the views of the American people. Others noted that data the Working Group has been gathering generally matched results from a variety of major national polls.

Members Agreed to:

- Frame the report through a set of values and principles
- Focus on consensus and acknowledge where there are areas of agreement including:
    - Generating as much content as possible in areas where there is agreement
    - Identifying and setting aside, for the time being, areas where there isn't a consensus and working on these later to seek agreements and overcome disagreements;
    - Basing input on individual members' interpretations of what has been heard, supplemented with results of hearings and other sources of information.

Members discussed some preliminary values and principles that would be used as a backdrop for developing recommendations and requested that the staff refine these for presentation at a later meeting. Staff were requested to further develop and circulate these for comments by the Working Group, with the aim of reaching conclusions by the following (mid-May) meeting.

Recommendations:

Members engaged in a preliminary discussion of possible recommendations. General possibilities offered included:

- a single universal Federally-operated system (proposed by Dotty Bazos);
- a dual system with universally available core services provided by government and additional coverage available in the private sector market (proposed by Catherine McLaughlin);
- various creative ideas gleaned from community meetings (proposed by Montye Conlan);
- catastrophic coverage mandated at the individual level and financed by a combination of premiums and taxes and that was portable to address high cost

care, it would not be comprehensive (It was suggested that this approach would be affordable and probably do-able. It would not address the ongoing needs of the poor.) (introduced by Richard Frank);

- a public health system approach that provides direct access for everyone to a core set of health care services paid for by a progressive tax (Include strong support for and improvement of the public health systems, neighborhood clinics, education, prevention and nutrition. This would focus on disadvantaged populations and be implemented through a Federal grant program that encourages creation of special districts – with special taxation areas – with FQHCs and hospitals, to create broad coverage.)**:**
- a universal system that provides access for everyone to a comprehensive plan financed by public progressive taxes (Include a quality commission that focuses on effective care, national benchmarks for quality at either the regional or national level. Provide health indicators developed by groups of both consumers and providers. Build on consolidating existing systems. Emphasis would be on care for individuals, not categories of individuals. Simplify how system works. Address how to make this approach affordable.) (proposed by Frank Baumeister and others);
- integrate categorical systems to achieve a more equitable system covering everyone (Get away from the stigma of "welfare" or "indigent." Build on the Oregon Health System concept.) (introduced by Frank Baumeister);
- recommend immediate action steps by trying to make some form of coverage available to everyone immediately; assure access to all and provide support for those who need some form of assistance. (Form a pool for small businesses. Extend/build on existing federal programs.) (introduced by Randy Johnson);
- stay with the employer-financed system (Address the needs of the lower income levels; improve public health infrastructure; eliminate preconditions limitations and individual insurance market and have the core system available to everyone who needed it.) ; consider the consolidation of existing government programs: potentially have one program with a combined program covering current Medicare, Medicaid and SCHIP with one set of funding and eligibility rules (introduced by Randy Johnson);
- present a comprehensive set of integrated recommendations that include essential elements (some of which are alluded to above by others) including: universal health care, fair-share payments by employers, capture of both public and private funds currently spent on health care, uniform portable benefits, an inclusive set of core services, expanded primary care, public-private partnerships, strong cost control provisions, improvements in efficiency, and support for technologies to improve quality (proposed by Joe Hansen); and
- placing emphasis on social responsibility, assuring the everyone is covered for a set of core services selected based on proven medical effectiveness (proposed by Aaron Shirley).

Staff was asked to work with Members to further develop and clarify alternate recommendations proposals for further consideration by the Working Group.

Next Steps

Members discussed briefly with staff some of the work that needs to take place rapidly. Activities included: laying out practical steps for completing work at hand with remaining resources; well-structured Friday afternoon telephone calls; “cleaning up” the values and principles materials worked on at the meeting and sending to Members. Richard Frank agreed to work with other interested Members in drafting a preamble to the Interim Recommendations.

The Chairperson adjourned the meeting at 2 p.m., on Monday, May 1.