The Archimedes Movement
Draft Vision and General Principles
Community Feedback: May – August 2006

Introduction

Community input was sought on the draft Vision and General Principles in three ways:

- A series of ten community meetings held in May and June 2006;
- Posting the draft vision and general principles on the website for open comment in June and July 2006;
- Asking community chapters to discuss and post summaries of their discussions in July and August 2006.

This report is an overview of the first two sets of comments. More detailed summaries of the community meetings are available upon request, while the website comments are public for you to review. The chapter input will be incorporated into the second version of the Draft Legislative Concept.

Recurring themes have emerged in the dialogue so far:

1) Oregonians are worried about the future of employer-sponsored health coverage **and** the inability of public-funded programs to continue to cover all who need help.
2) There is widespread agreement that the current system is flawed or "broken", and that 'staying the course' is going to lead to a system collapse.
3) Oregonians support the concept of universal access to health care but are concerned about how we get from 'here' to 'there' – how we define the transitions is very important.
4) Oregonians are willing to engage in dialogue about limited public resources and the difficult choices that lie ahead about how to allocate those limited resources.
5) Oregonians believe that there is a responsibility to individuals to participate in managing health resources.
6) Participants don't trust that policy makers will take action to protect everyone, rather that there are vested interests that have more power in policy decisions and have a vested interest in sustaining the status quo.

7) The addition of prescription drug coverage (Part D) to Medicare has made people even more concerned about the policy decisions that shape the current programs.
8) There is a lot of excitement that John Kitzhaber can provide the necessary leadership to lead a grassroots, non-partisan effort to start a health care debate.

The Community Forums

In May and June 2006, the Archimedes Movement conducted a series of meetings in 10 communities across the state – Salem, Corvallis, Eugene, Grants Pass, Medford, Beaverton, Pendleton, La Grande and two meetings in Roseburg. We were seeking input on a new vision for the future of health care in Oregon and across the nation. These meetings were scheduled for 1½ - 2 hours, and were broken into three sections:

- A 30-minute presentation by John Kitzhaber, MD describing the current state of the health care system and how we got to the current system we have today;[1]
- Discussion among the participants in small groups (we provided specific questions to the group facilitators);
- The small groups reported a summary of their discussion back to all attendees, summarizing their top comments on the vision and each of the principles, then added principles their small group felt were missing from the draft.

Each small group had a recorder (someone who agreed to take notes) and those note pages were given to us after each meeting. In addition, we noted on flip charts, the issues presented as the top issues from each small group.

From the Website

The Archimedes Movement website (www.ArchimedesMovement.org) is another forum to engage people in dialogue about the design of a future health care system. We have four areas of comments to draw from:

- General comments to the draft Vision (posted on May 2, 2006) and the draft Principles (posted on June 8, 2006);

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[1] The PowerPoint slides and a narrative of the presentation are Attached.

- Both postings were also emailed to the Archimedes email list (currently about 2,500) and some who are not comfortable blogging replied via email with comments;
- We also created separate forums on the site where users could post comments to specific principles, or pose additional principles for consideration;
- Local chapters have formed in Portland, Corvallis, Medford-Ashland, Salem, Silverton and Eugene. Each of these community discussions have commented on the draft vision and principles.

The Draft Vision

The draft Vision, posted in May 2006, reads:

> *To maximize the health of the population by creating a sustainable system which reallocates the public resources spent on health care in a way that ensures universal access to a defined set of effective health services.*

Comments:

- There has been support for the overall vision at all of the community meetings and on the website, with many community participants referring to health care as a 'basic human right'.
- Several have asked the vision statement to be reworded to distinguish it from a 'purpose' or 'mission;'
- Many have asked for an explicit statement defining 'effective health services' to include dental, mental health, alcohol and drug treatment and complementary therapies;
- Some wonder why the vision does not address both public and private resources in the system.

The vision statement that is now in the Archimedes PowerPoint presentation reads:

> *To maximize the health of the population by creating a sustainable system which uses the public resources spent on health care to ensure that everyone has access to a defined set of effective health services.*

The Draft Principles

Ten draft General Principles were posted on the website on June 8, 2006 and sent electronically to names on the Archimedes email list. A brief overview of comments is included after each principle.

1) ***Universality/Inclusiveness – Everyone is eligible; no one will be excluded.***

- Some referred to this principle as universal access, others as equal access, still others as 'everyone should be eligible';
  - ⇨ While **no one** suggested that some should be barred from coverage, there were concerns expressed about the immigration debate, and how to address the definition of who is covered (resident v. citizen);
  - ⇨ In order for this to work there must be mandatory participation; no one can opt out;
  - ⇨ In order for this to be sustainable there is an element of individual responsibility for one's own health;
  - ⇨ There is a belief that if everyone is covered, then overall costs would go down;
  - ⇨ Participants understand that the tradeoff for universality is rationing.
  - ⇨ One person described our need as *"Canadian universality with American choice and values."*

2) ***Equity/Fair/Just – The system will be fair; everyone will have access to the same set of effective health services.***

- Participants had a hard time distinguishing between the values of universality and equity, often using fairness and justice in place of the term equity;
  - ⇨ The new system should be affordable, and there should be timely access to care;
  - ⇨ Must address rural inequities;
  - ⇨ Must have a system in place to take care of people who cannot take care of themselves;
  - ⇨ One person said "the basic benefit should be enough that no one is afraid of it."

3) ***Population Benefit – Within the constraints of available public resources the system will set priorities to maximize population health, seeking the greatest health benefit for the largest number of people.***

- Participants used this principle as a bridge to discussing prioritizing health services that would have the greatest benefit to society as a whole;
  - ⇨ Many felt that once the 'basic benefit' was defined that people who have financial resources should be allowed to 'buy-up';
  - ⇨ There was explicit acknowledgement that services must be prioritized and the system cannot provide everything available;
  - ⇨ One participant said *"just because we can doesn't meant that we should;"*
  - ⇨ The population benefit should include education about care options – choices that can be made across the life span and disease progression;
  - ⇨ There is a public responsibility for the health and security of its people; on the other hand, there is a responsibility of everyone to contribute/participate;
  - ⇨ The basic benefit should be defined by public input.

4) Value – The system will pay no more than the lowest possible cost for the highest possible quality.

- Participants felt that the new system should be cost effective, that spending and consuming resources wisely is very important;
  - ⇨ They thought this principle overlapped with others – i.e., efficiency and transparency;
  - ⇨ Participants felt it would be hard to measure value consistently since costs will vary widely across the state.

5) Efficiency – The administration and delivery of health care will use the fewest resources necessary to produce the highest quality.

- There was little discussion on this principle; it was accepted as written;
  - ⇨ Most saw it as a means to simplify administration and bureaucratic inefficiencies;
  - ⇨ Language used to describe the system should be simple and clear;
  - ⇨ Universal, electronic health records where information can be easily shared should be part of any plan to increase efficiency.

6) Effectiveness – The relationship between health services and the desired health outcome will be backed by unbiased, objective evidence.

- There has been little discussion about the need for this principle – it was affirmed;
  - ⇨ One person stated it as *"we don't want to throw good money after things that don't work;"*
  - ⇨ This principle was most often described as either evidence-based care or a way to optimize quality;
  - ⇨ Services that are shown to be effective should have some relationship to improved quality of life;
  - ⇨ There will be need to rank services based on their efficacy;
  - ⇨ When services and their effectiveness are similar we should purchase the *"Volkswagen versus the Cadillac"*.

7) ***Economically Sustainability – The expenditures of the publicly financed component of the health care system will grow no faster than the growth in general inflation.***

- This principle was affirmed in all discussions, although there were concerns about the tie to general inflation rates;
  - ⇨ There were concerns that linking this principle to general inflation does not allow for changing demographics, pandemics, or changes in social values;
  - ⇨ Linking to general inflation could work in good economic times, and be undesirable when the economy is doing poorly (which would most likely be when there are more people dependent on the basic benefit);
  - ⇨ Several groups mentioned the need to frame this in a way that allows for more cost in the short term in order to see a benefit in the long term.

8) ***Explicit Decision Making – The criteria for decisions will be clearly defined and open to the public, including clear lines of accountability for the decisions themselves.***

- There was agreement that accountability was important;
  - ⇨ There has to be protection for providers who either exercise professional judgment, going beyond the basic benefit **or** those who stay within the basic benefit when patients are asking for more;
  - ⇨ There was a concern that unbiased evidence could be hard to find for all health care services.

9) ***Transparency – The evidence used to support decisions about the prioritization of health services; the measures of performance outcomes; the prices paid for services and the flow of money will be clear, understandable and observable to the public.***

- There was agreement that this was a huge and important issue;
  - ⇨ Participants wanted to know who would set prices and deal with high costs;
  - ⇨ There is a need for clear definitions and increased transparency throughout the system.

10) ***Community-based – The delivery of care will be organized to take place at the local or community level unless outcomes can be improved at other locations.***

- There was agreement that services should be delivered as close to local as possible;
  - ⇨ Accessibility needs to be stressed when determining what is local;
  - ⇨ Inequities between urban and rural areas needs to be addressed, while adding appropriate regional and national-based services;
  - ⇨ Costs of transportation needs to be added when determining what should be local and what can be regional;
  - ⇨ Local input into planning about access and the delivery system is important.

Additional Principles suggested

Participants and website users have also been asked to recommend other principles that should be considered when designing the new system.

1) ***Emphasis on Health Education, Prevention, Wellness, and Health Maintenance***

- The importance of education, especially among school-aged children, was emphasized as key to teaching people about healthy behaviors and lifestyles;
  - ⇨ There is a need for patients, client and family-centered care;

- ⇨ The recommendation that a basic benefit be focused on prevention, wellness, immunizations, and chronic disease management was made at every community meeting.

2) ***Individual/Personal Responsibility***

- ▪ This issue came up at every community meeting, and has been discussed widely on the website;
  - ⇨ Everyone should have first-dollar coverage for prevention (health education, immunization, screenings, etc.)
  - ⇨ Individuals should have a clear set of responsibilities/requirements to participate fully;
  - ⇨ The new system should encourage personal responsibility, and emphasize and reward practices that lead to good health;
  - ⇨ Both providers **and** consumers have a responsibility to be wise stewards of public money.

3) ***Have a non-profit system***

- ▪ The intent of the system should be to improve and maintain health, not to make a profit.

4) ***Realign Financial Incentives***

- ▪ There is a need for financial incentives to be in place to support and encourage:
  - ⇨ prevention, health education, wellness activities;
  - ⇨ providers to see patients with the 'basic benefit;'
  - ⇨ providers to enter and remain in practice;
  - ⇨ use of electronic health records;
  - ⇨ patient relationships with providers.