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# THE SAN DIEGO COUNTY COMMISSION ON HEALTH CARE REFORM

## A CALL FOR ACTION

January 27, 1992

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## INTRODUCTION

This paper outlines the formation of **The San Diego County Commission on Health Care Reform,** authorized by the Board of Supervisors of the County of San Diego (December 10, 1991 - 33).

## MISSION

The primary mission of this **Commission** is to examine the variables which impact the health care crisis in America (San Diego) and to develop an integrated set of recommendations aimed at an improved health care delivery system. Meeting together in deliberative sessions, the **Commission** will be charged with accepting and soliciting testimony from informed consumers, providers, insurance representatives, employers and health consultants, and exploring a plan which will bring discipline and coordination to a fragmented health care system.

## PURPOSE

The purview of this **Commission** reflects the needs of County government, in fulfilling its duties and responsibilities under various statutory and administrative mandates of the State of California, as well as the long-range health interests of the people of San Diego County. The specific purposes of the **Commission** are:

1. To evaluate the current status of the County's indigent health care system and make recommendations for redesign, if appropriate

2. To accept testimony from providers and consumers regarding current challenges in the health care system

3. To design a prototype health care system for San Diego County, both public and private, which considers a number of competing perspectives

The recommendations which emerge from this effort will result in new policy initiatives for the County Board of Supervisors, as well as recommended legislation for State and/or Federal consideration. Issues which will dominate the considerations of this **Commission** include:

1. Does Universal Health Insurance constitute a benefit or a detriment to health care access for Americans?

2. If Universal Insurance is recommended, how should it be financed and what incentives should be provided for the numerous small businesses in San Diego, many of which could not afford such a mandate?

3. The moratorium on Tort Reform in California expires in December, 1992. What revisions to current Tort Reform legislation should be proposed, that balance the needs of patients and providers, while diminishing the incentives for frivolous legal actions or those which permit an untoward event or outcome to be synonymous with medical professional liability?

4. How can we stimulate greater awareness and responsibility on the part of the consuming public to:
   a. assume a more active involvement in chronic disease prevention and management
   b. utilize health care resources more effectively
   c. become more health conscious, so as to reduce the unnecessary visits to clinics and emergency rooms?

5. Within the context of a laissez faire economy, how can reasonable cost containment strategies be implemented which balance the need for incentives for new development, with the negative impact of excessive revenue?

6. What should be the role and responsibility of the State of California in financing indigent health care, specifically care to Medically Indigent Adults, in light of the California State Constitution, Article XIII, Sect 6B?

7. What should be the role and responsibility of the County of San Diego in arranging and financing health care under Section 17000 of the Welfare and Institutions Code?

8. In light of Number 7 above, should the County of San Diego own and operate a county hospital? Can the **Commission** document the benefits and detriments of municipal hospital ownership and operation from fiscal, operational, and quality assurance perspectives?

9. Insurance companies report that between 25 - 31% of health care premiums are allocated to administrative costs and profit. Are there less expensive vehicles to distribute health care "premiums" from employers to health care providers within a given region?

10. Health care providers are finding it increasingly difficult to provide services for Medi-Cal patients, given reimbursement and eligibility procedures which are perceived as adversarial. Further, reimbursement for services sometimes does not cover the marginal costs of treatment. How can the Medi-Cal system be restructured to improve provider and patient satisfaction? Does the State's proposal for Managed Medi-Cal (AB336) constitute a reasonable approach to heretofore underfinanced, fee-for service access?

11. Are there more effective mechanisms or modifications to publicly financed health care eligibility systems than the current Medi-Cal eligibility process? In a universal health insurance system, would Medi-Cal revenue be channeled into the universal coverage program?

12. How can certain hospital admissions be avoided by expanding access to primary care services? Do the data exist which will support a disciplined inquiry into this issue?

13. The Canadian Health Care System is often cited as a model for this nation. Those who do so, typically fail to note unique and fundamental differences in the underlying economies and legislative processes of these two nations. What are the positive and negative features of the Canadian Health Plan? Which of those are transportable into a U.S. economic and political environment?

14. Fragmentation has fueled unnecessary health care costs in the United States. Can the **Commission** identify the major variables which contribute to a fragmented system and recommend alternate strategies? Specifically, can

the Commission identify Federal and State waivers needed, as well as structural changes required in the County, to accomplish improved coordination?

15. Can policies be recommended for the San Diego County Medical Society or legislative proposals for the Business and Professions Code governing physician activities which would encourage physicians within a given geographic area (such as a county) to volunteer a certain number of hours (perhaps 4) each week to non-profit, primary care or specialty referral clinics, where the uninsured can be served without red tape or disruptions to existing patient populations and care systems?

16. Can San Diego County grant immunity from medical liability, except in conditions of gross negligence, for physicians under County contract, treating indigent patients in County facilities? in non-county facilities?

17. What specific steps can be recommended to the Federal or State governments to improve the health status of children in San Diego County?

18. Can the **Commission** identify recommended legislative strategies to establish uniform policies regarding community rating for all insurance programs in California (or San Diego County) and eliminate experience rating as an acceptable practice?

19. Can direct associations be made between health and social life styles and behaviors which contribute to excessive health care costs? Can a strategy be recommended which would propel State and local governments to become more aggressive regarding prevention and community education?

20. What is the fiscal impact of health care provided to undocumented persons and who should assume the cost for care to persons not lawfully resident within the County?

**MEMBERSHIP TO THE COMMISSION**

Membership to the **Commission** is accomplished at the recommendation of the Director, Department of Health Services, with the concurrence of the Chief Administrative Officer and acknowledgement by the Board of Supervisors. It has been determined that such a **Commission** should be comprised of both consumers, government and providers, with care to assure that the deliberations not become provider dominated.

Membership has been solicited from persons familiar with various aspects of the health care crisis, representing consumers and employers. At this time, those recommended to serve include:

1. Member, Board of Supervisors
2. Chief Administrative Officer, or designee
3. Representative, large private employer
4. Representative, private philanthropy
5. Representatives (2), college or university with emphasis on health and human services
6. Representative, private insurance
7. Representative, familiar with emergency medical service transport policies and systems
8. Representative, major accounting firm
9. Representative, retired County of San Diego executive
10. Representative, religious community
11. Representatives (2), hospital community
12. Representative, local media - print or electronic
13. Representative, public relations firm
14. Representative, retired federal or superior court judge
15. Representative, immigration lawyer
16. Representatives (2), consumer health interests
17. Representative (2), private practice physicians, one of whom to be President of the San Diego County Medical Society
18. Representative, organized labor
19. Representative, National Medical Association
20. Representative, Access to Care Commission of San Diego County
21. Representative, neighborhood-based community clinics

22. Chairman, Health Services Advisory Board

23. Representative, Hispanic Physicians Association of San Diego

**STAFF SUPPORT & TECHNICAL ASSISTANCE**

The **Commission on Health Care Reform** will be supported by staff assigned from Physical Health Services, some of which will be specifically detailed to this project, as well as additional staff support from the Office of Planning, Policy and Development, as the need and resources arise. The Deputy Director, Physical Health Services, shall be responsible for administrative coordination within the Department of Health Services. Outside technical assistance shall also be retained from a consulting firm knowledgeable in health care, with foundation support anticipated from Alliance Healthcare Foundation or Kaiser Family Foundation.

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