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BLUE RIBBON COMMISSION OF HEALTH CARE REFORM

INTRODUCTION

This paper outlines the formation of a **Blue Ribbon Commission on Health Care Reform,** sponsored by the County of San Diego Department of Health Services.

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 purpopses 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

PLANNING FOR THE YEAR 2000

The primary mission of the **Blue Ribbon 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 **Blue Ribbon 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.

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 expires in 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 malpractice?

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 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 price controls be implemented which balance the need for incentives for new development, with the negative impact of excessive profits?

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, Section 6 B?

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?

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 revenue 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 an adversarial payment system and mercurial eligibility procedures. 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 exit 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, as well?

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 or require **all** physicians within a given geographic area to volunteer 4 hours each week to non-profit, community based primary care, or specialty referral clinics, where the uninsured can be served without red tape?

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?

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 ratified by the Board of Supervisors. It has been determined that such a panel should be dominated by non-providers, to avoid possible conflicts of interest.

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. Leon Williams, Supervisor, or
   Susan Golding, Supervisor, or
   John Macdonald, Supervisor, or
   George Bailey, Supervisor, or
2. H.W. Todd, Chief Executive Officer, Rohr Industries
3. Ruth Riedell, Executive Director, Alliance Health Care Found.
4. Peter Dual, Dean, College of Health and Human Services, SDSU
5. William Waite, Vice President, Robert Driver Company
6. Phil Ayres, President (Retired), Hartson Ambulance Company
7. Tom Kelley, Vice President, KMP Peat Marwich
8. Clifford Graves, Chief Administrative Officer (Retired)
   County of San Diego (or)
   Frank Panarisi, Assistant Chief Administrative Officer
   (Retired), County of San Diego
9. Bishop Robert H. Brom, Catholic Diocese of San Diego (574-6300)
10. Joan Kroc, Philanthropist
11. Neil Derrough, General Manager, Channel 39 Television or
    Ed Quinn, General Manager, KGTV Channel 10, or
    Gerald Warren, Editor-in-Chief, San Diego Union
12. Richard Brooks, Chief Executive, Phillips-Ramsey Advertising
13. _____Federal or Superior Court Judge, (Retired)

14. David Vallidolid, Esq, Immigration Lawyer
15. Max Goldlust, Health Access, San Diego
16. Roger Cazarez
17. William Rennert, MD (or Successor) Chairman, Access to Care Commission
18. Joe Francis, San Diego County Labor Council, AFL-CIO

TECHNICAL ASSISTANCE

The **Blue Ribbon Commission** will be supported by staff assigned from Physical Health Services, some of which will be specifically employed for this endeavor. Outside technical assistance shall also be retained from a consulting firm knowledgeable in health care.

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