

Universal Capitation Plan

Team: Developed independently with input from church, professional groups and NGOs, including those serving communities suffering from health disparities

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a) Comprehensiveness

(1) What problem does this proposal address?

This proposal addresses comprehensiveness because it addresses, access, expanding coverage, affordability, portability, benefits, quality, efficiency, consumer choice and empowerment, wellness and prevention (and protection), and sustainability.

b) General

(1) Please describe your proposal in detail

This proposal suggests a one-payer system with universal coverage (and access to services) for all residents of Colorado. This proposal is very similar to the one submitted by Health Care for All Colorado, but there are important differences. One is that the system would be run by a combination of providers and consumers who would be elected by peers to state, regional and local governing councils, providing both providers and consumers with true empowerment. Political appointments to governing positions will not occur to eliminate the possibility of slanting the system to serve special interests whose aims are pursued in response to political largesse. Another is that there will be requirements for local epidemiological assessments that will be very useful in identifying and planning local prevention, promotion and protection services as well as health care services. This will also be useful in helping county and state officials identify other needs significant impacting health (e.g. safety issues, housing, etc.) Providers can choose to practice independently or form group practices as they wish. Consumers are free to choose their own providers. A third difference would be in the manner that reimbursement would occur: either providers would receive a pay for service fee (such as suggested in the Health Care for All Colorado proposal) or there would be a capitation rate for each consumer determined by actuarial analysis, (i.e., members of groups with higher actuarial risk for illness or disease would carrier a higher capitation rate in expectation of a higher utilization of services.) This latter funding plan offers a much better possibility of assuring control of costs and is the one recommended in this proposal.

To organize such a plan Health Care Delivery Systems (HCDS) would need to be formed among providers. These systems would include provisions for all services offered in a one-payer system. In turn the Health Care Delivery Systems would have Primary

Well-being Centers (PWC) that provide a list of primary, wellness, counseling and allied health services other than secondary and tertiary services. Each Primary Well-being Center would serve a population of around 25,000. A list of providers for each of these centers would be made publicly available. Consumers would choose the Primary Well-being Center of their choice and that center and the Health Care Delivery System of which it is a part would receive a yearly capitation rate that varies according to the actuarial analysis for that person. If the consumer was dissatisfied with their center they would be free to change and join another center on an annual basis. This freedom to move and take one's capitation provides an incentive for providers to make the consumer feel welcome and provide good quality services.

In selecting services to be provided this proposal takes into account the major determiners of health in their order of importance and includes services associated with the most important determiners traditionally missing as systematically included in our health care system. These determiners, in rank order of importance, are environmental determinants (including those socially constructed), lifestyle, access to health care and genetics. (See Force Field Paradigm of Health attachment) To accommodate the first two determiners the following services are included in this plan: health protection, health promotion, health education, an epidemiologist for every 25,000 consumers and a social epidemiologist for every 25,000 consumers that are part of a Primary Well-being Center. The purpose of the epidemiologists is to determine the kinds of diseases or social conditions most prevalent for each local population of 25,000 people covered by these professionals for purposes of planning health protection, promotion and education as well as the kinds of treatment and rehabilitation services that seem most pertinent to any local group. The social epidemiology can also be used for planning and policy purposes by local, county and state politicians to understand and respond to local needs, assuming the will to do so. In addition this information can be used to plan and coordinate a seamless approach to services with other relevant local or state agencies that are important determiners of health (such as housing, job training, food, etc.)

A team of health educators will be a mandated part of each health delivery unit (i.e. the 25,000 population). These individuals will be trained to provide the following services: 1) community capacity building in which the local population they serve is

taught how to identify their own needs and concerns and how to plan to meet these needs and concerns, 2) para-professional training in which local populations who desire to help themselves learn relevant health information that empowers them to do so, and 3) any special health education programs desired and identified as needed by the local community, (e.g. lifestyle issues associated with preventing or treating diabetes, heart disease, cancer, parenting training), 4) provisions for alternative and complementary medicine desired by that community. When a patient needs services there will be an intake and evaluation that will determine if the patient is really need of somatic medical services or whether their condition might be psycho-somatic and need to be referred for mental health or other social services. The patient can still see the physician of their choice, but the physician will be able to follow-up on the recommendations of the intake person and encourage the patient to pursue other avenue of services. Services will include a full array of medical care, mental health, substance abuse, prescription drugs, rehabilitation and physical therapy, dental, eye care, home health care, nursing home, etc. The following special provisions will be made in how these services are delivered: 1) state and regional planning will occur to minimize costs associated with the purchase of expensive technology and to avoid the duplication of technology, which drives up medical costs; 2) purchasing pools will be formed within the state and with other states in purchasing supplies and drugs; 3) a list of generic drugs will constitute the drugs covered by this program. In the case of adverse reactions or by provider recommendation out of need, patented drugs can be used to replace generics. Otherwise, the consumer assumes the difference in cost between the available generic and the name brand; 4) governing boards of providers/consumers will identify the numbers of new providers who need to be trained to serve the population over which they have jurisdiction and devise and implement recruiting plans aimed at potential students who come from traditionally underserved groups (rural, Latino, African American, Native American, Asian and Pacific Islander); 5) students will be trained in the expectation that the same services will be made available for the same conditions and need since past research has shown discrimination by race and culture for the exact same condition; 6) a percentage of funds will be allocated in each service area (of approximately 25,000 population) for testing the efficacy of potentially cost saving interventions such as wellness, complementary and

alternative medicine geared towards wellness or more cost effective treatments, home nursing versus nursing home care, training of para-professionals in wellness, etc.; 7) there will also be a monitoring of service utilization by diagnosis to make sure such discrimination is not occurring based on race, creed, color, or area of domicile.

(2) Who will benefit from this proposal? Who will be negatively affected by this proposal?

Potentially all Coloradans could benefit from this proposal because it will guarantee universal coverage, eliminate pre-existing conditions as a consideration, eliminate administrative wastes in time and costs for providers and consumers, eliminate the fear of losing or changing job because of lost of health care coverage, control inflationary costs for individuals and businesses, add important “upstream” services in prevention, protection and promotion that can preclude or soften potential bouts with illness, increase employment opportunities for epidemiologists, health educators and other allied health professionals, empower providers and consumers and thus enhance working conditions for providers and quality of care for consumers and through consumer empowerment and other aspects of the program better address health disparities. Malpractice costs can be substantially lowered as settlements for future care will be unnecessary. Those who hold superfluous positions in the current system that drain the resources from direct services, which are mainly administrative positions, will be negatively effected.

(3) How will your proposal impact distinct populations (e.g. low-income, rural, immigrant, ethnic minority, disabled)?

This proposal will have a decidedly positive impact on distinct populations. It will guarantee accessibility, comprehensiveness of service, empowerment in determining what services are available and how they are determined, cultural competence and sensitivity. It will provide social epidemiological analysis that can lead to greater and more effective planning in public and health policy in the areas of social and lifestyle determiners of health, which can be greatly impact the health of these populations but not necessarily otherwise considered or addressed.

- (4) Please provide any evidence regarding the success or failure of your approach. Please attach.

One payer systems abound throughout the developed world. They provide universal coverage and have been shown to achieve better health outcomes at lower per capita costs with greater levels of self-reported satisfaction among providers and consumers. (The Health Care for All Proposal has an addendum on some of these programs for this question, so it will not be repeated in this proposal.)

- (5) How will the program(s) included in the proposal be governed and administered?

This program will be governed by panels of providers and consumers, with equal distribution of each. Political appointments will be removed as consumers and providers elect their own panel representatives. This system is truly democratic and representative and provides a level of accountability for care missing in the current system. In proposing the following model, it is subject to change based on a fuller discussion of various stakeholders, but it can serve as a starting point for discussion. There will be a state board comprised of four elected consumer representatives, four provider representatives and one representative elected by these board members. Two at large positions would exist (both for provider and consumer representation) for rural and urban areas. It is assumed the representative elected by the board will have special expertise to help guide the board in its decision making. The state board will sit over regional boards, each of which will consist of nine representatives elected in a similar manner.

The state and regional boards will have primary responsibility for regional and state wide planning in such areas of purchase of expensive technology, making sure all citizens are receiving good access to care, arranging for group purchases on medications, coordinate information sharing among regional and local panels on efficacious and innovative ideas and other issues that are clearly of a broader nature. Within each of the regional boards (the number to be determined at a later date) local boards will be formed for approximately

every 25,000 population. These boards will consist of three elected providers, three consumers and one person, again who will probably have special expertise that is elected or appointed by the other six board members. These local boards will focus on governance issues of a local nature, such as where to put wellness resources, how to better staff underserved areas, evaluating the need and special qualifications for the training of new providers in their area, evaluating epidemiology reports, etc.

In addition, within both the regional boards and state board, there will be an elected sub-committee of providers and consumers who originate from traditionally underserved groups and groups suffering from health disparities (e.g. African Americans, Latino, Asian and Pacific Islander, Native American). These sub-committees will provide consultation and public reports on how well the reformed system is attending to issues of cultural competency, training of new professionals of color and programs designed to overcome health disparities. The exact representation of these sub-committees can be adapted to regional needs. Changes in the number and composition of these boards are open for discussion, with the hopes that any changes suggested would strengthen and dilute provider/consumer empowerment.

- (6) To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?

This program will require Medicaid and SCHIP waivers. The Health Care for All Colorado plan discusses (on #42) how Colorado might use "Medicare-Choice" plans to bring in Medicare dollars. The potential legal complications of ERISA and possible ways around them are discussed in the Health Care for All Colorado Plan. If successful in overcoming legal obstacles this plan may become very attractive to companies because of cost saving potentials both current employees and retirees.

- (7) How will your program be implemented? How will your proposal

Current contracts with insurance companies will have to be honored until their expiration or a buyout will have to occur. Depending on what funding method is finally chosen, during the first year these funds will have to be banked so that they are later available when the one-payer system commences. In the transition providers will have to decide whether they wish to be a part of the one-payer system, and if so, how they wish to organize with each. Assuming that comprehensive wellness, mental health and substance abuse programs will be included, as well as epidemiological services, the organization of providers will have to include allied health professionals as well as doctors and nurses. Ideally hospitals will be converted to non-profit structures to be eligible for participation or will have to meet minimal standards on fair and consistent pricing, comprehensive planning for the kinds of services they can provide and the equipment for which they will be reimbursed, etc. Providers and consumers will need to elect their representatives to governance boards and in the beginning spell out the processes for doing so. Provisions for providing services to neglected rural areas will have to occur. There is a lot of complexity here, but it is felt the program can begin within a year for those who take the initiative to organize immediately and the entire conversion process would take up to five years.

c) Access

(1) Does this proposal expand access. If so, please explain.

This proposal excels at expanding access. First, it will provide accessible, comprehensive universal coverage for the under-insured and uninsured and reverse trends of growing uninsured. Second it will expand coverage for many already insured in different ways. It will remove high deductibles that discourage early intervention. It will provide services that are often excluded, such as mental health or substance abuse. Third, it provides comprehensive access to wellness programs including health promotion, prevention and protection. Fourth, it provides governance access to the whole system, which allows the consumer to have a bigger voice and restores some of the voice lost by providers in managed care.

(2) How will the program affect safety net providers?

This proposal provides both comprehensive financial and programmatic support for safety net providers because all consumers will be financially supported and providers will be reimbursed for all patients they see. In addition providers will have the resources to add important services that have been defined as part of this plan.

d) Coverage

(1) Does your proposal expand health care coverage?

By having funding mechanisms wisely used, eliminating unnecessary and unproductive waste in expenses, restoring health care planning and utilizing internships and residencies wisely, it should be possible to provide many services currently denied to many in part or whole. These include: wellness, local epidemiological services for better planning, dental, eye, mental health, substance abuse, home nursing, nursing home services.

(2) How will outreach and enrollment be conducted?

Outreach and enrollment will be handled locally by the different governing boards of providers and consumers. Their plans and successes will be reviewed by regional and the state board if there are problems for corrective action. But because of the differences in populations by frontier-rural-urban; race; socio-economic status; culture it is assumed that customization in approach will be far more effective than a one-size-fits-all approach.

(3) If applicable, how does your proposal define “resident?”

Someone who has lived in Colorado for (3) months and can offer proof of a job or who has resided here (12) months without a job. Special categories will be available for seasonal workers who can be treated immediately during their work residence while domiciled in Colorado. These definitions are not written in stone.

e) affordability

(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

Bankruptcy due to health care will become a thing of the past. Both employers and employees will have a tax liability. Employers can arrange to fund employee shares in pre-tax dollars. However, by eliminating waste the expectation that the combination of current taxes plus health care costs will be reduced for both individual and business tax payers.

(2) How will co-payments and other cost-sharing be structured?

This will be left up to the governing boards to determine if they are necessary. It will be recommended they determine whether it is an asset or not to have co-pays. Some argue that co-pays lower utilization and others argue that they add administrative costs, so that is why it will be left up to individual governing boards to determine what works best in their areas.

f) Portability

(1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

In a one-payer system health status, employment and public program eligibility will not be considerations. It will remain open to all without regard to these circumstances. Portability within the state is insured, and out of state visits will be covered according to reasonable guidelines that require charges not exceed a certain percentage of cost above medicare. COBRA guidelines will be followed for those leaving the state.

g) Benefits

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

The benefits are adequate because they are comprehensive and seamless, expanding coverage into areas known to be bigger determinants of health (environment and lifestyle through wellness and protection). This plan also requires epidemiologists to study trends in local populations to stay current with health planning efforts, including wellness and health care as well as providing social epidemiological data to city, county, and state politicians and planners on needed social or economic programs that eventually impact health status. It addresses limitations in a powerful manner: first it specifies the GDP to be spent. Secondly, at the same time it calls for careful analysis to eliminate waste and the concomitant inflationary charges. These include, but are not limited to:

- high administrative salaries

- other unnecessary administrative costs associated with a highly fractured and adversarial reimbursement system such as personnel to file myriad forms and fight capricious denials
- unnecessary administrative costs (compromising quality of care) in screening and approving services by non-medically trained personnel
- eliminating the purchase of expensive equipment when the similar or same equipment is available and being used under capacity (i.e. by having planning unnecessary duplication can be prevented)
- having a case manager consult with a physician so the patient can be directed immediately to right set of services
- setting up a system of dealing with mal-practice reimbursement that eliminates the need to cover future health care costs because the person is already eligible for services; this can also help to eliminate defensive medicine where unnecessary procedures are performed to protect the provider against potential lawsuits
- adjusting provider costs to reflect the savings from the aforementioned measures
- adjusting hospital costs to reflect better regional planning of equipment purchases and the fact they no longer have to bill for unpaid services to indigents
- reducing and eliminating the need for using the emergency room for non-emergency needs by having primary care centers available for the entire population

Third, the fact that care is universal and covers automobile accidents and work related injuries means that some of the insurance savings generated by no longer needing this coverage can be directed to help pay for the costs of the system.

Fourth, it contains provisions for community empowering prevention and for funding proven alternative and complementary practices often ignored, but which have been shown to have powerful potential in reducing health care costs. (See addendum)

Fifth, it issues the challenge calling for innovative ideas in structuring new funding streams. For example reversal of the Tabor Amendment by a new amendment that allows

a portion of additional state revenues to be dedicated to funding health services in a way that lowers the combine cost of taxes and health care costs (including deductibles, premiums and co-pays) or provides access for those who fail to have it. Properly structured this new amendment could result in the Colorado taxpayer having disposal income by having the reduction in their health care costs more than offset their Tabor refund, while at the same time insuring access to high quality care.

Another idea for new revenue streaming would be for the state or a regional association of states to form joint ventures with pharmaceutical entities that could manufacture generic drugs. There is a precedent for these joint ventures as they currently exist between private institutions doing pioneering research, who turn over patents to pharmaceutical companies in return for a royalty or profit share. In this case a state or regional group of states would provide start-up funding for pharmaceutical entities who would produce generics that the state or states would buy with the states profit-sharing portion being reinvested in providing services. In addition, the pharmaceutical entities so involved would agree to guidelines for reasonably pricing their product so that a reasonable profit would be assured even as production costs increase, but increases would not be excessive. It should be noted by so called free market “purists” that currently commerce and industry is heavily subsidized by taxpayer money in the form of tax breaks, depletion allowances, and a variety of deductions for various expenses. Previous research has shown such subsidies, while bringing great benefits to shareholders, have had questionable value to the overall public good. What is proposed here is that there be taxpayer subsidy to private enterprise, only in this case the subsidy will result in a clear win-win for the public as well as the private enterprise.

This proposal addresses distinct populations because those populations are empowered to run the system in their own localities and to and it provides provisions for consultation important to each of these populations in regional and state governance units. It also calls for governance responsibility in seeing that equal treatment and care is given to all, that adequate personnel from underserved communities be trained, that issues of cultural competency figure into the training of personnel from these communities and funding be provided to accomplish the above aims.

In determining the priority and limitations on funding, local boards can be empowered or make recommendations to regional boards on funding priorities. It is assumed these priorities will reflect the needs of local communities because elected leaders to governing boards are answerable to their communities.

(2) Please describe an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc.) and describe any differences between existing benefit package and your benefit package.

none

h) Quality

(1) How will quality be defined , measured, and improved?

Quality is defined by array of services available (including upstream wellness and epidemiological services), how well they integrate; patient and provider satisfaction; adequate staffing in nursing and custodial, outcomes in wellness and treatment; keeping current in defining health issues and responding to them; iatrogenic data. As outlined in the Health Care for All Proposal, an integrated state Health Information Technology system will be a great improvement over the current fragmented system. With the right safeguards built into it, this system could offer important data for future planning purposed. The availability of services on a local level such as epidemiological services, that upgrade the quality of the overall system, can be used to measure whether and where quality is improved.

(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.)

Quality will be improved by including services in the area of the biggest determiners of health (i.e. having health promotion, prevention, detection; having social epidemiological studies and using these studies for planning and policy in areas of public policy that impact health); by providing for complementary systems that can prevent disease or iatrogenic results; demanding more research on complementary practices; empowering providers and consumers to jointly make decisions instead of untrained

managed care personnel or profit motivated; offering a greater array of services and customizing these services to local need; improving provider training in complementary medicine, people skills, cultural competency; improving cultural competency by empowering groups to have system input on how what services and how they are delivered and by sponsoring the training of practitioners from these groups; by setting up incentives for practicing in rural and frontier areas—(e.g. fund universities more if they agree to have internships in these areas; fund students if they agree to live there or commit time there and have two TV analysis with research centers; fund universities to study outcomes of customized interventions, etc.)

i) efficiency

(1) Does your proposal decrease or contain health care costs? How?

A one payer capitation system is designed to have distinct advantages to contain health care costs by earmarking a percentage of GDP for these costs. If this is combined with effective management of wellness interventions and case management, cost goals are more likely to be contained.

(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.

Health Care Delivery Systems that perform the best to consumer satisfaction will end up with higher capitation dollars. This is an incentive to providers. For consumers local systems can be set up so that the better they take care of their health and keep their utilization rates and expenses lower the more money is available for them to utilize desired wellness services. In fact, the system can be set up so that consumers who participate in a healthy lifestyle maintenance plan and show improvements in lowering risk factors can earn a percentage of their capitation for fitness club membership or equipment other wellness services or complementary and alternative care services not covered in their local health care package.

(3) Does this proposal address transparency of costs and quality? If so, please explain.

In a capitated system costs are already included. Quality reports, based on the criteria identified and determined by governing boards, will be issued on a regular basis to the public.

(4) How would your proposal impact administrative costs?

This proposal significantly eliminates administrative costs.

j) Consumer choice and empowerment

This proposal provides first rate choice and empowerment and the two are interconnected. Consumers and providers choose the kinds of services they wish to offer and how they are delivered, and who delivers them; Consumer can choose their own physician within a health delivery system and can periodically switch systems if they are dissatisfied with their choice.

(1) Does your proposal address consumer choice? If so, how?

This proposal addresses consumer choice in at least the following two ways. Consumers can pick their providers and provider group. Consumers are empowered to elect representatives who can determine the kinds of services offered and how they are to be delivered.

(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

Upstream services are an integral part of this proposal. This proposal also mandates the manpower for personnel who can engage in community capacity building in wellness and health education.

k) Wellness and prevention

(1) How does your proposal address wellness and prevention?

The proposal requires wellness and prevention to be a significant and meaningful part of a benefit package and includes prevention, promotion and protection. It directs capacity building, which requires consumer involvement and empowerment, in the planning and delivery of these services.

l) Sustainability

(1) How is your proposal sustainable over the long term?

This proposal is geared towards a fixed GDP for health care; it also looks innovatively for new revenue sources that are not derived from individual or business taxes.

(2) (Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save. Please explain.

(3) Who will pay for any new costs under your proposal?

Elimination of waste and eventually new revenue streams innovatively planned will cover the cost of universalizing coverage and expansion of services offered.

(4) How will the distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

It is expected each will experience some decrease through a combination of the reduction of current system waste and the introduction of innovative revenue streams.

(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

This question is answered very well in the Health Care for All Colorado Proposal by Rocky White. In his answer he provides a model where increased costs for Colorado tax payers is more than offset by savings in health care premiums, all or part of which can be borne by employers. In addition the others kinds of taxes proposed by Dr. White, it might be possible to consider a prescription drug fee for the non-indigent of \$1-5 dollars that would go into a Colorado Health Fund.

(6) (Optional) How will your proposal impact cost-shifting ^{is}? Please explain.

It is assumed the new plan can avoid cost-shifting or it can be kept to a minimal amount.

(7) Are new public funds required for your proposal?

They are not required for the proposal but they can help expand services and they can be accessed without increasing the overall cost burden on the taxpayer.

(8) (Optional) If your proposal requires new public funds, what will be the source of these new funds?

New funds are not required to start the proposal, but to help expand and pay for added services innovative ideas can be used to generate new public funds, as described in g) 1) above.

How the Proposal is Comprehensive

This proposal offers a comprehensive one-payer system that is universally available to qualified residents of Colorado. The plan addresses services associated with impacting the primary indicators of health (environmental and lifestyle) as well as an array of health care services. It mandates comprehensive health prevention, promotion and protection services that can be customized to local need. It allows for greater use of proven complementary and alternative medicine methods, which have been shown to be more cost-effective, and which can be used effectively in both prevention and treatment. Assisting in the effort of prevention and health promotion is the provision for social and medical epidemiology that is localized for better planning and analysis of diseases, utilization rates, outcomes and concerns about social indicators that can affect health.

This proposal also provides for an integrated Health Information Technology system that can improve quality of care and help to control costs. It also promotes a system of state-wide organization and finance (capitation) that can help target the amount of money to be spent in the health sector in advance.

It provides comprehensive governance that restores power to providers at the same time providing new empowerment to consumers, with special safeguards for traditionally marginalized populations.

It is also expected that this proposal will provide comprehensive relief to individuals and consumers in what they now pay for specific and overall health care costs. At the same time it will allow provide comprehensive protection against unseen life circumstances such as job change or loss of job without threatening the ability to access needed services in a timely manner.

While the plan contains many positive features there are thorny issues often overlooked such as discrimination in practice, dealing with the homeless and inclusion of people in empowerment who are struggling so hard to survive they don't have the luxury of inclusion. A feature of this plan would be to mandate local, regional and state boards to make sure that these issues were being regularly addressed with periodic reports on how they are addressed and the success of various approaches.

11. (Optional) A single page describing how your proposal was developed.

OPTION A

I was visited by male aliens from Mars and female aliens from Venus. When, despite their alleged monumental differences, they all agreed the current U.S. health system is in critical condition, compromises the public good for private wealth, fails in upholding the Hippocratic Oath, and results in unnecessary sacrifice of human life and wealth, it became apparent something had to be done to restore the moral image of our species that lives in this state.

OPTION B

During professional training Dr. Henrik Blum, a world renowned health planner and professor, wrote a paper at my request outlining a one-payer system for the United States that would be government funded but consumer/provider run, universal and comprehensive in coverage and give greater emphasis to the areas that had the biggest impact on health status (i.e. environmental and lifestyle contributions). His ideas eventually became the guiding light for one-payer systems developed by the California State Assembly, the earliest of which passed as the Petrie Bill in the 1980s. I kept in correspondence and personal contact with Dr. Blum about this issue until he became too ill to continue our dialogue, shortly before his death. However, it failed to muster the two-thirds majority vote needed to fund it. In addition to this background, I participated in the drafting of the Health Care for All Colorado proposal, sought out the input from different ethnic and racial groups and an NGO that represents them, different consumers, including church representatives and their congregants and the opinion of health professionals.