COMING TO CONSENSUS ON HEALTHCARE

HEALTHCARE SUMMIT

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TRANSCRIBED BY: Lynda J. Goddard, CSR No. 10670

A P P E A R A N C E S

THE MODERATOR:

LEE ANN KIM

THE PANEL:

STEVE ESCOBOZA
Healthcare Association of San Diego and Imperial County

JERRY FLANAGAN
The Foundation for Taxpayer and Consumer Rights

ROBERT HERTZKA, M.D.
California Medical Association

GERRY JENKINS, R.N.
California Nurses Association

RICHARD LEDFORD
San Diego Regional Chamber of Commerce

SPECIAL GUESTS:

GREGORY KNOLL, ESQ.

Legal Aid Society of San Diego

ROGER LUM, M.D., Ph.D.
County of San Diego Health & Human Services Agency

SUPERVISOR RON ROBERTS
San Diego County Board of Supervisors

ALSO PRESENT:

AUDIENCE MEMBERS

I N D E X

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THE MODERATOR: Good afternoon, ladies and

gentlemen. Thank you so much for coming out. My name is Lee Ann Kim. I'm with Channel 10.

It is my honor to be here with you to moderate this healthcare forum, California Health Consensus. And in the next 90 minutes we hope to continue a statewide dialogue on some of the problems, the solutions, and strategies in dealing with the healthcare crisis here in California, and particularly in San Diego County.

And with us today we have consumers; we have patients, healthcare providers, government leaders and employers, as well as representatives from healthcare plans to continue this dialogue. And because we are so limited in time, we ask that we try and stay focused on some of the issues that we found to be of most concern on people -- from people on all sides of this issue, which are the costs and affordability of healthcare.

There were also concerns that California spends $150 billion every year on healthcare. Patients want to know: Is that money being spent efficiently? Also the stability, many patients want to know: In the next few

years, will I still have healthcare? For those who are on Medicare or Medi-Cal: Will my doctors drop me? And what if I lose my job; what then? And also, we're going to talk a little bit about quality and accessibility to healthcare.

So I wanted to go ahead and turn to our five main panelists here and -- who are going to each individually introduce themselves and -- and briefly address the question: In the last ten years, in the state of California, and particularly here in San Diego County, what have we seen happening in the healthcare system, and, you know, what do we see as the future if this continues?

And we're going to start with you Jerry.

MR. FLANAGAN: My name is Jerry Flanagan. I'm a healthcare advocate for The Foundation for Taxpayer and Consumer Rights. We're a nonpartisan, nonprofit consumer organization in California.

And the answer from a consumer's perspective is very simple, that during the '90s health insurance became -- began to get very, very expensive. If you look, the next three or four years, premiums are increasing; that means employers are going to be cutting healthcare benefits, there are going to be more copays.

The -- those who are lucky enough to have coverage are finding that when they need their health insurance, those treatments they need are being denied. And hospitals, doctors, and nurses are suffering from very similar concerns as well.

So we're here to talk about more public control over the process.

MS. JENKINS: My name is Gerry Jenkins. I'm a registered nurse at UCSD Medical Center. I've worked there for 25 years in the surgical ICU/trauma. I'm also on the board of directors for the California Nurses Association representing nurses here in Region 2 in San Diego.

And I'd say that the things I've seen change over the last ten years that impact nurses have been a definite increase in the acuity of the patients we see day to day in hospitals. There's also been an increase in the technology that nurses need to care for patients

appropriately and guarantee the safety of patients, which requires a greater demand and increase in the knowledge base nurses have to have, which impacts the amount of time it takes to care for patients, as well as -- and speeding up, an increase in the pace of work in hospitals, in general, it's really put a strain on recruiting and retraining nurses into the profession.

MR. LEDFORD: Good afternoon. I'm Richard Ledford. I serve as a member of the board of directors for the San Diego Regional Chamber of Commerce. In that capacity, I represent the small business community and some of the healthcare initiatives here in San Diego.

The business community has a number of interests, and we share those in common with consumers and the other panelists up here. Expense being one of the major ones. As we find in the '90s and apparently well into the year 2000s here, we're seeing some radical increases in the cost of premiums to employers, which, of course, in many cases is being passed on to the employees.

There are other issues of concern for us. And that's the health of our work force. Without a healthy work force, we can't provide our services, we can't produce our products. So that causes us some concern as more and more San Diegans look to alternatives to insuring themselves.

The other issue, of course, has to do with attraction and retention. And that's a big issue for high-end (unintelligible) here in San Diego. We have -- you know, we're -- we're likely to be considered to be the telecom of the U.S. We have a huge, burgeoning biocom area here, where our life science community is

growing like crazy. If the businesses there cannot provide the type of incentives, which include good healthcare coverage, they cannot attract and retain the kind of employees we need here in San Diego.

So it covers the whole range of things; everything from expenses to healthy work force to attraction/retention.

DR. HERTZKA: I have to learn how to follow directions.

I'm Bob Hertzka. I'm here representing the California Medical Association. I'm actually on track to be their president-elect in 2003.

From the physician point of view, we actually agree with much -- much of what is said. We think all of us are caught up in a system where the patient is being more and more disconnected from what's going on with the cost of their services. There's a sense over time, as employers try to provide better coverage and the legislature mandates more and more services to be included in health plans, people expect, you know, office visits for $5, prescriptions for $5.

And the legislature is considering 21 more mandates this year, at the same time mandating that hospitals spend every dime they'll make in the next ten years to rebuild, to make them seismically fit.

What ends up happening is insurance becomes out of reach. The whole thing is backwards. We should be

focusing on people having catastrophic coverage so that when they really are sick, insurance will be there, no question. But instead, we're spending all this time making sure every nickel and dime is covered, and we have to put a million middlemen in the system to -- to -- you know, to referee that. You could drop the cost of insurance by two-thirds by focusing on (a), a catastrophic component and (b), at the same time focusing on the basics. Hospital care, physicians, pharmaceuticals are things we all would agree are the core of healthcare.

MR. ESCOBOZA: Good afternoon. My name is Steve Escoboza, and I'm CEO with the Healthcare Association of San Diego and Imperial Counties. We represent the hospitals in these two counties.

Ten years ago we faced a national healthcare crisis. At that time, though, there was not a political will to address the primary drivers of that crisis, at that time; meaning we were not able or willing to deal with various access, able to deal with the cost escalation that was double-digit, and certainly were not meeting some of the patient quality issues that were raised then. We have the problem again today. It's

more severe.

But bluntly said, I think that what really has to happen at the national level is the political will to address these public policy issues in a way that cannot be done at the state level, cannot be done at the local level. I think at the local level, all of us have tried our best to address the issues that many patients present to us. But it's just not something that can happen without a fundamental rethinking of healthcare from the standpoint of is it a business? Is it a commodity? Is it something that should be a right or a privilege? These are basic questions that have to be asked. And again, I think it needs to occur at the national level.

THE MODERATOR: So it sounds like, in general, in the last ten years in California and in San Diego County healthcare has gotten worse. Either the costs are higher, less accessibility. And, you know, from -- even from a business standpoint, everyone is pretty much making less money.

So let's talk about -- I want to -- I want to read some statistics that I brought up from the Regional Chamber of Commerce. And things may have changed a little bit since last year. It said that 25 percent of California hospitals will close in the next ten years.

10 percent of the state's physicians will leave -- and I think that percentage might even be higher here in San Diego County -- more than 75 percent of doctors groups will be bankrupt, and employers will have to abandon the notion of providing health insurance because it's just too costly.

I know here in the audience we have a lot of underinsured as well as noninsured. And I wanted to go ahead and, you know, open the floor up to any of those who have -- who have stories to share or some additional problems that they want to share as part of this town hall meeting in terms of the healthcare system here.

Do we have any of the under- -- underinsured or anybody who represents any -- healthcare advocates that want to talk about that?

Over here in the front.

AUDIENCE MEMBER: Good afternoon. I'm Eva (unintelligible) North County Health Services, a large community health center in North County.

90 percent of our patients are -- are below the 100-percent poverty level. What we're finding is that the patients are now making major decisions about very minor resources that they have, and they're making decisions to stay away from healthcare. Because they make those decisions, the conditions that they have will

be exacerbated and will end up going to the emergency room, or they will not have the money to pay for their treatment.

We're also finding that the health -- the Healthy Families insurance is also going down among our population because patients are opting not to continue the health insurance for their children or opting to cover only some children and not others.

So that's just some of the basic problems that

we're finding with the -- the uninsured population.

THE MODERATOR: Okay. And we have some representatives from small business owners. I think Elizabeth Bustos (phonetic). She is here representing the Hispanic Chamber of Commerce, and she is also a small business owner as well.

If you can share with us some of the issues that you face.

AUDIENCE MEMBER: Thank you very much. What hat to wear first?

Certainly from the Hispanic Chamber of Commerce perspective and the small business owners that we represent, we are definitely in crisis mode. We're out there. We're speaking to our business owners. I myself am a business owner. And the issue is (sic) that we do not want coverage. The issue is that we do not want a

freebie. The issue is that we cannot afford the coverage.

I do work and am familiar with many family-owned businesses. When I first started out,

before I became a business owner, I was out in the community and actually interviewing, you know, restaurant owners, service workers. And my thought was that these business owners, they were the bad guys. Okay? How dare do they not insure their employees? I was shocked and appalled. So I went in there with a certain mentality, only to really, you know, come out with a very good education in that they would love to be able to insure their employees, except for one thing, they can't even afford to employ -- excuse me, insure themselves and their children. It really is crisis mode.

THE MODERATOR: Is there anyone here representing any of the hospitals, who can talk about the rising costs? I know the mandatory retrofitting is going to be a big issue in the next couple of years. Also, the nurse-to-patient ratio. And -- and frankly, the technology is really expensive. So let's -- let's talk about that.

AUDIENCE MEMBER: Thank you. I'm Blair Sadler (phonetic), Children's Hospital. And all of those

things are occurring at Children's.

We're kind of unusual because we wear three hats. We wear the county hospital hat for kids. We wear the university hospital hat for kids. And we wear the Children's Hospital hat for kids. As a result, being a trauma center as well, we're -- we're there 7/24, 365.

And the only -- one of the good things that's happened in the last decade is that a lot of new technology and a lot of new drugs, cancer drugs for kids, are saving lives. That the very same kids that are in bed today and getting better would have died ten years ago.

But we are in crisis as a -- as an institution that's 50-percent reliant on Medi-Cal. The State of California is either 49th or 48th or 50th, depending on which one you read, of level of funding in the 50 states. That's partly why it is a federal solution.

The CCS program that was just acknowledged here, two days ago, the 75th anniversary, the California Children's Services program, these are the most fragile, the most sick kids in the state of California. We have

to preserve and protect that program. We have to make sure that the specialty doctors that are uniquely skilled in treating these very, very special kids, they

had not had a fee increase since 1984, not one, until last year.

So we are very much concerned about the budget, crisis. This morning's newspaper, $21 billion, again, and we cannot, simply, stand more cuts. We've laid off people in October. It's the most painful part of what we do. We're cutting back on supply control. But pretty soon we're going to -- and we have waiting times. We have four- and five-week waits for kids to get to some of these incredible doctors.

Our emergency room, to build on what you just said, was built for 25,000 visits; we're now at 62,000 visits. Too often a child has to wait, who is not urgent, for four or five hours at Children's Hospital. That's simply unacceptable.

So we have enormous capital needs. We have enormous technology needs. And to be able to also pay

for the quality nurses that we need. And I -- in 22 years I've never seen anything quite like it.

THE MODERATOR: There are some statistics in terms of the number of uninsured. About five, six years ago here in San Diego County, they were estimating about 675,000 residents of San Diego County are uninsured. They have updated numbers for this year, that that number has dropped to about 375- to about 400,000. But

still, that's a lot of people who are not insured.

And so I wanted to turn to our panelists over here. Ron Roberts, who is county supervisor, Dr. Lum, who is the director of the County Health & Human Services Agency, and Gregory Knoll, Legal Aid Society of San Diego's executive director.

Ron, do you want to touch upon the number of uninsured here in San Diego County? And you and I discussed that many of those people are eligible.

SUPERVISOR ROBERTS: Well, we have a number of people who are eligible. And I think as one of the

speakers just a few minutes (sic) suggested, in some of the Healthy Families programs, we see people dropping out. There's -- there's always some element of cost. And that, in spite of the fact that it's a good deal, has made sort of a disincentive.

But in San Diego -- the good news is we don't have nearly the number of uninsured that we had just a few years ago; that efforts are being made in a collaborative way throughout this community. I remember when I first came onto the Board of Supervisors, with a smaller population then, in the county the number was in excess of 625,000. Depending on whose number is accurate, I'm hearing numbers today of anywhere from about 400- to 500,000. So we've seen a -- a significant

drop, but we still have a way to go.

Part of it is because of the characteristic, the economics of San Diego. San Diego is a small-business community. We all know the big businesses that are out there, the well-known, larger industries that are there. But the fact of the matter

is -- I think Richard Ledford can tell you -- well over 90 percent of our business, by population, is probably the small -- the smaller operations, which have a much more difficult time providing the types of health coverage, especially as those dollars have accelerated.

I think the encouraging thing, though, is that we have so many people working together. I think it bodes well. We don't have the -- the total solution, but we're going in the right direction.

THE MODERATOR: Now, this type of collaborative discussion and dialogue, was this happening ten years ago?

SUPERVISOR ROBERTS: It started to happen eight years ago.

THE MODERATOR: So this is really good for us to talk about some of those things.

One thing of concern for me in covering, you know, this issue in the news, is the number of physicians who are either dropping out, leaving San

Diego County, leaving California, because it's just really tough to even make ends meet. Especially that they want to serve, you know, the patient. They want to take care of people who are sick. But with Medicare and Medi-Cal fees decreasing for them, it's been really hard. And, plus, while fees are, you know, decreasing for them, the cost of living has been increasing exponentially.

Are there any doctors in the audience who can express some of their concerns here?

AUDIENCE MEMBER: I'm Tom Cummings (phonetic). I'm a family physician. I've practiced in Pacific Beach for 21 years, trained here at UCSD School of Medicine, UCSD Family Practice residency. And I've just had to leave practice last year over a feeling of being overwhelmed by diminishing returns on the tangible, for sure. I made half as much money in 2001 as in 1989.

And then the hassle factor increasing markedly, the feeling that I was working for the insurance company rather than patients, and that being a source of conflict of interests.

I'm looking now to see what I might do next in my life. But it was most frustrating as a primary care physician to continue.

25 THE MODERATOR: And just recently the North

1 County -- thank you, very much -- the North County
2 OB/GYN Medical Group had sent out letters to all of its
3 Medicare patients profusely apologizing, but letting
4 them know that starting January, they are going to drop
5 Medicare -- they are no longer going to provide for
6 Medicare patients because for them, each time they see
7 Medi-Cal or Medicare patients, they're losing money.
8 And it's not that they don't want to take care of them;
9 it's just that they can't anymore.
10 Jerry, I'm going to bring it back to you.
11 Let's -- any other issues that you see, or what are some
12 of the common problems that doctors, nurses, patients,
13 employees, hospitals, are facing together?
14 MR. FLANAGAN: I've think we've heard a lot of
15 the same issues here. Our organization has been doing a
16 series of similar events around the state.
17 And certainly the funding issue is a major
18 problem as we're looking at a state budget, which no one
19 asked for and no one wished for, a state budget that's

going away. We have an economy that we hope will recover soon, but in trajectory for the next several years is that it's going to be much lower than it was in the '90s. And because of that, there's a lot less money in the system, and that's an unfortunate reality.

This county has done an excellent job in the

last several years of forming these partnerships among business and consumers and healthcare groups to find ways to do the most that we can with the resources we -- with the resources we have. The rest of California should be doing that. We need to expand these models across the -- the state and build that kind of public control among the stakeholders here, about how to make decisions that balances the resources, make sure we have a basic comprehensive healthcare package, make sure we're doing everything we can do for access, and we're being efficient.

One of the major things we hear about is that HMOs can do a good job, can be good players in the

system. Although, many take a major chunk of the premium dollar, 20, 25 percent, to cover administration costs. That means less money to patient care, less money for nurses, harder to hire them, and doct- -- and also down the line.

So we're going to go through a very tough time financially in the next couple years. So we need everyone to be playing a very efficient role. And we are -- I'll make sure the HMOs -- I think there are some plans here today, to make sure that they're doing the best they can as well.

THE MODERATOR: And yesterday on Channel 10 we

had profiled two patients who are having problems specifically with their HMOs. One of them who -- and -- and, actually, we had like about 500 calls who kind of identified with one of our stories in that they -- they have critical needs; however, they're fighting with their HMOs in order to get those needs paid for, specifically for medicine or for timeliness in getting the kind of care that they need.

Is there anybody else who might share that or have some kind of thoughts about that here in the audience?

AUDIENCE MEMBER: Hi. My name is Kathy Olson (phonetic), and I'm actually with the Foundation for Taxpayer and Consumer Rights.

We also have an organization under my son, who was injured ten years ago. Medical tests were not done at the time, even though we did have two health insurance policies. We were both working at the time. He actually suffered, at the time, a major brain injury, which was misdiagnosed, was sent home, had his brain herniate. He -- instead of getting a CAT scan at the time, that would have cost maybe, even at that time, $1300, they opted to send him home early, three days. And so what happened is his brain herniated. He suffered catastrophic, irreversible damage.

We've been working with the Foundation for probably about five, six years now too. Because even

though we were covered and it's a covered benefit, it's very hard to access those services at times. He ended up being blind, traumatically brain-injured. He is orthopedically impaired. He's got many behavior issues because of the injury itself.

In the state of California, we are very lucky, though, The Foundation for Taxpayer and Consumer Rights, the Consumers for Quality Care portion of it, had worked on, with the cooperation of the state, a pamphlet for patients. It's the California Patients Guide. And we -- we wrote it under a grant and everything. And I think a lot of times patients really don't know, first of all, what their rights are, and to be able to access them and think, "Oh, you know, I have health insurance; I should be able to go."

They need to know, basically, what -- what their plan covers and how they access those problems. If you have one, you need to take care of it. And like everybody has said before, it does get worse. If you don't take care of it at the beginning, it can end up a catastrophe. And then we end up doing something that maybe you didn't have to for the rest of your life. But it does happen. So I think patients need to be smart

about what they are asking for as far as service also.

THE MODERATOR: Thank you very much for sharing that story.

I just want to just poll everybody. For those of you who, you know, live here in San Diego County, how many of you feel as though in last ten years that the accessibility for healthcare has gotten worse?

And what about the quality of healthcare has gotten worse over the last ten years?

Okay. I just wanted to pose that question out there.

So -- so we've heard a lot of, you know, problems. And I'm sure also here in San Diego County, being a border town, many people don't speak English. Just for the Asian-Pacific Islander community alone, we have nearly half a million living here in San Diego County. So we're talking about knowledge, you know, patients knowing what their rights are and -- and patients knowing whether or not they're even eligible for some plans. So that's also another issue.

Let's talk about some of the solutions. And

that's really what we want to focus on today, is what are some of the solutions in reforming this healthcare system.

And I'm going to turn to the panelists. If

there was anything that you can change, you were granted a wish, you know, in reforming our healthcare system, what would it be, and -- and what is working?

And we'll start with you, Steve.

MR. ESCOBOZA: Well, one of the things at -- at a very practical level that I think is working is that -- it is said that 20 percent of the population consume 80 percent of the resources in healthcare. To take a look at chronic illness, chronic diseases, and try to find the best practices that work for that population I think has been a very effective way of incrementally addressing some of those healthcare needs.

Again, the larger picture is one of dysfunction. But looking at the practical level and

what we can do for patients here in San Diego, I think the hospitals, the clinics, the physicians, are all looking at best practices and addressing it on a very practical, here-at-home basis.

THE MODERATOR: How is that done, though?

MR. ESCOBOZA: Well, again, you know, each of the hospital systems in particular try to integrate, through information systems, the records and so forth of patients, looking at measuring outcomes around certain treatment protocols. They see the practical reality of

what their work is doing, and they try to apply that on a systemwide basis. I think the physicians similarly do the same thing. Clinics are looking at information systems, again, for the patient loads that they have.

That doesn't answer the larger question of how do you comprehensively address the whole continuum of healthcare, from prevention, intervention, to treatment. We're spending the bulk of our resources on the treatment side, and we need to -- again, to look at the larger continuum and put more money into prevention

and early intervention.

DR. HERTZKA: Again, I think we've heard the comments everywhere that the insurance has become unaffordable, and that is a reversible issue. If -- if I could wave a magic wand, I would get everybody back to a health insurance plan like they have -- like people have for their auto or their home, where not every little thing needs to go through the health insurance plan. You could drop the costs dramatically.

And with the savings, you could even set up -- there are various models that have been approved by the IRS, that are being offered to postal workers and through some of the major employer cooperatives in the state here that have to do with personal spending accounts or medical saving accounts. A variety of

models, the benefit of which is that people actually can go out and choose their doctor.

When the -- when the hands go up for quality here, that quality is going down, a lot of that is -- is

really access. It's they're not getting to the doctor they want; they're having to wait a long time; they're not sure what's going on; they don't really trust what's going on; they wonder if the health plan is influencing it. If people had the ability, like they used to, to go and see the doctor they wanted, and got in to see them, and maybe they charge $10 more than the other doctor, but then the health plan wouldn't exclude them from them, people would feel a lot better, if they were more empowered in making these kind of choices.

In addition to that, I think when you hear something like a community clinic having 90 percent of their uninsured patients being at or around the poverty line, that is a fundamental failure of government. It is an absurdity that we have something called a "Medicaid program" and that there are people at the poverty line who are nowhere near eligible for that. That's a national travesty. If we have to raise taxes, whatever we have to do, we need to take care of our neediest citizens, and we are not.

And lastly, the ignored quality issue -- I'm

glad Mr. Escoboza brought it up. We do need to focus on the folks -- rather than build a healthcare system where we try to cover every little thing for everyone, the resources should be focused on the chronically ill, the diabetics, folks with heart failure, where we can save dollars and improve healthcare by working in a quality fashion to try to get -- again, as was said, to get the best care to the most people the most efficiently.

MR. LEDFORD: I think the gentleman prior to me just kind of covered a lot of bases. I'd like to hit one that's a little bit different, if I can.

If I could wave a magic wand, do you know what I would do? I would start by deciding what we wanted. That's kind of a novel thought. But I bet everyone out in the audience there has some idea of how they'd like to have services provided and what level. I suggest to you there's a cost to that.

But we have to decide first what we want. We've kind of done the opposite. We've let the marketplace squeeze the price down. We've let competition move it down. And at least, I believe, from the business community we view the services as being metered to us for financial reasons, and that gives us

the impression that the service isn't as good.

A personal case in point, I had to wait a week

to get my sick son in to see his doctor because he was not terminally ill, he was just sick. I mean, obviously, I think your point is perfect, really, Dr. Hertzka. I think we'd like to have more control over what happens to us.

So waving our magic wand, I would say let's start by having a community-wide meeting figuring out what level of service do we want, what kind of services do we want, how far down will we reach to get them.

When you talk about 200 percent of -- of poverty level, I mean, we're really talking $12 to $14 an hour. And perhaps for the older viewers out there, that seems like a lot of money, but you try to live on that in San Diego.

We have to make better use of our community clinics. You know, they provide excellent services at -- at very low cost. And businesses must is outreach

to them in some fashion or form for preventive care.

In addition to preventive medicine, we've got to deal with patient rights. And that gets back to control. We'd like to talk to our doctors. We'd like to have some sense that our doctor is in charge of our healthcare, and not an HMO and not an insurance company, you know, certainly not a bureaucrat who's counting pennies.

Education and outreach, two issues I just want to mention briefly. Education and outreach, waving my magic wand, 73 percent of our small businesses who do -- who do not insure their employees are not aware that 100 percent of that is tax deductible. That's a legitimate business expense. What we've found in just the short time we've been working this issue is that the small business community really doesn't understand the value of having health insurance for their employees. And in many cases those employees have never had health insurance.

They also don't understand that as you

outreach, you also find that many of those employees working for our small businesses are eligible for public programs, both new ones we hope are coming on-line, and existing ones. We have to find some way to reach out with our magic wand and make sure they're aware of that, make sure these are good things, they know they're good things, and we can engage them in them.

And lastly, I would say if I would could wave a magic wand from the business community, we'd make sure that our healthcare net stays where it is. It's deteriorated enough. We can't have a Children's Hospital disappearing on us because they're 50-percent dependent on funds from someplace else. You know, you

expect your -- your fire station to be open when you call, don't you? Well, I think from a business community standpoint, we expect our healthcare institutions to be available to our employees as they need them.

MS. JENKINS: Everybody's said a lot of good

things here. But from my personal point of view, I think the market-driven system, like you said, has driven costs down to the point where it's impossible to provide a service. So I think there does need to be some basic, fundamental overhaul of the system.

Personally, I think that we need to start looking at some universal coverage for all the citizens of the state to where everyone can access the healthcare they need in a timely fashion. And I think that's doable if you look at where money goes and how money is spent on the middleman and the other things. I think there are resources there that could do that for the citizens of this state.

MR. FLANAGAN: Mine is quite easy. I would like to make the system work for patients first and consumers first. And that ties into what comments were made about a public process, and I'll beat the drum on that as well.

I think that we need to have a -- a real

system. There have been those who have called our

system a "nonsystem"; i.e., there are -- nurses, doctors, HMOs are not linked together in a public process or a utility process to make sure we're balancing all our needs and we're balancing the resources that we have.

We have emergency rooms that are closing because some hos- -- you know, hospitals don't want to serve the uninsured. That means that hospitals in the urban centers are hit by huge increases in uninsured, and that means our ER rooms are flooded. And that -- for anyone else that has insurance, that means you've got long lines, and it also increases health factors as well.

So there is a high level of irrationality in a -- in our market because each of these entities, businesses, employer -- employers, hospitals, and nurses, have been working separately. And the model here that Supervisor Ron Roberts spoke of and has been placed in San Diego County is one that California should learn from, which is public/private process, that has a discussion with the public to say, "Here's the resources we have. How can we utilize these most efficiently? And what are our priorities?"

THE MODERATOR: So that leads us right into

Supervisor Roberts. I know that the county here in San Diego is one of the only counties in the state that dedicated all tobacco settlement funds back into healthcare. And, you know, so let's talk about some of the solutions that the county is trying to do.

SUPERVISOR ROBERTS: Well, we and -- I have to get my button on here.

You're right. The county has -- has put significant resources into this issue. And it's aimed at a whole lot of things. And we -- we're very -- we feel very good about that.

There's -- there's always been a feeling in this county, though, that if you look at the total amount of money that's being spent -- there are various pots of money that are coming from all of the different governmental sources -- and somehow if we had that, we could put it all in one pot, and we could control how that was spent rather than blindly following mandates and other things, we could do a lot better job. There's

no question about that.

We -- we've tried to get a waiver from some of the rules to show that sometimes it's -- it's not the amount of money you're spending, it's the way you're handicapped and -- and handcuffed in the way you spend those dollars. I think people would be shocked if you

started to look at the total amount of spending and the total amount of spending per person. So we're -- we continue to see if there's a way that we can consolidate some of those efforts and do a better job.

The reason why San Diego County has done so well over the last several years is because we've -- we've learned to do things differently. If we can allow -- if the state and the federal government would allow us a little leeway, I think we can show them how to do a much better job, even in this area. But sometimes it's -- governmental agencies like to build up governmental bureaucracies rather than to -- you know, to have services flow far more freely and -- and fairly.

That would be -- if I could change one thing, I

think that -- that would be it, to try to be able to consolidate, to eliminate many of these different pots as separate pots, bring it all into one, and be able to spread that in a different way over the -- the people who need services.

THE MODERATOR: Well, we certainly do appreciate the county's leadership in dedicating all the tobacco funds when other counties and cities are not putting that money back into healthcare.

We've talked a little bit about the -- the need for community clinics and just the importance of

community clinics, specifically out in the rural areas where the uninsured don't have access. And I wanted to talk about some of the -- the solutions for those who are underinsured or uninsured.

We have here Mickey Buyers (phonetic) of the San Diego Community Clinics Association, who may have some thoughts on that.

Is Mickey here? I thought she was here. No?

Okay. Is there anybody here who can speak about community clinics?

Right over here.

AUDIENCE MEMBER: My name is Gresham Bain (phonetic). I chair a steering committee called Volunteers in Medicine. I can't speak for Mickey Buyers, which is a government-funded clinic, other than to say they are a terrific operation, and they are severely compromised by the cutbacks in state funding, in particular. And without them, the emergency rooms, if you think they're gridlocked now in San Diego, you -- you would have an absolute nightmare without them and Mickey Buyers' hard work.

Volunteers in Medicine is a solution. Jack McConnel (phonetic), the inventor of Tylenol, started making free matching between volunteer retired physicians and people who had no health insurance on the

island of Hilton Head about 12 years ago. There are now 22 funded -- unfunded clinics, with no means of government support, that are totally community based,

built, funded, and staffed across the country. There are 27 more in operation, and we plan on starting the first of probably ten in San Diego next year.

The county med- -- San Diego County Medical Society was terrific in helping us design the feasibility of this by sending out a letter to recently retired physicians. And one of the problems that you've stated today about the lowering age of retired physicians, particularly in San Diego -- now I think it's below 55 years old -- feeds in to the concept of we're not much good for anything else after this.

Tom Cummings and I are friends, but I'm not sure I could do much of anything other than maybe help them, you know, wash boats and -- and relax, but we're too young for that. We practice medicine. We love to practice medicine. And we will volunteer to do it in our retirement years.

The Medical Society had 66 board-certified physicians sign up to run shifts on a free clinic. We are overwhelmed with donations from this community. I have a warehouse that's 25-by-8-by-10 feet full of medical equipment ready to open the clinic as soon as we

get space. And we are about to do the fund-raising and are talking to some of the public officials about land.

So I think volunteerism is not dead. This is America, and the overwhelming support that you have in the medical community and in the lay community -- when these clinics go up, they are, by definition, built by trades people in the small business communities of their locale. We're not allowed to raise large sums of money and then build it by writing checks. So the community gets vested in the clinic. And it fits that group of people between the indigent or Medicaid-eligible, poverty-stricken group and the employer-insured group.

But as you said earlier, 85 percent of the uninsured, who hover around 200 percent of federal poverty level, are, in fact, gainfully employed. And I spent 30 years in this city treating them for high cost in the emergency rooms. And it tears me apart that that's their only option.

THE MODERATOR: Thank you for sharing those thoughts. We have some -- someone else?

AUDIENCE MEMBER: (Unintelligible), medical

director at San Ysidro Health Center. We're a member of the Council of Community Clinics. Actually, for the last five or six years I've been director of medical education at Scripps and in close collaboration with

UCSD.

What we have done is we've built a family practice residency training program. It is a true collaboration between the academic medical center, the hospital system at Scripps, and the community clinic setting in which we work. I think that's really the answer to the future issues of collaboration being the -- the solution to this.

We have built what we call our collaborative "soup" residency, which is that we have, basically, took the potato from one place, the carrot from another, and piece of celery, and ended up with a totally different flavor than we could have possibly, had we tried to do it at one institution alone.

Scripps provided an excellent GME apparatus, an excellent, historically superb internal medicine

residency program at Scripps clinic, at Scripps Mercy. UCSD provided the academic and research components and all the advanced electives. But San Ysidro had all the patients. And we have huge numbers of patients at San Ysidro whose lack of insurance, but access to federal programs, because its history and its genesis in terms of dealing with the underserved communities.

The answer to me, my way of looking at it, it's really a community-based education program, that is

based in the community, that deals with work-force development issues in the long strategy. What we really need to do is to build a Salk Institute of Community Medicine, which basically takes the young, local students in the high schools, the young college students, from Southwestern College, for example, and connects them to the public health MPH student at San Diego State, a resident program either out of UCSD or our program down at Scripps. And it does the same thing that the Salk Institute is doing with little molecules.

You see, a research group at the Salk, basically, has a PI, an investigator, maybe a post-doc, maybe a medical student or some graduate student. And what they do is they study something, and then they publish it together. And that PI uses it for a grant for next year; the post-doc to get a faculty position; the medical student to get into a residency; the undergraduate to get into medical school.

And whether it's dental school, nursing school, or medical school, all of that is really just a needs assessment analysis that should be taking place in the community, that engages the local high school students in some research and gives them the idea that they could even go on to become a nurse or a dentist or a doctor. And really, on the local scene we have those resources

available, if we can just simply connect the pieces together. We have the fulcrum for that.

The critical mass in our setting at San Ysidro right now, we just need to talk to more agencies. And that was our biggest discovery, we had all kinds of

activities in the South Bay going on, but they were not talking to each other. They didn't know of each other's existence. And all we really did was connect those pieces and bring in the connections, together, to create a residency program that is not actually owned by any one entity. It takes the collaboration of all of us.

And people thought I was insane when I first talked about this; that we would never be able to build it; that it wouldn't work; and that, number one, we would never find residents that would come to our program of the caliber that we wanted.

THE MODERATOR: But it's happening.

AUDIENCE MEMBER: But Raoul Trejo (phonetic) -- let me give you a story. Raoul Trejo was born in Tijuana. He got his baby shots at San Ysidro Health Center when he was a little guy. And he graduated from Harvard Medical School and came back to town because he said, "You guys built it, and I wanted to come back." Okay?

THE MODERATOR: That's wonderful.

AUDIENCE MEMBER: He is one of our chief residents right now.

It's taking some very competitive credentials to get into our residency program now. And we have a number of young high school students who graduated from Chula Vista, Imperial Beach, National City, San Ysidro, who didn't, apparently, exist in people's minds, who came back to town with an incredible, interesting thing that we did not anticipate, and that was that they had sisters, cousins, and brothers working in the local schools and the local agencies. That, therefore, gave us immediate speaking engagements at the local role-modeling options, in the local kindergarten, first grade, sixth grade. And we required of our residents that they actually do a community project as part of their actual residency.

THE MODERATOR: Okay. So we're talking about -- thank you so much. We're talking about collaboration. We're talking about education, innovation, because, you know, funding -- money doesn't grow off of trees, so we have to do things a little bit differently. And it sounds a lot like the community has to really step up.

Do you want to make a brief comment?

MR. KNOLL: Lee Ann --

THE MODERATOR: Yes?

MR. KNOLL: Lee Ann, this is Greg Knoll.

THE MODERATOR: Oh.

MR. KNOLL: I'm sorry. I've been very patient. And if you know me, that's not an easy thing for me to do.

THE MODERATOR: Feel free to jump in.

MR. KNOLL: And I just have to say a couple of things.

You started this thing off by mentioning the words "efficient," "stable," and "accessible." Last night there were 550-some people that called your station just because you put a phone number up there that said "healthcare." And I -- and resoundingly, those 500 people say "no" to all three questions. It's not efficient. It's not stable. It's not accessible.

All the nice solutions that we've talked about here are very good. This county is -- is, as Jerry

said, working very closely in a collaborative effort. We -- we -- we have really cut down the number of people that don't have coverage. That's not the problem.

If you don't start thinking of federal and state governments, stop balancing their budgets on the backs of people with healthcare problems, we are going to implode as a very system --

THE MODERATOR: So you're saying --

MR. KNOLL: -- and the entire healthcare system will be volunteer.

We are one -- we are one Super Bowl disaster, one civil disobedience, one flu epidemic away from hospital closures and a complete inability to handle the situation.

THE MODERATOR: So you're saying that the solution for you is on the state and federal level --

MR. KNOLL: Yes.

THE MODERATOR: -- and that citizens in San Diego County --

MR. KNOLL: Yes.

THE MODERATOR: -- and California need to lobby their politicians and let them know that -- that they care and they want to have --

MR. KNOLL: It might be nice if the United States cared enough to make a constitutional amendment that it was the right of every child, man, and woman in America to have quality healthcare, just as a right of being an American.

THE MODERATOR: We have a quick comment over here.

AUDIENCE MEMBER: My name is Elena Dahl (phonetic). I'm with the Council of Community Clinics

here. We have 19 member clinics, serving over 400,000 patients a year.

And we do a rely on both government and private funding. The Early Access to Primary Care program, as well as the Child Health and Disability program, are two big state programs that we rely upon. We got through the budget cuts last year, the state budget, fairly

well. We were able to maintain our funding. But because we're already looking at a deficit here of $20 million, we're anticipating that -- we're concerned about that funding continuing. And because we do rely on that funding, in fact, we could -- we may have to cut services to our patients and cut clinic services as well.

So part of the solution, I think, is we need to get together as a community and look at these partnerships with the business community and others to create an advocacy plan so that we can be heard by the state, you know, about the importance of this funding.

The other thing I wanted to mention is with the Healthy Families and the Medi-Cal, significant funding was cut last year for the Medi-Cal outreach and the Healthy Families outreach. We had to lay off outre- -- outreach workers at our clinics who are enrolling the people who are eligible for services that are not

currently enrolled, and that's a significant

population. So that's something else that we need to do here in San Diego, is somehow look at a way of reinstating those services in light of the budget cuts that were made.

THE MODERATOR: And until things happen on the state and the federal level, I think all of us have to kind of give up a little bit of something. So I wanted to ask the audience, as well as, you know, some of our panelists: What is it that we all have to do to pitch in to solve this problem, you know, while we wait for the state and the federal government to step in and overhaul the system?

MR. FLANAGAN: Well, I think we certainly need a state solution. We need the HMOs and medical groups in this state that take a big chunk of the premium dollar and spend it on administration and not on healthcare to be controlled; to make sure that, one, they're -- they can make a profit. But they have to make sure that they're not gouging and that we're controlling, with a public control process and oversight, a public utility approach to controlling the amount of money that's going to administration, CEO salaries, and to make sure that as much money as possible is going on -- on patient care.

The only way we're going to do that is through a public control process. And I think that something that we used to do with energy of -- of doing a systemwide approach, a utility approach to energy, to make sure that we're getting lights on in all communities, the same way we're going to get healthcare to all the communities, which is a statewide system approach to make sure these regional solutions are working and the state as a whole and doctors, nurses, and employers are all working together to get the job done.

THE MODERATOR: And, Dr. Lum, you have some thoughts?

DR. LUM: Yes. I am very concerned about the lack of financing for the very things we value and cherish here in the community, but also in the state.

This discussion about a healthcare crisis is not a new one, as we know. It's probably been discussed for at least ten or twenty years. So it doesn't take much intelligence to realize that we have to come to

grips with the fact that we have rising public expectations with limited resources.

And when you look at the state economy, which is, obviously, taking a turn for the worst, and the $23.6 billion shortfall, we have to ask, is this state

prepared to afford an adequate healthcare system?

Put it within perspective, the state has to cut 23.6; you have to cut state general funds. Not federal funds, but have to cut state general funds. Now the state puts in a total of $21.6 billion a year in everything we know as Health & Human Services; child protection, adult protection, senior services, public health, labs, et cetera, the things we cherish. 21.6.

So it basically means we can completely eliminate everything we know as Health & Human Services in the state of California, and we'll still be short of the -- of the budget target. That is disconcerting.

Aside from that picture, which is gloomy, we have to ask, given the fact that this county contributes

property taxes to this state, we need -- have to ask, how much of that do we get back to support vital services here in the community?

There's a recent analysis that shows of the 58 counties, we're in the bottom 15 of all counties in terms of getting back our state property taxes.

THE MODERATOR: And why is that?

DR. LUM: It has to do with a -- a formula that the state legislature adopted back in 1978. It was through Proposition 13, when the world was very different. We know that San Diego has changed

dramatically over the past 24, 25 years. The state has not changed the formula.

THE MODERATOR: So what can we do?

DR. LUM: We need to work with our local delegation. I think voters, taxpayers have to say -- in order to support the kind of healthcare system we cherish in this community, we have to convince the state legislature and the Governor to change how they allocate state dollars back to counties.

We get, on average, $86 per person from our property taxes. That is not enough to support a healthcare system.

THE MODERATOR: So there needs to be a political uprising.

DR. LUM: We need to have forums like -- of this nature --

AUDIENCE MEMBER: (Inaudible).

THE MODERATOR: Why not?

DR. LUM: -- where we then talk about what kind of healthcare system do we want. It goes back to the point made by the panel before. Let's define the services we value.

Then we have to ask an equally difficult question; that is: How much will the system cost, and can we afford that kind of system? And if we can't

afford it, do we want to talk about raising taxes, or do we talk about lowering our expectations?

Now, how do we then talk about making our

system more efficient and effective where every dollar that we spend is well spent.

SUPERVISOR ROBERTS: When you talk about a political uprising, I want to make sure we clarify who the uprising needs to be aimed at.

UNKNOWN: Somehow I knew that was coming.

SUPERVISOR ROBERTS: Let me -- let me underscore something.

What Dr. Lum is saying, at the end of all this is: If you live in San Diego, we are going to get less per person from the state, far less, than anybody that lives in San Francisco. Why is that? That's political. That's politics. That nonsense. That's outdated. And any representative we send to the state legislature ought to be working full time to reverse that.

It is absolutely unacceptable that a system could have been put in place -- the state tends to, if you do well, say, "We're going to reward you by punishing you." And that's what -- that's what is at the heart of this. There isn't any reason, whether we're talking mental health, whether we're talking

health, whether we're talking any types of social services, that people in San Diego should be shortchanged by the State of California. And that is a fact, and that needs to be reversed. And there should be a political revolution over that.

THE MODERATOR: And there is -- also Californians, in general, are shortchanged on the federal level as well, not just San Diegans. So it just makes things a lot worse.

I'm sorry. You were patiently waiting. Go ahead.

AUDIENCE MEMBER: My name is Vera Flax (phonetic).

THE MODERATOR: Can you bring your mike up a little bit so --

AUDIENCE MEMBER: I'm -- my name is Vera Flax. I have my case worker to represent me, but she didn't get here. So I'll guess I'll have to represent myself. I know I have a -- an accent, and I ask you to excuse me.

THE MODERATOR: It's a beautiful accent.

AUDIENCE MEMBER: Okay. Now, as the gentleman

said, I am a patient from San Ysidro. I've been a patient for about -- from '82. Okay. In '83 I worked for -- for the state. And in '84 I got an accident. I

was hit by -- rear-end by another car in a small Grem- -- Gremlin. So I had to stop working and had back injury.

Three months after my retir- -- my insurance went out, I was found with cancer in the breast. My doctor -- I'm here as a miracle because of Dr. Davis at UCSD. He sent me to the Medi-Cal office to get some assistance, that they could work on me. They denied me. He had to take it up on his own, he and the other doctor, to work and help me. That's why I'm saying I'm a miracle here today. Okay.

When they did agree with him, they said my surgery would have to be -- both surgery in one day. So I was ten and a half hours in surgery. When I got up -- I went in at 8:00 that morning, got out at 9:00 that night. I thought it was -- I said to the nurse, "Oooh,

it's only one hour?" She said, "This is 9:00 at night. And you're" -- "you're not all out of danger yet, because you have to get up every hour on the hour and walk." That was one of the longest night in my life. Okay. I lived beyond that.

I worked for the states (sic). I'm retired, like I said. I did 20 years medical work for the federal government. I worked for the state. Now I have to be fighting the Medi-Cal -- Medicare again. They are

denying me. I have a bad heart, and I have other problems. They're denying me assistance.

THE MODERATOR: So what do you see as the solution?

AUDIENCE MEMBER: Well, that's what I -- I'm here for today, to find out what can be done about this. Because, like I said, I'm paying in to Medicare, not that I'm not paying. But they're saying I am not paying.

My file is a mess. I went in with my case worker on the first of this month, and -- at one social

office. And they said that, oh, they don't understand my file because on one part it says from 8 -- the year 2001 to now, I've been paying monthly, which is a fact. Because when they started to give me a hard time, I took my checks to her so that she could sign them. All I did was sign my name and mail them. And they said I haven't been paying. I have 12 or 13 months paid, and they're denying me.

I went for a heart check. They sent me a bill for $1400.

UNKNOWN: Lee Ann --

AUDIENCE MEMBER: I go to see my doctor, they said "$99." They send me the bill; I'm not eligible for Medicare. Then where is my money that I'm paying for

Medicare, at $55 a month, going?

THE MODERATOR: And I suspect that the story that you're sharing is one that many others do share. But let's -- we want to focus right now on solutions. And what you're doing right now is part of the solution,

sharing your story, going out and, you know, finding out, in discussion, in dialogue, with all different facets of the healthcare industry, what can we do.

So let's -- let's talk -- let's -- let's just stay focused on solutions, and hopefully, you know, we can get you some -- you know, the answers that you need and some of the access to some -- through some of these people out here.

What -- we talked about some of the solutions. Now, what do we do in putting those solutions into action? So we need to strategize on what we can do to make things better and -- and empower ourselves.

We have one person here to share his thoughts with us. And then I'm going to turn to the panelists after that.

AUDIENCE MEMBER: My name is Mike Matthews. I'm a member of Creative Opportunities, a nonprofit, client-driven, mental health organization that does education, advocacy, and outreach. And I want to thank Mr. Roberts for bringing up mental health.

I think that one of the biggest problems -- and there is a solution to -- is the interface between mental and physical health in this county. I see it time and time again with clients that come to us for help, and they say, "You know, I went to my psychiatrist. He ordered a blood test. The result was that I need to have something for high cholesterol, but I had to wait a month and a half until I saw him again to find out that I needed to go to a doctor."

And so what we need to do is get some collaboration between the physical and healthcare providers, they need to talk to each other. We need to work on people putting together wellness recovery action plans and advance directives so that the physical doctor and the psychiatrist can talk to each other.

Another important thing that we can do is to collaborate, not only there, but systemwide. Consumers of mental health services, as well as physical health services, can educate and advocate and outreach to each other. It's been successful in mental health. It works in substance abuse, with Alcoholics Anonymous, La Leche League, and all of those organizations that work together show that partnering together with each other works also. Thank you.

25 THE MODERATOR: Thank you.

1 And so, again, we're talking about
2 collaboration, education. But it's always easier said
3 than done, these solutions.
4 So, Jerry, I'm going to start with you. What
5 can we do to take some of these solutions that we've
6 talked about and strategize in putting them into action?
7 MR. FLANAGAN: I just want to say, I agree that
8 in the best vision in healthcare, that it's a national
9 approach and a national strategy. However, we can't
10 wait for the federal government to act on this. It's
11 California that's got to move some major solutions, and
12 we don't have to wait. We have 35 million people in
13 this state. We're the fifth leading economy in the
14 world. We have a huge amount of people that have great
15 expertise in healthcare, and we have a population size
16 that allows us to both purchase medicine and
17 prescription drugs and get the lower cost -- lower cost
18 per each individual.

But we need to have the Governor of the state of California to convene a special session in the legislature to talk about the crisis in healthcare. We cannot wait any longer. Businesses can't put up with the high -- increasing premiums. The uninsured need the answers that they're looking for. And the state of California must act.

There is a -- it could be legislative approaches. There are options to do new regulations. But I think what we need mult- -- ultimately is more public control in the process to make the decisions collectively and have a systemwide approach. And I think we may need to do a major rewrite of the way that healthcare operates in the state of California. And that's not going to be easy.

But what we see here is that when you sit down and talk about solutions, you actually can get somewhere. And the state of California needs to start doing that to take care of the communities across the state.

MS. JENKINS: Well, I kind of liked what he said when he talked about implosion. Because personally, that's how I think this whole thing is heading. I think the system doesn't work. I think that there's huge amounts of money that are allocated in totally inappropriate ways, that go to the wrong places, that could be put back into delivering healthcare to the citizens of the state.

I agree with Jerry completely. We need a statewide approach. We need to eliminate the profit incentive that allows for-profit corporate healthcare entities to pay their CEOs, as the second-largest one in

the country just did, $111 million for one year, with stock options, and put that money back into taking care of people. 25 percent administrative costs for CEO compensation and advertising is not where the health dollar needs to be spent.

The fact is government-regulated programs are administered at a much lower cost than privately

administered ones. They are administered for about 5 percent. These other programs spend, like I say, 25 percent of their costs on executive compensation and advertising. We need to eliminate that allocation of money into those things and put it back into caring for people.

I believe the money is here. It's just that reallocating it to where it needs to go, which is taking care of people. I see it every day in my job. The patient that rolls into the ICU, if they'd had appropriate, preventative intervention a year, two years before, wouldn't be sitting in an ICU wasting hundreds of thousands of dollars of taxpayer money.

I have personal experience. My stepchildren's mother had no job and no insurance, and by the time she figured out how to work the system, had late-stage, three, metastatic cervical cancer and died at the age of 39 because she couldn't access healthcare. And there's

something fundamentally wrong there.

I have a stepdaughter who had congenital heart

defect, corrected at birth. Can she get insurance? No. She has a preexisting condition. There's all these restrictions that allow people to fall through the cracks who, if given appropriate preventative care, would save millions for this state, if not billions. It's like penny wise, pound foolish what we do here. And it's got to stop.

I personally agree with him. I think in the next 10 to 15 years this system, the way it is, if we don't do some fundamental overhaul, is going to implode on itself, and healthcare will be a privilege that only the very richest people in this state are allowed to have, and the rest of us are going to be darn out of luck. Because that's the way we're headed.

And I think it takes statewide -- like Jerry said, I think it takes a statewide organized system, and not the individual counties struggling with this, the issue of reimbursement and all the rest of that. We need to have a big plan that covers everyone. And I really believe that's doable. So --

THE MODERATOR: Who's going to come up with that state plan?

MS. JENKINS: Well, I think the coalition of

people sitting at this table can work out how this thing works. Like I think the -- the concept of defining what the public feels is important and then looking at how we allocate those resources to provide that service to the public is -- is something that's -- that would -- would take a lot of work and effort, but it's doable, I think.

AUDIENCE MEMBER: Could I speak to that?

THE MODERATOR: Sure.

AUDIENCE MEMBER: My name is Sylvia Hampton, and I am the president of the Coalition for Quality Healthcare here in San Diego County. And I represent the League of Women Voters on that coalition. I'm also a member of the project management committee to improve access to healthcare here in San Diego, which has been working for six or seven years on -- on this issue.

The League of Women Voters did a study, a nationwide study, that came to consensus in 1992 around healthcare. And it was started because of the high costs that -- the costs that were going up tremendously,

and we were very concerned about that. And we have a position that supports public programs and public-private partnerships, which I think is probably the way we're going to go.

However, the Coalition for Quality Healthcare

is the state affiliate of -- or the local affiliate of Healthcare for All California, which supports universal coverage.

And what is happening in California right now is an options report that is -- has come out on nine different options on how to cover everyone in California. The -- the League of Women of Voters, for example, was against Prop 13, which resulted in all of these funding problems that we're experiencing here in San Diego because of the formula that was set in place at that time.

I would also like to comment on the Hilton Head clinic that was put together. The way I understand it is that -- that the people on Hilton Head are a very, very wealthy community, which is similar to the overall

community in San Diego. They were concerned because workers, healthcare workers, gardeners, cooks, the workers in that community were coming to work sick. They didn't have health insurance. And so the community responded with that free clinic. That's wonderful, but that's not the way to do public policy.

THE MODERATOR: So we're talking here now -- I mean, we've heard about some of these -- of these issues. We're talking about like what -- what do you think we can do in implementing some of these

solutions --

AUDIENCE MEMBER: We need to --

THE MODERATOR: -- to address that specifically?

AUDIENCE MEMBER: -- look at the options report. And they will come up with models that the legislature will work -- will look at, and then they will present the best option to the legislature to vote on.

And if it does not pass in the legislature, then you will see a political uprising of people demanding coverage for everyone so that we don't implode.

THE MODERATOR: I think we're kind of going in that direction.

AUDIENCE MEMBER: Many of our members are here today, by the way, of the Coalition.

THE MODERATOR: Thank you all very much for coming. It sounds like politics is one of the big solutions here.

Go ahead. We're going to go -- turn back to our panel.

MR. LEDFORD: My turn.

You've heard a lot of doom and gloom. And there's certainly some truth in the statements that have

been made.

Just as a personal point, Jerry, I'm not quite sure I've seen any government run anything for any kind of efficiency compared to what the private sector can

do. That's not an excuse for what happens with some of the HMOs but -- but the thought of having a large government bureaucracy handling healthcare for all Americans frightens, I think, most of us in the business community.

MR. KNOLL: It's okay, Richard, it could be a nice nonprofit.

MR. LEDFORD: Mr. Knoll and I get along quite well, thank you.

MR. FLANAGAN: But the end to that point, though, although there is a perception among the employers -- and it's dangerous, I think -- that the government can't run an efficient healthcare program, and there's -- it's not a perfect system, but it's filling a major role.

Medicare operates at a -- a -- 92 percent, 95 percent of the dollars that are collected into Medicare go to patient care. The administrative costs are almost not existent. When you look at --

(Simultaneous colloquy.)

DR. HERTZKA: But Jerry, now, that's -- that's

a major -- here's a policy point. Let's -- let's --

Medicare, maybe for the first time in its history, has finally dropped below 10 percent outright fraud. Okay? The reason Medicare has lower administrative costs is nobody looks at the bills.

After 9-11, scam artists flourished throughout Florida and collected; said, "You know, we're not sure, the computers may be down; we need your Social Security numbers." And the government got a raft of bills, phony lab tests, phony everything. The patient doesn't see the bills because it's covered by Medicare. And it's been written up everywhere from here to Tuesday.

But one of the reasons that health plans have higher administrative costs is somebody looks at the bills. So they ignore that. They also ignore all of the FBI agents that are here trying to then backtrack and get the fraud. They ignore huge elements that are part of the costs.

Every -- every hospital -- we get just installed 100 shredders at Sharp Maryberge (phonetic) Hospital because of a new privacy concept of the federal government, which is essentially a spin-off of Medicare,

because we're supposed to destroy everything that has a patient name on it. Well, that cost is quote, unquote, not part of Medicare's administrative costs.

I would submit that the mandates that follow government, whether it's seismic retrofits or privacy things, it -- it's a specious argument.

MR. LEDFORD: Okay. Okay. I started this. I want to --

THE MODERATOR: Okay. I'm sorry.

MR. LEDFORD: My turn. My turn. Again, I just --

THE MODERATOR: And again, we're talking about implementing --

MR. LEDFORD: Exactly.

THE MODERATOR: -- solutions.

MR. LEDFORD: Right. All right. Because you asked -- you asked what we had in common and what kind of solutions we can offer. So I'm going --

THE MODERATOR: Yeah. Please.

MR. LEDFORD: -- to suggest a couple things.

You've heard people approach this thing from the national level, saying the solution is to tackle Congress and tackle the White House and get this thing done. And you heard folks over here talk about how we need to address this from a state level, because that's really where the other pot of money is.

I want to tell you, think nationally, think regionally, whatever you want to do, but act locally.

All right? There are things we can do now. We don't have to wait for our politicians to coalesce around a decent refund for San Diego County. I mean, we have tried to do that since 1983, actually, when SB 123, I think was the bill, was passed, which created the funding deficiency between us, L.A., and San Francisco. It hasn't changed a thing, and not likely to, given the political scenario and the leadership in the state. So let's start working on something we can do now.

We -- we have solutions we've embarked on here. They're not perfect solutions. But they're

solutions that the audience here and those on TV ought to be engaged in. We have created, through the efforts of Ron Roberts and the county Board of Supervisors and the professional staff here, ways to outreach into the community.

We have now a vehicle, should we achieve a substate waiver, which will allow us, Jerry, to better utilize the funds that come into San Diego. We are a ways away from that, but we have a vehicle to implement that. San Diegan -- San Diego Healthcare Coverage Corporation is a parent company for that.

We also have -- and we have a representative here from the Business-Healthcare Connection -- a new nonprofit that is basically comprised of business

members, but has stakeholders of all kinds in it, which is in the process now of outreaching to the business community to educate them. I mean, we shouldn't just give up on the business community.

I -- the number one reason that small business in California would provide insurance is, guess what,

not if they're provided subsidies, it's because they want to. Because those of us in small business, and I hope those in small business out there will agree with me, have a concern about the people we spend more time with than our families. We don't want them sick, not because we're going to lose productivity; we don't want them sick because they're our friends. It's pretty simple.

So we have solutions now that we -- we think we can work on. And I would encourage everyone, certainly in this room and within the coalition, to focus on the local. Support our Board of Supervisors as they reinvest in our healthcare. If you're a business person, get down here and pay attention to what happens with the public programs, because they impact you; they impact your employees. That's important to you. Get engaged in the programs of outreach. Make sure that the community around you understands that the business community is engaged in this thing.

And understand that we are reaching, as a business community and as a community, beyond those who are working and uninsured. We're reaching to those who aren't working, who would like to be, who are currently uninsured.

MR. KNOLL: And -- and then can't that -- this collaboration that Richard is talking about, that all of the panelists have talked about, can't this be replicated in virtually every community in the state of California? It seems to me that if hospitals, doctors, business, nurses, consumers, and county government can all sit down and agree that there is a way to go, why can't we do that in every community, through maybe your foundation, Jerry, and try to -- try to see that if -- that if all those collaborations together can maybe have the healthcare summit you want at the state level to change the system completely from top to bottom.

This -- I've always thought this was unique, but why can't it happen in every single community? And that's where your political power comes from, I think, if all the communities are sitting around agreeing. Also it shows you how bad it is for all of us to be agreeing on every topic.

THE MODERATOR: I think -- I think that's

1 know, frankly, it's hard to get everybody together. And
2 then once you do get everybody together and you start
3 talking about all these issues, where do you go from
4 there? Who's the person that's going to write that, you
5 know, what the solutions are, because we all have our
6 individual ideas. So you're right. The dialogue needs
7 to continue in all different communities.
8 DR. HERTZKA: I think the big difference
9 here -- and Mr. Ledford here deserves a lot of credit,
10 and Jessie Knight (phonetic) is the CEO of the
11 chamber -- this is the only place in the state, I can
12 tell you, where business is at the table. All around
13 the rest of the state, consumer groups and people and
14 who write healthcare come up with something. And guess
15 what? They usually come up with an employer mandate or
16 something; you usually hear, "Oh, they're not in the
17 room. They'll pay for it." So that's -- it is unique.
18 I hope, Jerry, your foundation can publicize
19 this, because it's very special. What other county has

reduced the uninsured by a third in a very, extraordinarily bleak state budget environment? I think, you know, we deserve a little bit of credit for getting a few things done on the local level. And I -- I would applaud Richard's comments.

I'm actually the chair of San Diegans for

Healthcare Coverage. So I'm intimately tied to the Business-Healthcare Connection. I think it's a fabulous project. Dr. Ross from the -- one of the major healthcare foundations in the state gave us the big check to help get that going, and we appreciate that.

The -- as we look toward solutions, I think we're -- there's still a tendency, a little bit of blame here and there, and "These guys have too much money," or "These guys do this or that." I think it's very difficult, particularly for those of us who need healthcare -- and I'm one of them, and my family certainly needs healthcare and all this -- is we have to take a look at what we're willing to do individually.

When you go to public utility models or, you know, I certainly applaud the spirit of a national amendment that everyone is entitled to healthcare; that's -- that's fine. But it does create an environment where everybody goes to Albertsons and everything on the shelf costs 10 cents. You know, if you think you can go to Albertsons and everything in Albertsons costs 10 cents and you'll not leave with more than 10 percent more in your shopping cart than you do now, then -- then I'm all for public utilities and things.

I think the voters of Oregon took a look at

that, and fewer than 20 percent of them supported doing this. And Oregon is about as progressive as you get in this -- in this entire country.

So I think we do need to look at solutions that do include what the individual is willing to do. And again, it comes back to: If people really focus on what they really need, which is healthcare security and the policies that they buy are covering the major problems

of life and not the day-to-day things, enormous savings accrue. It makes it much easier for business to provide that insurance, much easier for individuals to access it. Certainly we need to deal with preexisting conditions and all the Mickey Mouse games that insurance companies will do if you let them get away with it. But that's -- that's what we have a legislature for. And we -- that can be dealt with. And it's been dealt with, and -- and many of the health plans, particularly in this county, behave extraordinarily responsibly in these areas.

So again, the -- the thing I would take away is everyone who's interested in this also has to look in the mirror and ask, "What am I willing to do to put in" -- "to put in my two cents" -- actually, it will be more than two cents, frankly -- "in the process?"

MR. ESCOBOZA: I'm not sure I can say much more

than what my colleagues have said, other than to sort of look at the system that we now have, which is comprised

of purchasers, payers, providers, and patients, and realize that of the models that are being discussed and have been discussed here in San Diego and will be discussed at the state level, whether it's pay or play or whether it's single payer or universal care, that what we have to emphasize is changing behaviors of each of those stakeholders in that system; purchasers, providers, patients. And I -- and I say "change behaviors," you can apply a model, a template, but if you can't get people to react in a way that, in fact, makes the model better, then you really don't have much.

I guess what I'm talking about is the system that we have in the future has to incentivize people to change their behaviors toward healthier living and life-styles, has to make the providers be more efficient and more effective in -- in the outcomes, in the work that they do for patients.

THE MODERATOR: Can you give us an example?

MR. ESCOBOZA: Well, again, I talked about it earlier, before. You know, you -- you give treatment that shows outcomes based -- based on best practices. The idea is incentivize the system so it works for everyone in the system. We now have a system that has

no incentives for any of those stakeholders, and that is really part of the problem that needs to be addressed.

DR. HERTZKA: One model that's been suggested, but is not in -- in a vision of a system, what if you looked at a group of patients who were diabetics, who were at risk for complications, and you had a system where you could say, "If you're willing to be part of this intensive treatment protocol and willing to step up to the plate and have these visits and have these tests and take these medications and do these follow-ups and show a little bit, we can offer something to you at dramatically less cost than the current system where you're penalized for being ill, and your premium is high and you have to march around all over town." Why don't we build something that has higher quality, and as Mr. Escoboza suggested, give people incentives to do that. A whole host of chronic disease states where enormous amount of dollars are spent.

THE MODERATOR: I believe some of the managed care providers, as well as health plan providers, are also coming up with an incentive system that some people

may or may not agree with. And maybe we can talk about that, if you'd like to. I believe it was a system that may start next year in providing bonuses to doctors based on qua- -- you know, quality. Not that doctors

don't always give out quality. But -- but it's also based on, I guess -- I don't know exactly. There -- there were like five or six different things --

DR. HERTZKA: There -- there --

THE MODERATOR: -- and it's like a ratings system.

DR. HERTZKA: There are 15 or 16 criteria, and it's been -- it hasn't been well-received in the physician community.

One of the criteria actually is how fast you'll see a new patient. We just got a law passed that makes it illegal for health plans to pressure physicians to take more patients than they can handle, but now we're going to get a bonus for taking patients faster, which probably means more patients than we can handle.

It gives us incentives for generic drugs we may or not agree with. And when broken down, offers every physician in the state who is a Blue Cross provider $8.53 a year, which, you know, frankly, from my point of view, they're talking about several thousand dollars potentially.

The physicians I know are doing the best they can. And if they're given guidelines and suggestions and studies that show that they can do something better, they'll do it. The notion that you can change a

physician's behavior for a thousand dollars or something like that is really quite insulting, and we think actually coincides with open enrollment and marketing. And we've actually been quite critical of those specific programs.

Although, the intent, you know, the global intent of quality is fine. Give us the information; we'll do it, because we want the highest quality care for our patients. Don't insult us by suggesting that $8 will make us revamp our office.

MR. LEDFORD: There's one more frightening thing that's occurring out there. It's coming from the business community, not from an HMO or from an insurance provider. We're finding some large corporations now are beginning to set aside dollar amounts for their employees, let the employees decide how to spend it or if to spend it. And that -- that's of concern, I think, to most of us, certainly in the small business community, because we view that as more or less a shirking of the relationship that occurs, that naturally occurs between an employer and employee. So we're concerned about that.

We're concerned that that's one way of cutting costs without really engaging the people you work with in a dialogue over what kind of insurance is necessary,

what would work for them, how does it fit their family, how can we extend insurance to cover dependents, you know, how we can make it more affordable for all of us.

THE MODERATOR: And since we have

representatives here from both the hospital industry as well as the health insurance provider industry, what kind of things are you doing to implement, you know, solutions, to be more efficient, to cut down costs, but yet not compromise the quality of care?

Blair?

AUDIENCE MEMBER: At Children's Hospitals we've developed 62 what are called "pathways." They're developed by doctors. They're based on the best medical evidence available. And they look at that evidence -- part of what Steven was looking at.

And so when a child comes in with asthma, instead of 13 different asthma doctors treating him in slightly different ways, they treat him in the best way. And we have a 90-percent compliance rate with those pathways. That's -- so every new resident, every new doctor, every new nurse works with those pathways. That's something that I think is a good prototype for care.

I'm also really worried about the children of California. I'm worried about they're unhealthy. I'm

worried about the fact that they're losing days from school. They're not getting to doctors on time. So we're going to have to make some real tough choices, as has been said. But I hope when we talk about advocacy and political uprisings, that we -- kids don't vote; we got to vote for them. We got to make sure they all continue to get covered and so they are healthy and ready to learn. Thank you.

THE MODERATOR: Any other thoughts on implementing solutions?

Briefly. Come up to the mike, please.

AUDIENCE MEMBER: Thank you very much.

I'm -- I'm making this comment not as a business owner or as coming from the perspective of the Hispanic Chamber of Commerce, coming from the perspective from a healthcare advocate. And we've listened to -- we've talked about moving toward solutions, which is really positive. We've talked about solutions, which is even more positive.

But I want to talk about what needs to happen before we actually begin implementing solutions. And that's really having a frank discussion about where those solutions are going to be focused and on whom

southeastern San Diego, the reality of ethnic and healthcare. Health disparities exists. And that's the reality. And it's a whole different dialogue, but that's what it is. It is a dialogue.

Huge disparities; cancer, diabetes. It's not a coincidence that Latinos, African-Americans are impacted the most; diabetes, healthcare -- excuse me, heart disease, strokes, just some examples. And the people that are impacted the most are the people that won't necessarily have a voice at this table, won't necessarily be able to come and make the forums. And these are the people, the individuals, that all of you need to be very cognizant about.

Communities are dying earlier. I mean, I -- it -- it sounds melodramatic, but isn't, because we see it every day. We see it as observers and advocates; those communities live it every day.

And, ma'am, you need to be the lead story. Okay? Not Enron, not WorldCom, and -- I mean, that's important too. Okay. Because of the reality is that communities, in certain communities, are becoming more and more disenfranchised.

And when we talk about solutions, we need to talk about the reality of racial and ethnic health disparities, which is an uncomfortable dialogue to

have. But it needs to continue, and it needs to be in the radar screen every single moment you talk about solutions. Thank you.

THE MODERATOR: Thank you. And I also challenge everybody in this room. There are -- there are so many television stations here, news television stations here, as well as newspapers and community newspapers. We need to know your stories. We need to know what you're doing. If you have an announcement in regards to a community forum, I challenge each and every one of you to contact all of us and build that relationship, because we can all only tell our viewers

what we know. And so, please, you know, utilize us as a resource as well.

AUDIENCE MEMBER: I think that one of the issues that was just raised is very important to put on the table, as well, with the state government and the federal government. We're a border community. And as a border community, we have unique needs and we have unique problems, meaning we have a lot more uninsured people because they're not legally resident or they don't meet the right immigration status, or more importantly, a member of their family does not meet the right immigration status.

The other thing I wanted to raise was the fact

that -- I think it was Richard raised -- that we need the federal government and the state government to let us implement at the local level, to implement solutions at the local level. If we identify them, we need them to at least let us test them. And I don't believe in California-wide tests. California, as we've talked

about, is the fifth largest economy in the world. You can't -- you can't implement tests in that kind of an economy. You need to do it at the local level.

AUDIENCE MEMBER: I'll be brief.

I have to echo the last two comments. In other words, the issues on the border and the issues of the demographic changes are critical. David (unintelligible) at UCLA is very clear that the Southern California demographics are going to be the national demographics 10 to 15 years from now.

So everything we do right here is a pilot project, is a demonstration project, and has all kinds of health policy implications for the national scene. We need to think of that very clearly. We have got to address the underserved communities, because it's really a demographic change in the mix of patients. And unless we get more doctors, more dentists, more nurses, et cetera, from those communities -- I mean, it's less than a few percentage points at all the medical school

faculty, nursing faculty, dental faculty, et cetera,

et cetera, et cetera.

Healthcare, as an institution, has failed those communities. And we really have got to deal with that because of those demographic changes. We cannot avoid the issue, and especially -- especially at the border.

THE MODERATOR: Thank you for bringing that up. And -- real quick.

AUDIENCE MEMBER: I'm Michael Barton (phonetic) from Scripps. And this -- this has been a very fascinating discussion. There -- these discussions have happened before.

The -- every single one of these solutions work in one way or another. The problem is that they need to work together. And that -- it's fine to talk collaboration, but as -- just as a -- as a overarching approach to how we could look at the solutions.

Healthcare has always -- the delivery of healthcare is no big mystery. It's a combination of three things: Cost, quality, and access, in balance. Any time any one of those gets out of balance -- you pay too much attention to racheting down costs, quality has an impact. If you just pay attention to quality, and -- and cost is no -- no -- no matter, cost becomes a matter. If access is out of balance and some people

can't get into the system; it's out of balance.

Every single one of these solutions on a local or statewide or a national level needs an analysis. And then going ahead on the analysis, looking through the prism of keeping costs, quality, and access in balance. And just doing a fiscal analysis is not sufficient. Just doing a quality analysis is not sufficient. We must do all three together and see how every one of the solutions, working together, helps to keep that in balance. That's the master solution.

THE MODERATOR: Thank you so much for sharing that.

We've got to wrap up very quickly. We have about two minutes.

Oh, I'm sorry.

UNKNOWN: Lee Ann, if I --

THE MODERATOR: Why -- why -- why don't you start. Very, very quickly. We only have two minutes.

AUDIENCE MEMBER: My name is Bill Wish

(phonetic). You've seen these bumper stickers that say, "How am I doing?" 800" -- "call this number." (inaudible) --

THE MODERATOR: If you could hold the mike to your mouth.

AUDIENCE MEMBER: I'm on Medicare, and I have

all that stuff (inaudible) from the bottom up.

The problem --

THE MODERATOR: Can you hold the mike up to your mouth.

AUDIENCE MEMBER: The -- the problem needs to be solved. You need to solve the problem from the bottom up and not from the top down. Your average taxpayer works until over June just to pay taxes. We cannot get much more money from people. They have to feed their families.

And national defense is going -- we're at a national point here. And during 1962, Cuban missile -- missile situation, the Russians had nuclear subs 15 miles off our coast here ready to lob in nuclear

missiles --

THE MODERATOR: Sir, we're almost out of time, but -- because I have one more person, and then we have to wrap up. But your number one way of -- of solving, and then --

AUDIENCE MEMBER: Well, we need thousands of doctors. Here's the solution --

THE MODERATOR: Okay.

AUDIENCE MEMBER: We need -- we need a medical system -- transparency of the medical system. Break the monopoly of the MA- (sic) -- the doctors, AMA and

pharmaceuticals, so that the average person becomes medically sophisticated. For every symptom, there are eight cases. It's impossible for doctors to --

THE MODERATOR: It sounds like you're talking about --

AUDIENCE MEMBER: It's impossible for doctors to --

THE MODERATOR: -- patients being better

educated and -- and being more empowered.

AUDIENCE MEMBER: No. We need to get the people educated. We have to have schools. And --

THE MODERATOR: Okay.

AUDIENCE MEMBER: Because -- and then in our next war, we have to have thousands of medical-knowledge people to help other people.

THE MODERATOR: Okay.

AUDIENCE MEMBER: There won't be enough doctors.

THE MODERATOR: All right.

AUDIENCE MEMBER: And then it will save the government billions of dollars because we'll save billions of lives. Because we need educated people --

THE MODERATOR: Thank you for your comments.

AUDIENCE MEMBER: We can't keep a monopoly.

THE MODERATOR: I'm going to move on to this

next person. Thank you very much. Appreciate it. Thank you.

And then --

AUDIENCE MEMBER: It's got to be bottom up.

THE MODERATOR: Okay. Thank you very much.

AUDIENCE MEMBER: Well, I'm -- I'm from the bottom up.

THE MODERATOR: Okay. Very briefly.

AUDIENCE MEMBER: I represent In-home Supportive Services Advisory Committee under AB 1682.

Dr. Lum, thank you for your support. The Board of Supervisors, thank you, Supervisor Roberts.

I represent 13,500 workers who provide in-home care. 250,000, roughly, in this state are -- people are able to stay at home because of people like me. And I take care of my brother. I have been untrained, but I've been doing this for about 50 years, probably all my life.

Those of us who are on the advisory committee want to thank San Diego County for establishing an employer of record through the public authority. We have never had an employer of record. We were paid minimum wage. I have, for my brother, 283 hours a month, which is the maximum allowable for a disabled person. I receive no benefits, until recently health

insurance. Health insurance was one of the number one issues we needed across the state for low-income people. We are not uneducated people necessarily, just in unfortunate circumstances.

THE MODERATOR: So you're saying more people like yourself are part of the solution.

AUDIENCE MEMBER: That we are part of the solution.

The health insurance through SHARP (phonetic) has enabled 5700 people to qualify in this county who did not have health insurance. For 22 years health insurance for myself was at times unavailable. I sacrificed at times my own healthcare.

So I think, across the state, we are seeing every county providing better services for in-home supportive services workers. We need to continue to do that with funding. The -- the advisory committee I chair is very concerned about the funding for all in-home supportive services. And if you look at the California state budget, IHSS is everywhere. It is a very political issue. However, I sit on a committee

that is nonpolitical.

So we are part of the solution. We take care of the disabled to keep them out of institutions which -- which saves billions of dollars. We are asking

for funding for training, better training for us at home, who are providing these services. It keeps the family members or the person we're providing care for out of the emergency rooms. It saves them trips to the hospital. Billions of dollars, if we were not here providing these services.

THE MODERATOR: Well, we certainly applaud what you do.

AUDIENCE MEMBER: And I thank you for that. And I wanted that opportunity to say thank you.

THE MODERATOR: Thank you. Thank you.

We're -- we have run past time. But Ron Roberts, I wanted to give you a final say in terms of what is being done on a county level to implement some of these solutions.

SUPERVISOR ROBERTS: First of all, I am very

thankful that there's a roomful of people like this. And while it sounds like there's a lot of divergent opinions -- sometimes we talk about how to slice the pie. Our job is equally, how do we make a bigger pie? How do we do things a little different? How can we, for instance, create additional monies?

Dr. Lum and I were smiling earlier when we were listening to some of the comments because there's a -- a debate that's going on currently as, for instance, at

something called a Prop 10 Commission. It's now called the First 5 Commission. And it has to do with how do we spend over $30 million a year. We've been advocates of this money going to healthcare for kids. Now, there's another group, equally strong out there saying, "Well, what's more important than healthcare for kids is maybe educating kids." And it's -- these are the dilemmas you get into.

What I would suggest to you, that to see as many people here who I think are putting a priority on

healthcare, they would probably agree with us, Dr. Lum, that the priority ought to be in the healthcare for kids, and especially the zero to five, and the preventive and the working with families and getting them to understand.

These are the kinds of dilemmas that we have. There's not enough money to do everything in this world. When we can have this kind of dialogue and we can get people who clearly are seeing that it may be possible to do solutions. My fundamental belief is that there is enough money in the system. The money is being allocated incorrectly, and we need to change. We need to reform. As we've heard, even here in San Diego, we need to change the way those dollars are being spent so they're more productive and there are more people who

are served.

THE MODERATOR: And certainly in the last 90 minutes or so, this is just the tip of the iceberg of what we need to talk about. So we thank every one of you for coming here and being part of this discussion.

We hope to continue this discussion. And maybe we could have like a three-day retreat all together, you know, some far away place, out in Alpine or something, so that we could work together.

I want to really quickly thank all of our panelists and Supervisor Ron Roberts, Dr. Lum, Gregory Knoll, and all of the people out in the audience who joined us. Thank you very much. And, you know, again, let's continue this discussion.

Thanks. Have a great day.

REPORTER'S CERTIFICATION

I, Lynda J. Goddard, Certified Shorthand Reporter in and for the State of California, CSR No. 10670, do hereby certify:

That the foregoing proceeding was transcribed by me from a videotape and that this transcript is a true and accurate record of the proceedings to the best of my ability.

In witness whereof, I have hereunto set my hand this 13th day of March, 2003.

LYNDA J. GODDARD, CSR No. 10670