

SPECIAL COMMUNICATION

Community of Solution for the U.S. Health Care System: Lessons from the U.S. Educational System

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The Folsom Group asserts that radical changes are needed to fix the health care system in the United States. The U.S. education system is one potential model to emulate. Could a future health care system-level community of solution be modeled after the U.S. education system? Could community health care services be planned, organized, and delivered at the neighborhood level by district, similar to the structure for delivering public education? Could community health centers, governed by community boards, serve every neighborhood? This essay imagines how U.S. health care system reforms could be designed using our public school system as a roadmap. Our intention is to challenge readers to recognize the urgent need for radical reform in the U.S. health care system, to introduce one potential model for reform, and to encourage creative thinking about other system-level communities of solution that could lead to profound change and improvements in the U.S. health care system. (J Am Board Fam Med 2013; 26:323–326.)

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Health care delivery in the United States is fragmented, with no central structure or organization.^{1–5} Despite incremental efforts to increase access, improve quality, and reduce unsustainable spending, dysfunction remains systemic. The Folsom Group suggests that achieving an organized health care delivery system will require radical change.⁶ In this commentary, we envision how radical system-level reform might borrow from another public sector: education. This imagined community of solution for the U.S. health care system

is modeled after an admittedly idealized version of the U.S. public education system, with a mix of public and private providers governed by regional planning, organization, and oversight.

The Neighborhood-based Health Care System

We envision a future scenario in which community health centers (CHCs) would serve each neighborhood “health care district,” similar to how each neighborhood is now served by a public school or system of schools. Each district would build a dynamic organizational structure to meet the needs of its population, with federal oversight of local and regional planning and distribution of resources.

Basic Access

This nationwide system of health care districts would enable “functional partnerships”⁶ in local communities. These partnerships would involve community-tailored and organized systems of primary health care delivery coordinated with public health services. For example, a new mother could easily establish care for her newborn son at the neighborhood district CHC where she received prenatal care. As a new member of the neighborhood, her son would be registered automatically at birth. The mother would receive a home visit from

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a public health nurse during her son's first week of life, and he would be scheduled for a well-child visit at the CHC the following week. Community health workers would be available to coach this new mom and provide information about community resources (eg, parenting groups, outdoor sites that are safe for children, healthy grocery stores, and family-friendly exercise facilities).

Administration and Oversight

This national system of neighborhood CHCs with local oversight could be administered in a manner similar to that of the U.S. education delivery system. Citizens could be elected periodically to serve on community district health boards (similar to school boards) with the authority to supervise central administration, balance budgets, and conduct system-wide strategic planning. These health boards would be accountable for the health of the district as outlined by federal mandates; however, they would be given considerable leeway for local adaptation and would have latitude to spend funds on resources beyond traditional health care services (eg, parks, sidewalks, farmers' markets). CHC-level advisory boards could be organized to plan and develop additional services based on individual and population needs. The board of each CHC could collaborate with clinic staff and leadership to ensure that their CHC was providing patient-centered services that met national guidelines for evidence-based care.

Integration and Coordination of Specialized Care

The population locus for care would be the district health board; each district's system of CHCs would provide comprehensive public health, preventive health, and primary care services. Mental health and dental care services could also be integrated at the neighborhood level and would, ideally, be colocated. This system would also ensure access to additional services for those with special health care needs. District health boards could organize the coordination of such care and obtain secondary and tertiary care services by direct provision or contract, depending on local capacity and need.⁷

To facilitate this coordination, all CHCs in a given district would use the same electronic medical record system, with a highly functional health information exchange providing links to affiliated secondary and tertiary care service providers. A system-wide health information exchange would

also facilitate care outside the district, if needed or desired. For example, while most people would receive services in their own neighborhoods, this system would support receipt of care in other districts depending on proximity to work, residence of other family members, or specialized needs. In addition, data from individual clinic records would be standardized to enable de-identified integration at the district and national levels, providing data that could be used to determine resource allocation as well as epidemiologic surveillance and other population health management purposes. Clinical data from the electronic medical record could also be linked with other community-level data from public health, social services, educational, and environmental agencies, enabling service coordination and future planning.

Funding the System

Much of the funding for this system could come from existing public insurance dollars divided up by district, with allocations based on population measures of health and health care needs. These funds could be pooled with other public revenue sources that fund public health services, safety net clinics, and preventive health care. This pool of public monies is expected to grow under the Patient Protection and Affordable Care Act. Many of these funding streams currently are allocated based on need, and this redistribution could be risk-adjusted to avoid widening disparities. Further funds could be collected from employers who choose to allocate a portion of an employees' benefit dollars to support these direct services rather than paying the monies to insurance carriers who indirectly compensate for services but do not guarantee care coordination or access to care. Ideally, this could lower the overall costs of private insurance premiums. This funding solution would undoubtedly spark controversy; however, there would also be public support for a program that was efficient, well-organized, and truly comprehensive. The public might also appreciate a system that relieves some of the financial burden of paying high insurance premiums, which may be lower if required for only catastrophic injury and supplemental care.

Another option, perhaps one more politically palatable (since the private insurance system is an entrenched paradigm that has been reinforced by the Patient Protection and Affordable Care Act), would be a neighborhood-based insurance scheme

run by the health districts, which pools public and private insurance funds being spent on a defined neighborhood population and expands public employee insurance programs such as those that currently insure school employees. One example might be neighborhood public health insurance options available through state health insurance exchanges. In this alternative model, the health district would be responsible for administration, coordination, and oversight of the insurance program.

Next Steps

As the Folsom Report advised, to address fully the problems of the current health care system, we must move beyond incremental changes.⁸ Profound, system-level change is needed.^{9,10} We present our public education system's neighborhood-based, universally accessible organizational and delivery structure as one model for a system-level community of solution for U.S. health care.¹¹ While it is easy to envision a radical new system such as the one we propose, it is far more difficult to implement system-level reforms that are effective and politically feasible. The first step is building acceptance of the idea that basic health care is a public good and requires sustained investment of public funds.¹² The next is achieving better coordination between health care financing and delivery structures to ensure universal access and quality. Capturing public funds that pay for a community's care in the current (unorganized) delivery system structures—and reallocating that money within a new system of organized care delivery—would be a critical step toward developing an equitable, neighborhood-based system such as the one we envision here. Some of the resources spent on private insurance coverage could also be redistributed to support this system further.

Other countries already have established similar models of health care delivery and organization. For example, primary care trusts in the United Kingdom work with local agencies that provide health and social care to tailor services to the needs of local communities. These primary care trusts are at the center of the National Health Service and control the large majority of the National Health Service budget, ensuring that local health care needs are being met.¹³ In Canada, national health insurance is organized at the provincial level and

many services are delivered privately; however, regional health authorities play a key role in helping to link local residents with the health care services they need. These regional entities are mandated to assess the health needs of the community and ensure that the system is meeting these needs.¹⁴ In Italy, local health authorities are responsible for administering hospital and community health services in a geographic area.¹⁵

Within the United States, some states are moving toward local or regional coordination of care for certain subpopulations, especially Medicaid beneficiaries. For example, Community Care of North Carolina is a community-based infrastructure with regional networks that blanket the state and target patients and populations in need.¹⁶ Oregon has developed coordinated care organizations, which are regional networks of health care providers who have agreed to work together in their local communities to care for patients covered by the Oregon Health Plan.¹⁷ Thus far, these state models use a hybrid approach that builds on current financing and delivery models but with additional structures and incentives for regional collaboration and care coordination. The neighborhood-based health care system that we envision would require a much bigger shift in the health care financing and delivery paradigms, expanding beyond the Medicaid population to include everyone and involving the provision of a more comprehensive set of services with a global payment structure.

Our vision of this neighborhood-based health care system is not precisely analogous to how education is currently organized and delivered in the United States. We recognize that the education system is imperfect: there are unsafe schools, inequitable distribution of education resources, low literacy rates, discouraging high school drop-out rates, and inadequate public funding.^{18,19} Although it is beyond the scope of this commentary to suggest solutions to the challenges of public education, a reverse analogy that imagines how the education system might look if influenced by the health care system cautions against privatization of this public good.¹¹

Our imagined health care system reforms are modeled on an idealized public education system, with safe clinics for every neighborhood, community involvement, regional planning, and adequate funding for evidence-based services of uniform quality. We suggest that this idealized system for

providing education services to every neighborhood provides a model for how a U.S. health care delivery community of solution could be structured to provide efficient, comprehensive, locally organized health care for all.

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