



*A Catalyst for Positive Change in Workers' Compensation and Disability Benefits Systems*

## **DISCUSSION DRAFT – 22 DESIGN PRINCIPLES\* OF A HEALTH CARE SYSTEM THE UNITED STATES CAN BE PROUD OF – AND PAY FOR**

### **POLICY LEADERSHIP AND DIRECTION**

1. A set of general design principles similar in nature to those laid out below should be adopted by Congress with abundant input from the citizenry at large, preferably through open meetings in communities around the country.
2. National performance requirements or specifications for the healthcare system should then be established that reflect those design principles. These can be used to evaluate the adequacy and appropriateness of all legislative and regulatory proposals and programs in the private and public sector, regardless of whether health insurance, healthcare delivery, and the healthcare workforce is otherwise regulated by states.

### **HEALTHCARE AS A PUBLIC INVESTMENT**

3. Public funding of healthcare should be regarded as an investment, and should accomplish the public's purposes -- which should be explicitly articulated for all to see.
4. Total public investment in healthcare must explicitly be allocated in proportion to public investment in other domains essential to the public welfare and that undergird the economy such as transportation, education, national security, etc.

### **COVERAGE AND PRIORITY**

5. A basic level of benefits (a package of simple and low cost preventive, primary care, and immediately life-saving acute care services) should be provided for everyone: all citizens, legal residents, and children under 18.
6. Beyond the basic package of services, public investment in healthcare (both wellness and sick care programs) should preferentially be made in people of working age with current or future ability to be productive contributors and taxpayers, and to children with future potential to contribute and pay taxes. Public investment should focus on driving the engine of the economy and assuring prosperity for all.
7. Since the reason for most sick care is the disruption of normal life due to illness, injury or the progression of a condition, a main focus of all healthcare services should be on achieving functional

outcomes rapidly and mitigating the disruptive impact of medical conditions on daily life. For those of working age, that means on ability to start work, remain at, or return to gainful or productive work and remain employed.

8. Care for those with life-threatening illnesses and unfavorable odds of recovery must include clear communication of the likelihood of death & full recovery, informed consent for life-prolonging treatments that includes information about quality of life and drain on personal resources, and must be provided with generous and capable psycho-social support to assist them in dealing with fear, loneliness and physical decline, prepare them for death emotionally, psychologically, as well as logistically (assistance with daily living) and administratively (advanced directives, wills and trusts, logistical arrangements).
9. Since most everyone experiences occasional symptoms and 100% of people eventually die, a lifetime cap should be established for public funding of each individual's health in Medicaid, Medicare and any public option programs.

#### **PRICING AND PAYMENT**

10. All individuals must have to pay for some part of their "sick" care, and it should be proportionate to their income.
11. All individuals should be able to personally pay for whatever they have enough money to buy, whether luxury insurance packages or healthcare services of marginal incremental value -- as long as the services meet public safety/protection standards.
12. Prices must be transparent "at the front line" where care is delivered. In order to support real competition, prices should be visible when decisions are made to provide / purchase a particular service.
13. Cost benefit discussions about healthcare decisions (that consider healthcare and other costs alongside other personal, family, and social benefits) will be encouraged and seen as appropriate.
14. Pricing variability should reflect comparative differences in the way that front line medical services are delivered and the overall value of the life outcomes produced for the patient, not an intermediary's market power in pricing negotiations.

#### **INCENTIVES: REWARDS AND CONSEQUENCES**

15. Individuals must be held accountable for taking care of themselves, and experience some consequences for not doing so.
16. Payment mechanisms in a variety of public programs should be coordinated to incentivize the delivery of evidence-based and cost-effective preventive care and health education. Positively reward people for seeking it as well as healthcare organizations for offering it -- so it is readily accessible and people actually use it. Create consequences for not providing it / using it and keep adjusting them until they are effective.

17. Public sector physician payment mechanisms should preferentially reward primary care physicians who provide evidence-based and cost effective preventive care, patient education, early screening and simple cost-effective interventions, and who optimize the health & function of the chronically ill through interventions with proven efficacy and favorable cost-benefit ratios. Cost-benefit analyses should consider the benefits of healthcare on quality of life, extent of prolongation of ability to fulfill social roles, productivity, employability, and the costs of both healthcare and disability benefits.
18. Credible and readable information about the relative efficacy of and patient satisfaction with alternative treatment regimens should be available to the public and to all healthcare providers. This includes comparing drugs and procedures with each other, as well as comparing them with non-pharmacological and non-invasive regimens. It also includes comparisons with non-medical interventions in domains other than traditional healthcare (e.g. health education, self-help organizations, consultation with a social worker or other source of practical advice and counseling, workplace interventions).
19. Physicians / healthcare providers should select drugs / treatments free of attempts by commercial interests to influence their specific product choices either directly or indirectly (via direct-to-consumer advertising, for example).
20. As likelihood of recovery declines, public payment mechanisms should progressively disincentivize delivery of high cost services in order to assure that continuing care is being driven by the healthcare professionals' compassion and the patient's fully informed consent rather than by the healthcare delivery system's momentum and appetite for revenue.
21. Incentives should be created to encourage deployment of health care workforce to areas of need (geographic & specialty) and the scheme should keep being modified until the distribution actually meets the nation's needs more adequately.

\* The starting point for this list was an informal discussion among a group of New Englanders who meet for dinner occasionally to talk politics, and call themselves The Courage Party. All of them were >60 years old at the time the original list was formulated. Some months later, it was revised and expanded by Jennifer Christian, MD, MPH. Constructive feedback and suggestions are welcome at [jhchristian@gmail.com](mailto:jhchristian@gmail.com).