National Health Care Reform

Proposal Objectives

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A Proposed National Health Care System

- Single Payer, government managed, health Care system (no insurance companies)
- Lifelong, affordable health care for all
- Federally subsidized ability to pay and have a normal, middle-class life
- One benefits package: Fee-for-Service, benefit definitions and provider compensation. Budgets are based on benefit needs.
- Consolidated patient records: consistent formats, authorized access:
  Immediate access, treatment coordination, accountability, trends/epidemics
- One, national, provider network: qualified, properly-compensated providers, and geographically attracted to distribution of needs.
- Oversight and accountability enforcement by each state, without conflict of interest, and dedicated to patient advocacy and intervention with teeth.
- Psychotherapy to rehab disturbed minds:
  PTSD, trauma, mental illness, depression, poverty, long-term-care estrangement, child development, suicide, behavioral disorder, bullying, mass violence, household violence.

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Objectives: *Whereas* and *Therefore* Assertions

- Equity
- Quality
- Affordability
- Accessibility
- Accountability
- Efficiency
- New System Delivery
- Strategic Leadership

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Equity

Whereas

We have a health care, CASTE system

- Wealthy should be embarrassed)
- The current system does not cover long-term care except for persons in poverty.
- Open insurance market, hospital, cost-shifting drives higher rates for all.
- Employer-paid, only while employed
- ACA, "Cost sharing" deductible (benefit barrier)
- Medicaid, is poverty-only, with a charity/rationed budget, including poverty households, Medicaid-elderly, mentally ill and others with severe disabilities.
- The poverty population is growing (job losses, health care and household crises).
- 26.2% of U.S. population is enrolled in Medicaid (in other words, in poverty).

Therefore

We Need an Equitable System

- Health care for all, including long-term care, poverty and mental illness.
- Single payer with full responsibility and accountability.
- No gaps, no descending levels of quality.
- One benefits package for all, no poverty trap
- No more capitated (rationed) budgets (no more arbitrary delays or denials)
- Single provider network (no out-of-network penalties)
- Funding based on needs and services to be delivered
- Consolidated patient records for all, regardless of where care or diagnostic services occur (potential for AI review and treatment guidance).

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Quality

Whereas

- Insurance companies profit from care restrictions, cost cutting incentives, restricted provider networks, profits, butthey don't deliver care.
- Cost cutting leads to inadequate care, provider poor compensation, and declining workforce.
- Insurance companies also ignore doctor's judgment and deny or delay benefits, creating a geater risk to the patient, and creating doctor, frustration/job dissatisfaction.
- Cost cutting has led to use of less qualified staff, reducing quality of diagnoses, treatment and quality of personal care.
- Capitated budgets (particularly Medicaid) deny needed services and adequate hospital staffing to low priority recipients. Services are rationed to fit the budget.

Therefore

- Insurance companies will be phased out achieving a major, cost reduced with better care (no hidden cost cuts)
- No rationed health care (capitated budgets)
- Proper care provider qualifications, certification, compensation, and staffing level will be required.
- Professional judgement replaces insurance company delays and denials
- Accountability drives responsible benefit specifications and delivery of quality care.
- System will restore number and qualifications of the workforce and ensure adequate funding.
- Poverty is a disability that requires psychotherapy to inspire and opportunity to recover.

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Affordability

Whereas

- Coverage is subject to Prohibitive deductibles ("cost sharing").
- Frequent health care bankruptcy and poverty (Health care if you can afford it).
- Employer paid and negotiated) coverage stops when employment stops: poverty risk increases during economic crises.
- Insurance companies provide no health care, no quality assurance, cut quality, contribute and increase a major cost, and take profits
- Medicaid debt is a family, poverty trap. If you get a job, get independent help, get married, you may lose essential services.

Therefore

- Federal subsidies provide liveable income without prohibitive deductibles or income boundaries
- Subsidies mitigate household, economic crises and support/sustain poverty-recovery (psychotherapy and job opportunity).
- Provide replacement job training and hope
- Eliminate Medicaid debts
- Quality, continuous, health care coverage (no gaps, for life) without health care debt.
- No hospital cost shifting to recover cost of charity care (care is covered).
- Providers with qualified staff, who receive appropriate compensation.
- Wealthy (economic winners on the backs of the middle class and poor) must contribute their fair share of national, health care costs.

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Accessibility

Whereas

- Hospitals and health care professionals cannot survive in low income areas due to Medicare and Medicaid poor compensation rates
- Medicaid, budget constraints, deny needed care for elderly, mentally ill and others in poverty.
- Cost cutting has led to a health care workforce that is underqualified and overworked. The number of qualified professionals is declining due to poor compensation and working conditions.
- Persons with limited resources who cannot afford private, long-term care, must be in poverty before they qualify for Medicaid austerity as the only option.

Therefore

- Medicare and Medicaid low compensation rates disappear, along with inadequate, capitated budgets (budget based on x dollars per person)
- Patients get care and providers get proper compensation, regardless of the wealth of their patients.
- Judgement of professionals is respected for their qualifications and expertise.
- Persons in need of long-term-care are covered for equitable care regardless of their wealth or poverty (they can afford it).
- The health care work force must be expanded for accessibility, with qualified personnel and appropriately paid jobs, through recruiting and expansion of educational opportunities.

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Accountability

Whereas

- No accountability of funding sources and insurance company payers—no traceability, no oversight, no quality assurance (depends on only state licensing and regulation).
- "Recipient Rights" has conflict of interest with management, budget-compliance and provider-protection priority.
- Budget managers have no knowledge (or concern) of actual needs for care and the poor quality of care delivered.
- Medicaid care providers are forced to "ration" care in an attempt to, at least, serve those most seriously ill, particularly persons with a severe mental illness or other disability, and sympathetic circumstances.
- Medicaid has no interest in their impact on communities.
- The current system is a disgrace, both in the quality of health care delivered and the unnecessarily complexity, degradation of the profession, and degradation of the under-advantaged.

Therefore

- Independent, state-level, oversight and reporting agencies will give Congress (and all levels of the bureaucracy) a health care political priority with state advocacy citizen's interests, recipient rights enforcement, and system accountability.
- Professional oversight of treatment planning and professional discretion for complex, long-term and difficult cases.
- Fee for service accountability: providers "deliver the goods"
- States no longer have conflict of interest in Medicaid funding (no Medicaid and ACA budget match—state conflict of interest)
- Regulation of all potential conflicts of interest.
- Capitated care budgets are no longer an option (no rationing).
- The independent oversight and accountability agencies must audit the system design and operations for continuous im provement and high standards of performance and international leadership.
- Value-delivery software (based on VDML) will provide traceability from budgets to benefit delivery claims for strict funding/bucgdt to service-delivery accountability.

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Efficiency

Whereas

- Multiple levels of administration delegation and budget allocations (don't know who was paid for what. Fragmented traceability.
- Providers must bill multiple payers with diverse benefit restrictions and contract terms
- Redundant administrative functions, provider networks, information systems, levels of budget fragmentation, and benefit packages, plus advertising cost, and cost cutting incentives vs quality improvement.
- Patient records are scattered among providers impeding recipient and provider access, and epidemiologic analysis of trends/epidemics, side effects, and fraudulent provider claims.
- Providers have multiple payer contracts, creating confusion and clerical overhead.
- Recipient rights has conflicts of interest resulting in unsubstantiated claims.

Therefore

- Consolidated patient records system, one, transparent benefits package, one provider network
- Single payer accountability
- Consistent provider contracts (one per provider) based on standard templates.
- Economies of scale and responsible AI
- Shared software across providers and regions, for consistency, adaptability, operating efficiency.
- Regional offices of national system for local administration, problem resolution and other administrative services with nation-wide, standard systemss.
- Independent, state-level, efficiency and equity (rights) oversight and accountability assurance.
- Early intervention, particularly children.

New System Delivery

Whereas

- Current health care payers and service providers have many differences, complexities and practices that are not necessary nor understood by the persons they serve.
- A new system must be consistent and easily understood by the persons served, the providers and the operational personnel, the Congress and the voters.
- Redundant information systems and changes are time consuming, expensive, and require more extensive recruiting and training efforts.
- Revised staffing requirements and caring aptitude must be addressed for qualifications, certifications and compensation. This is not charity. This requires culture change.
- A unified and efficient and harmonized system can't be delivered by quick fixes anymore.

Therefore

- Phased development and deployment by populations/systems and by state, and by region
- Insurance companies phased out
- Personnel upgrades: certification and proper qualifications and compensation
- Funding: Human Rights, obligations
- Proper orientation of recipients and on-going patient knowledge and understanding of their relationship to the new system, and expectations.
- Objective quality of care and interpersonal relationships with staff. Where to get help.
- Population education and orientation during transformation and continued for on-going for new recipients and new hires.
- A culture of empathy and dedication.

Strategic Leadership

Whereas

- A growing poverty population calls for household proverty prevention and recovery when it happens.
- Millions of people suffering from untreated mental disturbances, need help
- Psychotherapy is an emerging treatment to improve lives of many who are trapped in their disturbed minds, including people suffering from mental illness, people trapped in poverty, elderly people in long-term care, and families suffering from domestic conflicts.
- Need intervention in schools for students suffering depression, trauma, bullying, potential suicide and at risk of violence.
- There is a major workforce shortage, a decline of qualified professionals and limited capacity of educators to develop them.

Therefore

- Expand psychotherapy intervention for people in mental distress, through collaboration with childhood educators and other human services.
- Educators collaborate with mental health to develop children's brains into knowledgeable, middle-class adults and voters.
- Health care must support unsolicited intervention by parents and relatives for persons in denial, homeless people and persons traumatized by poverty.
- A major campaign is required to upgrade and expand the health care workforce.
- This health care enterprise must be committed to a mission to provide equitable, quality, health care to all, always.

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See related documents at these links:

Health Care Reform Proposal (136 pages)
http://www.amioakland.org/documents/26-02-15ProposalforAnAccountableHealthCareSystem-PDF.pdf

This link is my background as related to this proposal.
http://www.amioakland.org/documents/25-12-19FredCummins-MyAdvocacyBackground.pdf

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