

R I G H T C A R E  

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**FOR A NEW HEALTH SYSTEM:  
THE RIGHT CARE ALLIANCE CALL  
Approved April 2020**

RIGHT CARE ALLIANCE  
[WWW.RIGHTCAREALLIANCE.ORG](http://WWW.RIGHTCAREALLIANCE.ORG)

## **PREAMBLE**

The COVID-19 pandemic has laid bare the harsh fact that America's health care system is unfair, unaffordable, and unsustainable. The system's deficiencies have become glaringly apparent to all. We, the members of the Right Care Alliance, say the time to rectify those deficiencies is now. If America truly believes that all people are created equal, and that they are endowed with unalienable rights such as life, liberty and pursuit of happiness, then the opportunity for health should be a right, because without it, none of these other goals is attainable. The freedom from preventable infections, illnesses and suffering is an essential freedom. Whenever any aspect of our society becomes destructive to these ends, it is the right of the people to alter it. The COVID-19 pandemic forces us to confront the failures of our current health system and forge a more perfect one.

The Right Care Alliance is a grassroots organization of patients, their families, community members, nurses, doctors, and other health professionals dedicated to catalyzing a new health system. In a time of crisis, when official political leadership fails, grassroots leadership must emerge to defend and support our communities. We call for a radically different system, one that is accountable to the people it serves, and that places patients and communities first to provide the Right Care. Right Care brings healing and comfort to patients, and satisfaction to clinicians. We know that access to high quality, affordable, and accessible care must be an essential pillar of such a system and we believe that patients, not profits, should be at its heart. Right Care holds the health and well-being of patients to be central to all other aspects of the system. Right Care is affordable, effective, and available. It is compassionate, honest, safe, and timely. It is prepared for such exigencies as pandemics, and does not needlessly endanger either patients or health care professionals. Achieving Right Care will require transforming how health care is delivered and financed. It will also require a new relationship between our health care system and our public health infrastructure.

A nation's health system is a deep reflection of how its citizens treat each other, based on the moral bonds that join them together in common purpose. To defend, protect, and care for one another is the essence of patriotism. As such, the design and functioning of an ideal system of Right Care should be imagined and forged by patients and communities in partnership with health care professionals and institutions. We can and should design a new way of delivering health care because we know we can do better.

We acknowledge there are many barriers ahead, and that within the outlines of a new and more perfect system much remains to be filled in. We can succeed only by harnessing the power of our imaginations and forging the political will to realize this vision. The Right Care Alliance is committed to mobilizing the courage and organizing the actions that increase the public's power to make these changes happen.

## ***The Problem***

We call for radical action because the present system has become a quiet thief of the American Dream.

While the care of acute and emergent conditions in America is second to none, the COVID pandemic has exposed the deadly dangers of fragmentation, poor coordination, poor access, inadequate public health preparedness and haphazard planning. Federal agencies failed to anticipate the need for aggressive testing and contact tracing, as well as the need for large supplies of personal protective equipment (PPE) and respirators, thus endangering millions of people. As a consequence of these deficiencies, there has been a steep growth of infections and deaths. We now have the distinction of leading the world in the number of COVID-19 cases even as the U.S. health system is also the world's most costly.

Despite the fact that America spends significantly more per capita on health care than any other industrialized nation (twice what Great Britain spends; 1.5 times Canada, 1.8 times France), our life expectancy is lower than most other high-income countries, and many medium -income countries, including Costa Rica and Cuba. Most other high- and medium-income countries provide universal health care. In America, millions of Americans who are uninsured or under-insured do not get the care they need and consequently suffer and die needlessly. It is estimated that at least 38,000 Americans die each year because they have no or inadequate health insurance coverage, while excessive medical debt may be the leading cause of personal bankruptcy. As premiums, co-pays and deductibles have risen inexorably over the last 30 years, average worker take-home wages have barely kept up with inflation; more and more of our wages are consumed by the rising cost of employer-provided insurance. Most Americans live under the threat of financial ruin from an unexpected illness or injury, and many suffer “job-lock,” or the fear that changing jobs risks losing insurance coverage. We maintain that being held hostage to a job is a basic violation of fundamental freedoms. In the current health care system, our rights to life, freedom from financial ruin, and the pursuit of happiness are blocked at every turn.

These problems stem directly from allowing U.S. health care to evolve over the last five decades into the extremely complicated and often dysfunctional set of industries we see today. With virtually no coordination among hospitals, drug makers, public health agencies, and community based care, our state and local governments have been left scrambling to mitigate the devastation of COVID-19. Mixed and confusing messages from our political leaders, as well as fears about price gouging and surprise medical billing, have limited access to testing and care, making it impossible to identify rapidly and isolate those who are infected. Rather than preventing infections, health care professionals are now required to rescue the sick, a condition that is overwhelming our emergency rooms and intensive care units. The lack of a national funding

mechanism or coherent insurance policies means that patients are facing unknown bills that are potentially catastrophic.

For many decades, health care has been a lucrative business for the few and unaffordable for the many as the medical-industrial complex has steadily consolidated and gained pricing power. Procedure-based payments to health care practitioners and hospitals and over-reliance on technology has encouraged practitioners to do more *to* the patient and less *for* the patient. The result is overuse, underuse, and misuse. If waste can be defined as any activity that does not significantly improve the health and wellbeing of patients, fully one-third of the spending in the present system is estimated to represent waste, totaling nearly one trillion dollars.

Meanwhile, doctors, nurses and other clinicians' lives, liberty and happiness have also been curtailed. After a relentless rise in pressures to increase "productivity," and deliver more services in less time, they are now also expected to face risks of illness and death without adequate equipment, and without the right to speak up about the deficiencies where they see them.

More and more in recent years, the corrosive needs of the system have prevented our health professionals from treating the whole person, body and mind, stoking clinician burnout and rising rates of suicide. Primary care physicians, the bedrock of an efficient health care system, are increasingly disillusioned due to regulatory and administrative chores and inadequate reimbursement for the care needed by their patients with multiple chronic illnesses, such as heart disease and diabetes. Frontline nurses confront "compassion fatigue" and burnout on a daily basis while working in environments that compromise patient safety, quality, and simple human kindness through unsafe patient-to-nurse staffing ratios. Too few medical students are choosing primary care, creating a shortage that intensifies the burn-out of those remaining, while the increasing cost of education, high levels of student debt and low primary care reimbursement all worsen the shortage.

Now, as frontline health care workers struggle valiantly to confront the flood of COVID-19 patients, the failures of our health system are threatening our economy, and paradoxically our nation's health. For decades, health care costs have been rising, straining businesses and local governments' ability to provide insurance to employees and residents. At the same time, the spiraling costs rob federal, state, and local governments of the resources needed to fund public health agencies and battle the major drivers of illness such as stress-driven personal behaviors; financial insecurity; poor nutrition; lack of safe, affordable housing; and poor education. Before COVID-19, rising number of Americans who were struggling with economic and social hardships were dying from suicide, drug overdoses and alcohol —so-called "deaths of despair." During the COVID-19 pandemic, they are the most vulnerable to both the disease and the economic consequences it will leave behind. Yet in their very moment of need, the health care

system is part of the problem, siphoning money away from where it is needed most: massive investment in underfunded social and mental health services, and prevention.

Health care disparities cause worse health outcomes for vulnerable populations, including people of color, low-income individuals, older adults, those with special health care needs, as well as rural and inner-city inhabitants. CDC data show that people of color experienced disproportionately high COVID-19-associated hospitalizations. The current health care system fails vulnerable people, especially when they most need it.

This failure to build a robust public health infrastructure, a robust primary care infrastructure, and to maintain tight coordination between acute care medicine and prevention and public health is having tragic consequences even as we write this.

And who exactly is in charge of America's health? Currently, the accountability of our health care institutions is a mirage. The health care management industry borrows corporate language to persuade the public that the only thing our system needs in order to improve is bold "leadership" informed by the latest acronym or technology. Private equity firms on Wall Street are taking ownership of physician groups to participate in lucrative wealth extraction from Main Street. Manufacturers, principally the pharmaceutical and medical device industries, have captured both the conduct of medical science and the regulatory agency that is charged with ensuring their products are safe and effective. The ills that plague us — the fact that so many of our health care system outcomes are much worse and cost much more than every other high-income democracy — persist. At the state level, politicization plays out in the failure of attempts to exercise oversight over not-for-profit hospitals, the leakage of health care dollars from patients to private interests, the blind trust put in self-regulation of the health care professions, and disclosure rules in order to protect the health care system's reputation at the expense of the public's right to know.

Our elected officials in Washington, D.C. have talked about reforming this broken system since the first single payer proposals were put forward in the 1930's. But the discussion, even today, is limited almost entirely to coverage and access: who pays for insurance, and how much. There is virtually no discussion of the deep dysfunctions underlying every aspect of the system, including how health care practitioners and providers are paid, how they and manufacturers are regulated, how medical science is conducted, and how the system's resources are allocated around the country. While the Affordable Care Act of 2010 was a step in the right direction towards universal coverage, it was not fully universal, nibbled at the edges of using different payment models to improve care, and generally failed to address the numerous flaws in the way care is delivered. The recent debates over an incremental approach like a public option, or more rapid moves to "Medicare For All" continue to miss the crucial ways in which the delivery of care must be transformed at its core in order to place the needs of patients, clinicians, communities and our whole society above the profit-seeking interests of the few.

Even those with adequate insurance too often get ineffective care or suffer from serious safety errors and embedded waste. Medicare as it is currently structured has lower costs than private insurance, largely through the lower prices it pays and its administrative simplicity. However, the lack of coordination prevents even more Medicare cost savings and contributes to low satisfaction and quality for too many. The Right Care Alliance does not believe that simply providing universal funding to expand the current dysfunctional system is the best strategy for the change that we need.

With no clear path in sight for addressing not just the problem of lack of insurance, but also unaffordability, poor quality care, a disheartened workforce, neglect of public health, invalid science, regulatory capture of agencies, economic capture of Congress, and a failed market, we are compelled to speak and to act. Our health care system will not be fixed by half measures, but only by transformative change across all aspects of how it is paid for, regulated and organized, how clinicians are trained, and how medical science is conducted. Only through a radical transformation in the way we deliver and govern health care in our country will we eliminate excessive profiteering and free up the needed resources to afford the high quality, publicly accountable health system our country deserves.

Bringing about the necessary transformation will not be easy. The health care industrial complex accounts for more than 18 percent of the economy, and that fact alone makes it difficult to change. It also wields vast political power and has historically resisted all reforms that would interfere with its economic interests. The health sector spent \$594M on lobbying in 2019, more than any other lobbying sector. Therefore, we believe that change will only come when ordinary Americans serve not just as economic actors in the system, but as activists. This document is intended not just as a description of the problem, but also as a blueprint for where we must aim our transformational efforts. It has been said that no wind is the right wind if you do not know which port you are sailing for. This document represents an effort to describe that port and to declare our intention to do whatever we can, as citizens, activists, patients, and clinicians, to arrive there.

# CORE PRINCIPLES OF A NEW HEALTH SYSTEM

## *In the new health system:*

1. The United States achieves universal, publicly funded insurance coverage, which is integrated into a redesigned, not-for-profit health system that eliminates overpricing, waste, needless complexity and is locally accountable to the people it serves;
2. Health system design and control rests with patients and communities: mechanisms exist for democratic oversight and decisions about what is covered and how resources are allocated, including sites of care, the distribution of technology, and the training and distribution of health professionals;
3. All people, regardless of who they are or where they live have access to necessary, high quality care, including mental health, dental and vision services, without financial hardship. Demographics, geography and cost are no barrier to getting care;
4. Robust, readily available primary care serves as the system's foundation, coordinates care across sites, and cares for the whole person;
5. Prevention is fundamental to good health and well-being, and a strengthened, adequately staffed and financed public health infrastructure is seen as an equal partner with health care. The Centers for Disease Control and Prevention (CDC) serves as the central hub for coordinating research, generating guidelines, and disseminating best practices and messages on the promotion of wellness and the control and prevention of disease;
6. Care is safe, timely, efficient, and effective;
7. The system for delivering care is designed to build respectful, caring partnerships between communities, patients and their health care practitioners. Patients and practitioners are provided sufficient time to engage in shared decision making and act as partners in achieving best medical practice and outcomes;
8. Waste of all kinds is reduced, including unnecessary diagnosis, testing and treatment. At the same time, underuse and misuse of care are minimized, as is care-associated harm;
9. A system that resolves malpractice claims outside the legal system, provides adequate compensation to patients who are harmed by medical mishaps, effectively investigates the causes of harm, and requires that health care institutions implement efforts to remediate those causes. Lawsuits are fewer and a remedy of last resort for cases of egregious negligence.



10. Patients and communities are provided with easy to understand, up-to-date information on what is covered and the costs to society, as well as the quality, safety and outcomes of health care providers, such as hospitals;
11. Conflicts of interest are reduced and health industry monopolies eliminated in order to reduce the corrupting influence of profits;
12. Technology is used in ways that primarily serve patients and the public good, and medical science is funded, conducted, and used in a manner that also serves the public good;
13. Information about the quality, cost, effectiveness, efficiency and safety of care is transparent, and providers of care, including nursing homes, hospitals, and other care facilities, are accountable to patients and their communities;
14. Care includes discussions of prevention as well as treatment of disease and injury and health care practitioners, patients and communities act in partnership as advocates for the health and well-being of all;
15. Social needs and disparities that significantly impact health and well-being such as adequate housing, jobs with living wages, access to a good education, nutritious food, and a clean, safe environment are addressed comprehensively;
16. The health care delivery system continually learns and improves in a manner that benefits the public good as well as individual patients.

# The Blueprint for a New Health System

## ***Governance Model***

### **The Problem:**

The way in which health care is currently delivered lacks sufficient transparency and accountability to patients and their communities.

### **The Solution:**

#### ***Federal Governance***

To ensure national standards (but with local control), the federal government will mandate new Regional and Local Health Boards. They will oversee local delivery systems and hold them accountable to make sure they provide the “right care”: all the care that is needed, prioritize prevention of disease, and optimize population health. The federal government will determine the minimum coverage of services that would be guaranteed nationwide in all locations: hospitals, doctors’ offices, clinics, nursing facilities, long term care, and home care. These guaranteed essential services will primarily consist of high value tests and treatments that have been proven to be safe, reliable, and effective. This basic national coverage package will have no co-pays or deductibles. Patients will be free to purchase private insurance to pay for unnecessary, cosmetic, and unproven tests or treatments that are not covered by the national insurance plan if they so choose.

A National Council composed of primary care clinicians, specialists, representatives of patient advocacy groups, nurses, and health care economists will determine reimbursement for health care services and enforce the system’s core principles. It will mandate parity of behavioral health services and monitor coverage, contracting, and payment decisions. Regional and local health boards will be free to approve and oversee contracts with local health care delivery networks to fund additional services beyond the national minimum, provided they remain within their budget. These services may include any areas, for example home-based care, meal services, or help with transportation, as long as they are necessary to improve the health of the patient.

#### ***Regional and Local Governance***

Regional and local health boards will monitor their health systems’ performance for quality, safety, and oversee health care spending and compensation to prevent profiteering. Health board budgets will be based per capita on the national budget. Regional Health Board governance will be public and include a mix of elected, appointed, and selected members, and all positions will be paid.

All hospitals seeking to provide care in the new system will be required to be part of an integrated non-profit delivery system. To qualify for contracts, these delivery networks must be

controlled by community boards in which members of the health care provider groups will have guaranteed representation by statute, but always less than 50 percent of board seats, with a mandated percentage being primary care clinicians. Salaries and wages to health care network employees will be decided by the network management teams, with statutory guardrails to prevent excessive compensation. These delivery networks will determine compensation through negotiations with individuals, professional societies, and unions.

All health boards will have Technical Advisory Committees (TACs) with experts in health care finance, medical evidence, health care quality, public health, and social services. The TACs will develop quality measures that reflect shared decision-making using evidence-based data. Public review of quality and safety, with regular audits of clinical appropriateness to monitor over and undertreatment, will be used to ensure global budgets do not incentivize low-value care. Performance evaluations will include meaningful outcomes such as symptom management, physical functional status, and social functionality. Online data infrastructure will provide regional and local boards and the public with up-to-date information on quality and all performance measures.

### *Mission-Oriented Leadership*

In the new health system, the composition of hospital boards will mirror the system's values. Boards will be co-led by a health care professional and a patient advocate. Governance standards will require a democratic process that ensures representation of front-line staff, public health interests, and community leaders. Hospital boards will be integrated and function within the larger clinical delivery network that receives global payments from regional health boards; its decision-making will be subject to public scrutiny by local and regional governance bodies.

## ***Financing & Payment Model***

### **The Problem:**

The current volume-based, fee-for-service payment model rewards overuse, produces fragmentation, and creates barriers to low-cost, early treatment and preventive care.

### **The Solution:**

We call for single-payer financing at the federal level, which will expand the current Medicare tax collection infrastructure to include and cover the entire population residing in the United States.

The new health system will be based on global budgets disseminated through contracting with non-profit provider networks. Recognizing that nearly all health care is local, federal funding will be distributed into regional budgets, which will be based on units of population and

controlled by Regional Health Boards. Regional funds will then be distributed and managed at the local level. Provider networks will seek contracts from their Regional Health Boards based on capitated payments. Payments will be fully risk-adjusted to ensure that there are no financial incentives or disincentives to care for complex patients and to ensure that regions with greater morbidity burdens have sufficient resources for health care. Network surpluses and deficits will be public funds and will be managed in compliance with the Local or Regional Health Board.

These payment reforms will require that primary care teams are paid on a per-patient, per month basis and that health care will extend beyond office visits. Primary care clinicians will be rated and compensated based on the quality of their person-centered care. Incentives may include cost savings, as long as any capitated payments to primary care providers allow flexible use of funds to manage practices and health stations in a localized way.

An increased national budget for public health, medical education, and medical science will create separate funding streams. These funds will be integrated and coordinated with health care spending and will flow to the Regional Health Boards to be integrated into regional Master Health Plans.

We recognize that a detailed financial analysis will be required of the proposals in this Call. We are confident that the new health system will be affordable for our society, given the anticipated savings from higher investments in primary care and preventive public health through integrated neighborhood care, the elimination of administrative complexity with single payer funding and reduction of profit-driven overuse and unnecessary care. Most importantly, in the last analysis, the amount we spend on health care in the new health system will be a democratic decision under public scrutiny, and subject to public approvals at local, regional and national levels.

## ***Integrated Health Care Delivery Model***

### **The Problem:**

The current health care delivery model is fragmented. It prevents clinicians from focusing on prevention, effective communication, and patient safety; it severely underutilizes the role of lower-cost paraprofessionals; and it invests in technology that maximizes fee-for-service revenue.

### **The Solution:**

#### **Neighborhood Health Stations**

Neighborhood Health Stations (NHS), comprehensive facilities that integrate all health-related services, will use a team-based approach that includes *inter alia* doctors, nurses, dentists, optometrists, pharmacists, social workers, community health coordinators, psychologists,

psychiatrists, physical therapists, and nutritionists. Each NHS will provide 90 percent of the health care services needed for 90 percent of the people in its catchment area. Integrated with emergency medical services (EMS), social and behavioral health services, and home-based care, each NHS will be responsible for improving the health outcomes of the surrounding community. Once fully deployed, savings from this program will ensure the long-term affordability of health care delivery for the entire nation.

#### Primary Care as the Foundation

Primary care will serve as the backbone of the new health system through health stations, primary care clinics, and even solo practices operating outside the NHS. For all these settings the new primary care will be team-based and provide wraparound care, especially for the elderly, frail, and chronically ill.

Primary care practices will be paid on a per-patient, per-month (PMPM) basis at approximately double their current fee for service rates, after risk-adjustment. This will incentivize the delivery of more comprehensive, prevention-focused care to a smaller pool of patients. A key element of this approach is enabling primary care teams to use capitated funds to run their practices in an individualized way. Additional incentives based on quality and cost outcomes will be determined at national and local levels.

The global payment rates will support integrated primary care teams that are not traditionally reimbursed through fee-for-service mechanisms, including RNs, nutritionists, pharmacists, mental health professionals, and community health coordinators. Additional resources for paraprofessionals will be provided to help improve population health, manage patients with chronic conditions, and coordinate services for patients with complex care needs.

#### Patient-Centered Care Design

The new health system will be designed for patients and their communities, by patients and their communities. It will enable health care organizations to invest in critical patient-centered care such as health literacy; so, providers deliver transparent, plain language information to patients at all points of contact. Hours of operations, scheduling options, patient flow, the design of clinical facilities, and clinician performance will be subject to public review and input through Local and Regional Health Boards.

Data and health records will be fully interoperable and automated. They will include a robust patient data system that will maintain patient privacy while linking data to hospital-wide and regional systems. Patients will be encouraged to maintain and possess their complete medical records in electronic form and will be able to make entries in their medical records and correct errors.

### Provider Networks

Non-profit, publicly governed, integrated health care delivery networks will offer seamless acute care from hospital to home. These networks will consist of hospitals, clinicians, and skilled nursing facilities. For behavioral health, post-acute home health visits, chronic disease management, health maintenance, and end-of-life care there will be local neighborhood-based networks consisting of health stations, community nurses and health coordinators, mobile emergency and paramedical services, and home health workers who will be integrated with the primary care teams of the local neighborhood health stations.

Rural areas with low population density will also benefit from integrated delivery networks. One possible model would be a “hub and spoke” structure of nurse practitioners and physician assistants in rural areas, supported by primary care, specialty physicians, and other clinicians from medical centers who support and assist via telehealth to assure high quality care.

### EMS in Community-Based Care

To appropriately triage individuals in crisis and avoid preventable emergency department use and incarceration, the new health system will scale-up solutions for appropriate disposition of care. It will embrace the movement within EMS, emergency departments, and law enforcement toward providing Mobile Integrated Health Care (MIHC) by paramedics in the form of community paramedicine.

### Aligning Financial Incentives with Patient Safety

The new health system will enable every health care provider to both take care of their patients and improve the system in which they practice by giving them the most valuable resource: time. Rather than separating “experts” from the frontline clinicians who are the best suited to make change, the new health system will create an integrated improvement force by providing "protected time" and training for all clinicians to take part and offer leadership. Health workers at all levels will participate with patient safety experts in this process in a transparent manner within each integrated delivery network. Final accountability will reside with their Local and Regional Health Board.

### Behavioral Health

Population health requires clinical integration and collaboration between medical and behavioral health professionals. This model will enable standard access to both pharmacologic and non-pharmacologic interventions for behavioral health and help balance the current trends of over/under treatment. Behavioral health funding will be integrated within global budgets, and behavioral health care will be integrated with primary care, something that is shown to not only improve behavioral health, but overall health as well.

As part of the general shift to home and community-based care, psychiatrists and psychologists will train paraprofessional mental health workers, including social workers, to serve as the frontline of care. Such an approach improves health outcomes, reduces health care spending, and provides greater community support. Given the high co-occurrence of behavioral health and substance use disorders, the new health system will invest in behavioral health facilities and infrastructure to ensure an adequate, population-based distribution of inpatient care, with hospital units, free standing psychiatric hospitals, and longer-term residential care facilities.

### *Dental and Vision Care*

Dental and vision care at all stages of life cannot be neglected in a truly integrated health care system that addresses overall health. Untreated, dental problems can lead to serious health issues, and a reduced quality of life. This is particularly true when they affect a child's ability to eat, learn, and attend school. Right dental care includes any treatment that is necessary and can help to avoid preventable emergency department visits. It does not include cosmetic treatments that are not clinically necessary.

Periodic eye and vision examinations are just as important. Many common eye diseases such as glaucoma, retina problems from diabetes, and macular degeneration often have no warning signs. Many eye problems and diseases can be treated if caught and treated early, preventing vision loss.

In the new health system, dental and vision care will be integrated with primary care in neighborhood health stations, enabling better coordination among health caregivers and facilitating referral for more specialized care when required. Primary dental and vision care funding will be part of global budgets.

## ***Re-imagining the Health System Workforce***

### **The Problem:**

Currently many people find accessing primary care difficult and the demand for primary care is expected to increase further due to population growth and an aging population. This will be an even bigger challenge as the new health system is redesigned with a primary care focus and expanded to cover the entire population. Nurses, psychologists, and social workers are key members of an integrated primary care team, but often are not permitted to work to the top of their license.

## **The Solution:**

### *Expansion of the primary care workforce*

The new health system will provide health professional training subsidies for primary care, with a goal of increasing the primary care pool to represent 50 percent of all clinicians. Primary care will be provided by teams of doctors, nurse practitioners, physician assistants, psychologists, pharmacists, social workers, and home care workers, all coordinated through community health coordinators. Nurse practitioners and physician assistants will work to the top of their license and play a greater role in primary care delivery. RNs, meanwhile, will expand their scope of practice to include chronic care management. Family physicians and general internists will remain central to the evaluation and management of more complex or unusual cases, and for referrals to specialty care.

### *Clinician Education and Training*

The new health system will support patient-centered clinical training, with a focus not only on clinical excellence but also the universal delivery of right care. Applicants will be assessed in a holistic manner: the ability to communicate effectively, work collaboratively, and qualities such as altruism, empathy, humility, and emotional intelligence will receive equal weight with prior academic performance in the admissions process.

To attract a student pool that truly reflects the diversity of the nation, the new health system will promote the recruitment of students from low-income communities because they are more likely to return to those communities and serve them. This is particularly true for people of color. To support the recruitment and retention of low-income students, the new health system will fully subsidize clinical education and training.

A new curriculum will be more flexible in its length, with different tracks with varying amounts of basic science, behavioral science, and epidemiology. Curriculum for physicians will focus less on board exam preparation (i.e. “teaching to the test”) and more on practical aspects of modern clinical care, including patient communication, ethics, pharmacology and physiology of aging, evidence appraisal, end of life care, quality improvement, and health system design. Curricula for all health care providers will integrate clinician well-being, given the alarming rise in suicide and burnout rates.

## ***Real Public Health***

### **The Problem:**

The rising cost of health care and the sector’s poor performance occur against a backdrop of inadequate resources and attention to public health, which has long been a poor stepchild to its profligate sibling, both in terms of the amount of money allocated to state and federal public



health agencies, and in terms of Americans' perception of its relative importance in their lives. The failure to invest in public health infrastructure has been laid bare by the COVID-19 pandemic, which the U.S. could have addressed early and effectively had public health leaders had the power and the means. Public health has a vital role to play in addressing both infectious disease and the chronic illnesses caused by community and social determinants of health.

**The Solution:**

Public health can be invigorated with 21<sup>st</sup> century models and methods of disease surveillance and intervention, a transformation that will require a focus on both infectious disease, and on the major drivers of chronic disease such as poor diet, lack of exercise, smoking, psychosocial stress, substance abuse, and adverse childhood experiences. The new health system will support funding for federal, state, and local public health agencies, providing the technology innovation, manpower and infrastructure to address the rising tide of infectious diseases and other illnesses that will accompany global warming.

At the same time, evidence is growing that the most effective methods of treatment for chronic risk factors and drivers of poor health are best situated within peer groups and community settings, rather than within large hospital systems or medical facilities. Many of the drivers of ill health can be more effectively addressed at the local level, including affordable housing, healthy food availability, and support for at risk families. Such a public health system would bridge the medical and the social spheres. Moreover, it would establish an important space for the prevention and reversal of the on-going medicalization of everyday life.

A central feature in the design of the new health system will be the coordination of public health funds and health care funds at the regional and local levels through the health boards. The mandate of the health boards will be to optimize population health through all necessary methods: disease surveillance, monitoring, prevention, and acute medical care.

***Health in All Policies***

**The Problem:**

The delivery of “right care”, even with close coordination with public health measures will not by itself adequately improve individual health outcomes or population health, given the enormous influence of social determinants of health such as poverty, food and housing insecurity, and homelessness. This is even more apparent in light of the COVID-19 epidemic, which is taking an enormous, unprecedented toll on the economy, while exacerbating inequities between our society’s “haves” (e.g. white collar workers with access to health care, and who have paid sick leave and the ability to work from home) and the “have nots” (e.g. low-income workers and

workers in the “gig” economy, who often do not have health insurance, paid sick leave or access to unemployment benefits).

**The Solution:**

Policy makers must acknowledge the adverse health effects that stem from all forms of public policy, from education, environmental protection, and urban planning to agriculture, transportation, and taxes. The new health system will advocate, inform and support the application of the principle of “health in all policies” in all other sectors of society. For example, agriculture policy has the power to change the way people eat, and to make healthful foods cheaper and more widely available. Housing and transportation policy can make it more difficult or easier for people to live near well-paying jobs and get to them. Wage and tax policy can reduce financial insecurity. The new system will take responsibility for integrating an understanding of social determinants of health into local and regional policy. It will also need to integrate health care and the social safety net, which touches the lives of nearly half of the U.S. population.