Values and Principles Work Group – Recommended Considerations for Board Discussion.

General Recommendation:

Recommend that the board should fully endorse and adopt the HEC statement and pledge to complete all its work in full support of the goals of that statement, the elimination of bias in decisions and in actions, and in overcoming past bias, extending unconditioned welcome to all as an absolute principle of universal health care.

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

- *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
    - *The equitable distribution or redistribution of resources and power; and*
    - *Recognizing, reconciling, and rectifying historical and contemporary injustices.*

https://www.oregon.gov/oha/EI/Pages/HEC%20Plan%20Definitions.aspx

Four Overarching Principles as identified by the work group:

1. **Maximize Health**
2. **Fair Distribution of Medical Resources**
3. **Minimize Financial Hardship on Individual Patients**
4. **Community Ownership and Governance**

Sub Principles and Measurement Discussion

1. **Maximize Health – What does it mean to maximize health?**
    a. **Individual Fulfillment.** The primary measure of success should be the attainment of every individual resident to be satisfied in their opportunity to make and act on timely, well-informed health decisions for themselves, unimpeded by external forces of bias, location, or financial impediments to access.
    b. **Population Measures are Secondary.** General population measures of life expectancy may be useful secondary measures when used with caution to avoid subjective basis, and the fallacy of averages, but not when they overcome the power of the individual to be satisfied in their own well-informed decisions.
    c. **Community Action against Contagion**: In the case of specifically identified community contagion, community, state and national interests to protect the population at large outweighs individual decision making for reaction to that contagion.

2. **Fair Distribution of Medical Resources**
    a. **Distribution Fairness is Complex.**
        i. Fair to whom?
        ii. Fair by effort expended on each patient?
        iii. Fair by equal outcome for each patient regardless of effort?
        iv. Fair by patient probability of benefit?
        v. Fair by region?
        vi. Do individual decisions that adversely affect health affect fairness?
        Feedback: Fair by recognizing and responding to systemic/structural barriers to accessing health care and achieving good health (eg. Cultural competency in care, rural access, trust building with groups that have been historically harmed by the US healthcare system such as indigenous populations and black women)

    b. **Give Voice to the Patient Population** in setting fairness. Matters of defining fairness and how it is applied to distribution of direct should be informed by the community itself, taking care to use a process that is inclusive and based on consensus.

3. **Minimize Financial Hardship on Individual Patients.**

    a. **Spread out cost** of significant illness and injury
    b. **Reduce risk** of high-cost events
    Feedback 1: Keep cost sharing to a minimum/Require adequate investment in the cost of care by the healthcare industry/public funding (is there a way to protect from increasing costs being "externalized" to protect profits for shareholders by just passing those costs along as increased cost-sharing to consumers?

    Feedback 2: we can expand on this so that in encompasses not just those experiencing significant illness/injury. For example, reducing cost barriers to accessing care for general health maintenance/screening etc. (more specific example: the elimination of copays/payment at time of service).

4. **Community Ownership and Governance**

    a. **Financial Stewardship**
        i. Economic sustainability
        ii. Balancing competing demands for community resources
        iii. Fair distribution of cost
        iv. Removal of inefficiency and waste
        Feedback: removal of inefficiencyand waste, perhaps a different word? I'm not sure we can fully remove but we can minimize or mitigate.

b. **Principles of Good Governance**
    i. Transparency
    ii. Accountability
    iii. Representation by peers
    iv. Political sustainability
    v. Financial sustainability
c. **Community ownership**
    Feedback: we should expand on this

Specific question of work group members.

a) The purpose of the work group is to forward draft material for full board discussion. Would you support the above draft being given to the board as written?
    a. If not, what addition, edit, or clarification would make it acceptable?

Feedback 1: I would support the above draft be given to the board with the above recommended additions/edits (in tracked changes).

Feedback 2: Could benefit from some refinement.
What process would be in place when there may not be consensus across communities and populations on what is fair.

b) Further specific questions:
    a. In this draft the HEC statement and introductory material has been moved to the top as a General Recommendation. Do you like this change? Would you prefer a fifth overarching principle to account for and mitigate the role of bias in decision making?

Feedback 1: I like the HEC statement moved to the top as general recommendation and the account for and mitigate bias component supports that statement. In my view, the final statement "and in overcoming past bias, extending unconditioned welcome to all as an absolute principle of universal health care" might be more actionable and effective if it were changed to "and in rectifying past bias, work to identify and eliminate systemic and structural barriers to health." It isn't about being welcoming, but about institutionalized and systemic barriers that create and maintain health disparities.

Feedback 2: I think this could potentially work either way. I found that our discussions seemed to go back to this on each issue we discussed so an overarching principle, if there's consensus, seems like it would make sense. Alternatively, keeping as is and then calling it out specifically under each current principle.

    b. Based on discussion, the wording of "protect against poverty" has been changed to "minimize financial hardship on individual patients" is this okay or do you have a better suggestion?

Feedback 1: I think this change is more clear. I agree.

Feedback 2: How about minimize financial hardship AND protect against

poverty? Financial hardship is harder to define and more subjective. We have definitions of poverty which the Board can choose to adopt or build upon. I agree with the prior discussions that protecting against poverty isn't enough and would support including both. We may need to discuss, perhaps with the full Board, what exactly "minimize financial hardship on individual patients" means. I also wonder if including some language that acknowledges it's not just the individual patients. For instance, parents of dependents or children of elderly parents, who may experience financial hardship as caretakers.

c. Do we need to better define equity?
Feedback 1: Yes. Especially for the purposes of fair distribution, and per Dr Chi's comments at our last meeting.

Feedback 2: I think the OHA definition of health equity is thorough and aspirational. When I think of a definition, I think of its purpose to simplify and provide clarity. This is hard with equity which is complex and can be nebulous. Looking at the most basic Oxford definition of equity, "the quality of being fair and impartial" it doesn't fully capture our aim and contradicts its own sentiment since being impartial goes against being equitable. Ideally I prefer definitions to be succinct and concrete, but not at the expense of lacking in actual definition. The HEC statement to me feels a bit more like a mission statement than a definition, though I don't have a reasonable alternative and agree with the sentiment. Perhaps the clarity will come once we put these sentiments into action. One part of the HEC statement that we should clarify in the future is the mention of collaboration with all regions and sectors of the state. This should be expanded upon and specified once we get into the process of community engagement and deciding how to operationalize. One thing that was discussed in the first meeting but we didn't get to last meeting was defining "fair" and what that means.

c) Are we ready to fully recommend the concept of a citizen jury as a tool to provide community input on issues of fairness, and of success measures?
Feedback 1: Yes, as long as we keep this in the spirit of a working document so we can pivot if we find a better model.

Feedback 2: This is a compelling tool to use in seeking community input. My only question is regarding the feasibility - cost, time, resource availability. I'm not sure if this can be answered within our workgroup. From the resources that Dr. Chi provided, it seems that this is a time consuming process and also limits the number of individuals that this process can accommodate at a given time. This seems compounded by the need to do several of these across different populations and communities to get a full and equitable picture. I support recommending the concept for consideration but we need to ensure this can be accomplished and potentially find a compromise if not.

d) What other issues do you see that we should resolve at the final meeting of the work group on Wednesday?

Feedback 1: Reviewing the article on alternatives to QALY so we can finalize the fair distribution recommendation.

Feedback 2: Some thoughts though dependent on what others may want to prioritize: Consider defining “fair”, revisiting definition of equity if there is not consensus, wordsmith the “community ownership piece”, discussion of additional considerations for Part 3, additional discussion about citizen jury feasibility if appropriate for the workgroup (vs full Board).