VIEWPOINT

COVID-19: BEYOND TOMORROW

Health Care Policy After the COVID-19 Pandemic

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The coronavirus disease 2019 (COVID-19) pandemic will end sooner or later as all pandemics do. Even though the severe acute respiratory syndrome coronavirus 2, like many other viruses, may linger, it will no longer be an existential threat. Neither the reason for the end, nor its timing, is clear now, but it is not too soon to begin discussing postpandemic health care policy.

To simply return to the prepandemic health care system during a presidential election year would be a mistake. This is a time to think more boldly about the future of the US health care system. The health care system is dysfunctional for many individuals in the US; it is too costly, too unequal, and too uncertain in its eligibility and coverage, with an increasing number of uninsured. However, designing and implementing a better health care system will not be easy. In exploring the challenges and difficulties ahead, it is useful to distinguish between those that are primarily technical issues (although these are not exempt from politics) and those that are political obstacles to significant reform.

Technical Issues

The technical issues involve 2 main issues: how to raise the nearly $4 trillion each year to pay for US health care; and how to organize and deliver the care and compensate those who provide it. The experience of other high-income countries indicates that the most efficient and equitable method to finance universal coverage is through a flat tax on consumption, such as a value-added tax, collected from businesses but passed on to consumers via higher prices.[1] An alternative is a retail sales tax, which is more cumbersome and costly to collect than a value-added tax, but makes the connection between the tax and health insurance more apparent to the public.

> Even though it has seemed that major reform of health care would only occur in the wake of a major war, a depression, or large-scale civil unrest that changed the political balance, it now appears that the COVID-19 pandemic may provide the dynamic for major political change.

Those who object to a flat tax (the same rate for everyone) because they think it is not progressive are mistaken. High-income individuals pay more because they consume more, but everyone gets similar health insurance regardless of income. The combination of the tax and the insurance is quite progressive. If it were not, left of center governments in the Organization for Economic Cooperation and Development would not eagerly embrace a value-added tax. In contrast, employment-based insurance sets essentially the same price for any given policy regardless of income. High-income individuals only pay more if they choose a more expensive policy, but that does not help pay for care for low-income or unemployed individuals.

An important goal of health care reform should be to replace the current byzantine system of premiums, taxes, tax exemptions, deductions, subsidies, and out-of-pocket payments with a much simpler system of financing health care. An equally important goal is to replace the current multiplicity of public and private health insurance programs with 1 universal program that covers everyone from birth to death. Because the US health care system is so large, it would probably be necessary to approach these goals in stages. It is important, however, to realize that the complexity of the current system is one of the main reasons it is so costly, with high administrative expenses.

A few countries find it more feasible to achieve universal coverage through compulsory health insurance administered by insurance companies under close regulation and supervision by the government. The intent and effect of such programs is similar to that achieved by tax-supported public insurance. For historical and political reasons, the US might prefer this approach in contrast to a so-called single-payer system. Regardless of approach, universal systems have proven to be the best way to ensure that everyone has access to care without bankrupting individuals or governments.[2]

How to raise the money to pay for health care is important and continues to receive attention. But more important are questions about how to organize and deliver care and how to compensate the individuals and organizations that provide it. Answers to these questions could have a substantial effect on how much money must be raised (ie, the cost of care). If US health care spending was at the same per-capita rate as other high-income countries, the total would be $2.7 trillion instead of $3.7 trillion, admittedly it is difficult to reduce health care costs. It is critical that savings be found so that those dollars can be redistributed to provide more effective care to more people.[3]

Most health policy experts agree that the prepandemic health care system was inefficient. However, there is no consensus as to what delivery system would be better for the US diversity of health plans. The competition among the plans will have several advantages if the plans follow a few general principles. First, the health plans should be private. Government-run health care would not

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work well for the US for its entire population. Over the past decade, Medicare has become increasingly privatized, with about 35% of its recipients enrolled in private insurance plans. Second, public insurance would pay for everyone to be enrolled in a health plan of their choice, with open enrollment every year for anyone who wants to change plans. Third, the plans would receive a risk-adjusted capitation fee to compensate plans for the differences in the expected use of enrolled populations.

Capitation reimbursement provides incentives to use resources efficiently, unlike fee-for-service reimbursement that provides incentives for overuse. This is not just a theoretical proposition. The Kaiser Permanente Health Plan has been paid per capita for more than 50 years and has seen its enrollment increase to 12 million patients, one-third more than in the Veterans Health Administration care system. Fourth, within that general framework, each health plan should be free to deploy resources as they deem best. Some plans might want to pay physicians a fixed salary; others might want to have productivity incentives for their physicians. Some plans might choose to deploy many nurse practitioners and physician assistants, others might not. Most plans would probably want to emphasize primary care, reserving specialists and subspecialists for patients who need their attention. The details of this kind of health care system have been published.[2]

Most goods and services do not have or require capitation payment because price serves to allocate resources according to the customer's willingness and ability to pay. Consumers do not knowingly pay more for a good or service than the benefit they expect to get from it. Health insurance changes the dynamic. When insurance is paying the costs of medical services, patients want any care that offers some expected benefit, regardless of cost. Physician-led health plans that receive risk-adjusted capitation payment are in the best position to allocate resources more efficiently and effectively according to judgments about benefits and costs.

Political Obstacles

Changes in the health care system have always been opposed by many. As Machiavelli observed,[4] proposals for a new order face strong opposition from those who benefit from the old order. This group includes high-income patients who prefer a health care system that caters to their interests and values.[5] The prepandemic system allowed direct visits to specialists and subspecialists. It provided quick access to expensive diagnostic technology, surgical interventions, and high-priced new drugs that offered only minor improvement in length or quality of life. It featured hospitals that had patient rooms that were larger and more private than in other countries and that had relatively more intensive care units. The cost of this system, more than $11 000 per person per year, is tolerable for those with high incomes, but oppressive to most individuals in the US and ruinous for many, leading to missed medicines and bankruptcy.

High-income individuals also prefer US health care research that emphasizes product improvement and ignores cost of care. Other countries also engage in product research, but there is a substantial difference when purchasing that product. Those countries have research organizations like England's National Institute for Health and Care Excellence or other institutional arrangements to compare the benefit of a clinical innovation with its cost.[6] If the innovation is judged to be too costly relative to its benefit, it will not be approved. US laws explicitly prohibit consideration of costs. That approach works well for those with high incomes but not so well for those with average or low incomes. Opposition to change will also come from the manufacturers of drugs, devices, and equipment who have made large profits under the old system, and from some physician specialists who have made large incomes.

Most voters do not have high incomes, but another major obstacle is distrust of the government by many in the general population. In a Pew Research Center survey from 2017, the public was asked to choose between larger government with more services and smaller government with fewer services. Forty-five percent of 5009 respondents chose smaller government.[7] That sentiment may still be true but may change as current events unfold. Proponents of health system reform should think for ways to reduce, if not eliminate opposition. For example, high-income individuals should have the right to access care not covered by the public insurance if they pay for it. Such options are common in England, Israel, and most countries that have universal coverage with public insurance. The manufacturers of drugs, devices, and equipment will not like harder bargaining over price, but they might realize that the alternative would probably be price controls, which increases inefficiency all around.

Distrust of the government is difficult to dispel, but it is possible to do so as President Roosevelt proved with his New Deal reforms in the 1930s. Even though it has seemed that major reform of health care would only occur in the wake of a major war, a depression, or large-scale civil unrest that changed the political balance, it now appears that the COVID-19 pandemic may provide the dynamic for major political change.[8] If that occurs, major health care reform will be more attainable.

ARTICLE INFORMATION

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