Leading in health care: Beyond the COVID-19 pandemic

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Editor's Note: Medical professionalism and "Being Worthy to Serve the Suffering" are core tenets of Alpha Omega Alpha Honor Medical Society (ΑΩΑ). As a leading inter-disciplinary medical organization for 120 years we recognize exemplary physicians throughout their careers, beginning in medical school and residency. Over those years, ΑΩΑ has supported our members and profession through our mission and we sponsor and support many ΑΩΑ Programs and Awards for medical students, residents and fellows, faculty, teachers, and have published *The Pharos* our journal for 85 years in both print and electronic versions along with other AOA member Communications. More than 120,000 active members are supported through ΑΩΑ's 135 Chapters in medical schools.

ΑΩΑ recognized the aspirations and challenges in medical professionalism and over the last decade established a biannual medical professionalism retreat focused on medical professionalism and best practices to investigate, learn, and explore and have published an electronic and print version monograph to distribute broadly to members, medical schools, medical students, and other physicians and health professionals.

In 2021, ΑΩΑ hosted its first-ever all virtual retreat "Medical Professionalism Best Practices: Leadership and Professionalism in Times of Crisis." An outcome of that retreat is the fourth in a series of ΑΩΑ published monographs.

The 2022 monograph, edited by Richard L. Byyny, MD, FACP, Douglas S. Paauw, MD, MACP, and Sheryl A. Pfeil, MD, includes chapters by retreat presenters who represent diverse voices from numerous schools, specialties, and professional backgrounds.

Following is a reprint of Chapter 1 of that Monograph, "Leading in Health Care: Beyond the Covid-19 Pandemic:

As Winston Churchill once said, "Never let a good crisis go to waste." From the devastating COVID-19 pandemic, we have learned myriad lessons—good and bad. Lessons that we cannot let go to waste.[1]

As history has taught us, leaders are often forged from unexpected crises. During the COVID-19 pandemic, physicians and physician leaders have been called on to inspire people, patients, teams, and each other to stand strong, and be resilient and resolute in a common devotion to serving the suffering. Many of our colleagues and health care team members have been leading from the trenches and have delivered care and support with competence, understanding, candor, consistency, character, and caring while also placing themselves, their colleagues, their family members, and others at great risk of contracting this deadly disease. These are medical professionals who answer the call to duty responsibly and with clarity and encouragement. Many, including Dr. Anthony Fauci (ΑΩΑ, Weill Cornell Medical College, 1965), Dr. Deborah Birks, Dr. Céline Gounder (ΑΩΑ, University of Washington School of Medicine, 2004) have been forthright professional colleagues speaking truth to power and leading with dignity, respect, knowledge, and a commitment to their fellow Americans.

One of the biggest barriers to overcoming this pandemic has been the fact that the United States truly does not have a health care system. This pandemic has exposed the lack of an effective, responsive, and affordable health care system. Winston Churchill provided a wonderful analogy for the state of our current health care system, it is "a riddle, trapped in a mystery, inside an enigma."[1]

The U.S. is the only developed country in the world that has not determined that health care is a fundamental human right with universal health care for its citizens. Universal health care should be considered by all as a social good, a national priority, the responsibility of everyone.

Medical Professionalism Best Practices: Leadership and Professionalism in Times of Crisis

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The current situation is a relic of the establishment of our democracy in 1789, when there were just 13 colonies with about four million people to govern. One of the primary goals of our constitutional representative form of government was to prevent a monarchy. Hence, we have the federalist model that was partially designed to prevent an autocracy or monarchy from occurring in our country.

Every U.S. citizen is a citizen of two governments—national and state. The federal government operates under a Constitution dealing with the responsibilities of the central and regional governments to prevent central tyranny. The federal government has limited power, thus delegating to the states most governmental functions.

We have grown into a very complex country with 50 states, 14 territories, and 331 million people. Matters that are considered within the express or implied powers of the Constitution—currency, the post office, interstate commerce, and the military, etc.—are governed by the federal government, while everything else, including health care, is governed by the states This results in 50 versions, or systems, of health care within our country.

Allowing states to do their own thing and experiment with health care policies and funding in the absence of overarching federal policy provisions and legislation has proven to be chaotic and debilitating.

The federalism approach to the COVID-19 pandemic has not worked particularly well, leaving our country's response disjointed and confusing. Federalism was a barrier in responding to COVID-19 public health and medical issues that impact all our citizens, regardless of where they reside. It was slow to respond to the challenges of the pandemic, creating inequities in the treatment of citizens from different states or regions. It has created the perception of a cumbersome decision-making process with the inability to collaboratively implement processes to achieve outcomes for the greater good. Our recent and long-term experiences provide strong evidence that we need significant changes at the national level to improve health care for all.

Serving society as a public good

The toll of the pandemic in the U.S. has further exposed the need for universal health care to meet the needs of patients, physicians, health care providers, the public's health, and to serve society as a public good.

In January 2020, the American College of Physicians (ACP), the largest professional physician organization in the U.S., published its health and policy committee recommendations to transition to a system of universal health coverage. Its vision of a better health care system includes universal health care for all ensuring that everyone has coverage for, and access to, the care they need at a cost they and the country can afford. It details payment and delivery systems that put the interests of patients first by supporting physicians and their care teams in delivering high-value patient-centered care. It suggests that spending be redirected from unnecessary administrative and other for-profit revenues to the funding of health care coverage, research, public health, and interventions to address the social determinants of health. It empowers clinicians and hospitals to deliver high-value, evidence-based care through a process that prioritizes and allocates funding and resources with the engagement of the public and physicians. It supports financial incentives that are aligned to achieve better patient outcomes, lower costs, and reduced inequities. And, it encourages the redesign of delivery systems to make it easier for patients to navigate and receive care conveniently and effectively. Paramount to the ACP's plan is a health care system where all people receive unbiased, equitable, and excellent health care services.[2]

The ACP put forward two options—a single payor option or a public option with greater insurance company regulation to provide care needed for all at a cost patients and our country can afford.

In February 2021, a coalition of health care associations including the American Medical Association, America's health insurance plans, the American Academy of Family Physicians, the American Benefits Council, the American Hospital Association, the Federation of American Hospitals, and the U.S. Chamber of Commerce agreed to pursue universal coverage. They noted, "While we sometimes disagree on important issues in health care, we are in total agreement that Americans deserve a stable health care market that provides access to high-quality care and affordable coverage for all."[3] The coalition agreed to pursue universal coverage through market-based solutions built on the Affordable Care Act.

These are bold affirmations that physicians and health care providers are in alignment for change within the system. How to accomplish this goal remains a major challenge for our country's leaders and for physicians, other health professionals, and the public at large.

A social good

Now is the time to enact a U.S. health care system to provide universal health coverage as a social good. It must become a national priority to fulfill our public and social contracts.

Currently, in the U.S., the military health care system, Indian Health Services, the Veterans Health Administration, and Medicare are all government single payor systems. Medicaid and the Child Health Insurance Program are jointly funded by the federal government and state governments.

Over the past two years, during the COVID-19 pandemic, Medicaid and CHIP enrollment increased by 16.7 million, a 23.4 percent increase nationally.[4] It now covers more than 87 million U.S. residents, about 45 percent of U.S. childbirths, more than 60 percent of long-term services, and 25 percent of mental health care. Medicaid is the largest single payor of health care in the U.S.[5]

Medicare provides health coverage for 54 million elderly, or about six percent of the population.[6]

This means that approximately 50 percent of U.S. citizens are covered by single payor health care systems.

Private health insurance markets cover about 179 million U.S. citizens or slightly more than half of the population through more than 900 insurance companies at a cost of $1.195 billion or 28 percent of health care expenditures.[7]

The remainder continue to be uninsured, and a serious accident or an illness or other health issue that results in emergency care and/or an expensive treatment plan can result in financial ruin, bankruptcy, and take a colossal toll on patients, consumers, and society.

The right thing to do

So, why should we do more, if approximately 50 percent of our people are already covered by some form of single government insurance? Why do we need universal health care?

Universal health care in the U.S. is the right thing to do!

Even though many in the U.S. have some type of health insurance, many remain uninsured, underinsured, or live with the risk of losing health insurance should they lose their jobs. We need universal health care to overcome these inequities and stressors.

This raises the question: Is health and health care a public good? Who provides the services in rural, urban, and underserved locations if the providers, hospitals, technology, and services cannot be profitable to insurance companies? Should private insurance companies be required to serve unprofitable communities and individuals as part of their public responsibility? Should they be required to provide support to develop a system, with other providers, to serve and support those locations as a part of their social responsibility?

When health care is available to all, no matter their geographic location or zipcode, workers can afford to move from one location and job to another where they can provide more value to grow the economy. This supports economic development, especially in rural and disadvantaged communities.

The cost of health insurance

The ongoing dramatic increases in health care costs also need to be addressed. The U.S. spends roughly 50 percent more than other industrialized countries on health care, and health care costs are approaching 20 percent of the nation's gross domestic product. The average American family spends approximately $14,000 dollars a year, out of pocket not counting deductibles and co-payments, on health insurance,[8] and employers spend approximately $16,000 per employee per year.[9] This affects the cost of services and goods in the general economy for everyone.

There is a little known law, enacted by congress 70 years ago, that both exempts insurance companies from federal antitrust law and consigns the right to regulate insurance in all other respects to the states. Therefore, insurance companies can essentially dominate markets within states without violating antitrust law, and are prohibited from providing insurance across state boundaries. The result is that, according to the Commonwealth Fund, the U.S. has the highest number of uninsured citizens in the industrialized world.[10]

A Commonwealth Fund a report published in 2021[10] found that:

- The U.S. spends more on health care as a share of the economy—nearly twice as much as the average developed country—yet has the lowest life expectancy and highest suicide rate.
- The U.S. has the highest chronic disease burden and an obesity rate that is two times higher than the average of other developed countries.
- Americans had fewer physician visits than peers in most countries, which may be related to a low supply of physicians in the U.S.
- Americans use some expensive technologies, e.g. MRIs, and specialized procedures, e.g., hip replacements, more often.
- The U.S. performs better in terms of some preventive measures, e.g. breast cancer screening and flu vaccination in older people.
- The U.S. has the highest number of hospitalizations from preventable causes and the highest rate of avoidable deaths.

Americans have the highest level of health care spending, yet have fewer physician visits than other countries.

The Commonwealth report determined that the U.S. should reduce health care costs and strengthen access to health care and primary care systems. It concluded that the U.S. health care system is the most expensive in the world and that Americans continue to live relatively unhealthier and shorter lives than those in other high-income countries, and that efforts need to be made to limit increases, lower costs, and improve affordability and access to care.[10]

A National Health Reserve System

Comprehensive health care reform and universal health care—I call it a National Health Reserve System (NHRS)—could be the solution. The NHRS would be a transparent system of governance and oversight with clear responsibility and coordination for universal health care in the U.S. based on the needs of patients and communities, at an affordable cost. A NHRS would work within, and across, regions and states to provide health care for all. A two-phased approach to transition to universal health care based on a NHRS model would be optimal for all involved.

Unfortunately, federal guidelines for Medicaid are broad, allowing states a great deal of flexibility in designing and administering their programs. As a result, Medicaid eligibility and benefits can, and often do, vary widely from state to state, making each state's program unique. This means that each state has its own Medicaid eligibility standards. However, in all states, Medicaid plays a key role by providing affordable health coverage for vulnerable populations and is the largest source of federal funds to states. The U.S. can provide long-term national support for the recent state expansions of Medicaid—allowing for the changes implemented during COVID-19—and make Medicaid a national and regional single payor with state cooperation. This would result in half of Americans receiving health care in a single payor system.

An NHRS would centralize Medicaid and CHIP as a national program for all 50 states and the U.S. territories, and have it administered by the national Centers for Medicare & Medicaid Services (CMS) with continuation of Medicaid offices in each state. The eligibility rules would be the same for everyone and coverages would be determined on a regional basis. CMS, with the support of states and regions, would fund the system, provide continuity, and provide proper health care management and reimbursement for services, as they do with Medicare. All Medicaid and CHIP recipients would be covered by a comprehensive set of health care services for adults and children. Institutional long-term care would be included as part of the benefits package.

The remaining 44 percent of privately insured people would see no change as they would continue to be covered under their employer-based health insurance or be self-insured. However, should they lose their jobs, and hence their employer-based health insurance, they could easily convert over to the NHRS system and its national coverage plan.

All patients in Medicare, Medicaid, and CHIP—and in the future those in the NHRS—would have an electronic smart card with their electronic health record.The smart card would include their medical record, billing functions, and other data linked to a central repository.

Eligibility and reimbursement of Medicare, Medicaid, and CHIP would be separate, but the process would be integrated. All licensed and certified providers would be eligible to participate in the Medicaid program. Medicare and Medicaid would develop and implement a national fee schedule.

The result would be having more than 50 percent of the U.S. population enrolled in a national health care system under the oversight and governance of the NHRS. This would be transparent to those currently covered under the aforementioned government programs, and by adding the uninsured under this system, 56 percent of Americans would be insured under a single payor system. We would achieve universal health coverage in systems that are integrated, coordinated, managed, responsive, and affordable. We would be putting patients and community needs first.

A transparent system

The NHRS would be a transparent system of health and medical care governance and oversight with clear responsibility and coordination for universal health care in the U.S. based on the needs of patients and communities at an affordable cost.

The creation of an NHRS by the president and congress, modeled after the Federal Reserve System, would provide a quasi-independent centralized national governance, policy, and regulatory organization for health care that is evidence- and data-driven for public health in the U.S.

The NHRS would focus on health outcomes, patient satisfaction, and the efficient use of resources. It would be run by a Board of Governors that provides broad supervisory control over health care and health care organizations to ensure that the system operates responsibly.

The Board of Governors would be a federal agency consisting of nine governors appointed by the President and confirmed by the Senate, each serving a 14-year term with no option for reappointment, thereby maintaining political independence. The Chair and Vice Chair would be appointed by the President from the existing Board

of Directors, confirmed by the Senate, to serve four year terms, and could be appointed for multiple terms.

The NHRS would have 12 geographic districts with representation of states in the district included in each regional district. It would have a national board representative of the 12 districts, and a governing board which would include nine members. No member of the board would serve for more than nine years to ensure full national representation while preserving continuity.

The 12 district boards would predominantly be composed of experts in the medical community—physicians, nurses, and other health professionals—representing hospitals, private practices, clinics, government and private insurance carriers, academic health centers, health care finance professionals, state and local representatives, and those who receive health care services in that region.

The NHRS would organize and utilize experts, data, research, and evidence to evaluate all aspects of health care delivery and funding in the 12 geographic regions, and collectively determine the best policies, organization, regulations, cost, and reimbursement in support of improving health care across the U.S.

The values of the NHRS would be a commitment to the public's interest, quality, excellence, independence, and analysis. Its primary objective would be to improve the health and well-being of patients, communities, and the entire U.S. through professionalism, innovation, and virtue in doing what is best for Americans. It would utilize the values of medical professionalism to serve patients and limit conflicts based solely on financial profit. It would forge a collaborative, responsible, organized, federal and state health care system.

The NHRS would work to ensure seamless access to services for patients, regardless of their income, socioeconomic status, or geographic location. It would work to eliminate health inequities and promote scientific and practice-based research to improve patient health and clinical care. The NHRS would be politically independent and financially sustainable over the long term.

Under an NHRS, Americans would gain the security that comes with stable, high quality, affordable health care coverage. The NHRS would positively affect people's health and lives. However, to be successful, an NHRS must be transparent and politically independent, but ultimately accountable to elected officials and all Americans. It would make decisions in public, and Congress would subject it to strict auditing and reporting requirements.

The time is now

The time is now for much needed transformation of the U.S. health care system. The COVID-19 pandemic has made this more apparent than ever. We cannot, and must not, let this current crisis go to waste.

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