Current Perspective

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Health Policy During COVID-19

Are time and COVID-19 shedding any light on some of the big questions—"Is the COVID-19 experience providing enduring lessons?" . . . "Are we moving the quality needle?" . . . "Are bigger integrated systems better?" . . . "How much should we pay for health care?"

While we've been dealing with the pragmatic realities of practice ("Does taking my office staff's temperatures every morning really make a difference?" and "How can I see fundus details through this fogged mask and shield?"), health economists and policy wonks are publishing opinions destined to inform Washington policy debates for years to come. While these opinions tend not to receive the public attention of vaccine development, this work remains important in shaping how 17% of our national GDP will be spent. Here are four recent, notable articles:

Lasting lessons? How enduring will the COVID-19 lessons be about clinical care? A paper in the August 2020 issue of *Health Affairs* posits that CMS' temporary lifting of nonclinically-relevant administrative burdens has enabled teams to function more effectively with less stress and frustration.[1] The authors note that before COVID, physicians in ambulatory practice devoted two to three hours per day to mostly EHR work—much of that contributing to burnout. Sixty hours per physician per week is spent on prior authorizations and insurer interactions. ". . . what make sense around a conference table . . . may not be effective at the point of care . . . " Every physician in America would agree! The authors provide specific examples, and they issue a call to not waste the crisis lessons but consider only those administrative burdens that are evidence-based.

Quality improvement? In *The New England Journal of Medicine,* McGlynn noted that after decades of focus on quality, some important public health measures have barely moved.[2] While about half of U.S. adults are hypertensive and the disease accounts for 23 deaths per 100,000 population, the percent of American hypertensives with effective blood pressure control has gone from about 37% to about 45% after nearly two decades. The author asks what approaches to measurement, organizational structure, delivery models, nonmedical (social) factors, and financing will be necessary to achieve desired medical outcomes.

Is bigger better? The last two decades have witnessed a fantastic financial integration of American health into megasystems involving physicians, hospitals, investors, insurance vehicles, retail pharmacies, benefit managers, ambulatory surgical centers, and/or long-term care facilities with highly sophisticated (and expensive) management resources. All of this was accomplished with the putative goal of improving access, quality, and net cost savings. While this integration is inherently anticompetitive, it has been justified as necessary to make progress in medical and societal objectives. Does it?

A survey by Fisher and colleagues of nearly 3,000 hospitals and physician practices serves to further muddy the waters.[3] Quality scores did not favor financially integrated systems for a majority of the measures and did not favor systems with complex structure. Does this mean that the underlying assumptions are incorrect—or imply that the conditions have not been reached for megasystems to unleash their potential value? Or did they simply fail to execute?

Heath care spending? Finally, a recent analysis repeats the fundamental question "Do we spend too much on health care?"[4] The United States spends about twice as much as many other high-income nations—even adjusting for differences in income. Why? What are the most important metrics in judging the results? Are higher prices generating reasonable incremental value improvements? The authors ask not *whether* health care is a right, but *how much* health care is a public right. This clearly is not a new question, and it harkens back to the "death panels" debate of a decade ago.

Today, as we adjust our PPE in the clinic and do the real work of direct patient care, papers are being written and opinions are being rendered that will inform the debate within the next administration and Congress (whether Republican or Democrat). Our responsibility as one of the key stakeholders in this coming debate is to be knowledgeable and provide expert perspective.

1 Sinsky C, Linzer M. *Health Affairs.* 2020;39(8):1405-1411.
2 McGlynn EA. *NEJM.* 2020;383(9):801-803.
3 Fisher ES et al. *Health Affairs.* 2020;39(8):1302-1311.
4 Baicker K, Chandra A. *NEJM.* 2020;383(7):605-608.