

Confronting Challenges in the US Health Care System

Potential Opportunity in a Time of Crisis

Melinda B. Buntin, PhD

The sheer number of challenges facing the Biden Administration and the 117th Congress in the health policy sphere is staggering, as is the range of potential solutions offered by the authors of the Viewpoints in the JAMA Health Policy series.¹ The most pressing challenges involve addressing the global COVID-19 pandemic. Yet policy makers would be remiss if they did not leverage this opportunity to also address the fundamental problems with the US health system laid bare by the nation's response to the pandemic. These include major challenges related to health insurance coverage, the solvency of publicly funded programs, the stability of the health care safety net, market power and consolidation, inequities in health care access and outcomes, public health infrastructure, and the failure to effectively use technology to help counteract these problems.

Personal health crises, such as experiencing a myocardial infarction, can spur patients and their care teams to work to improve underlying health habits and conditions that contributed to the health event. Similarly, the havoc wrought by the COVID-19 pandemic is a clarion call to improve US health care coverage, financing, and organization. The status quo practices of the health system in the US—like poor health habits of a patient with heart disease—have left it susceptible to poor outcomes.

The high cost of the US health care system is its biggest weakness. In the US, national expenditures on health care goods and services were approximately \$4 trillion in 2020, accounting for an estimated 18% of gross domestic product.² High prices for care explain a large part of the difference in spending between the US and other developed countries. Surprise billing is just one aspect of the pricing problem, but one that, as Colla³ describes, illustrates many troubling trends in medicine. Consolidation of hospitals, insurers, and large and small practices has accelerated during the pandemic and as Dafny⁴ explains, can be expected to lead to higher prices in the commercial market in the future. Chernew⁵ elegantly discusses how market power and consolidation in the health care industry, exacerbated by the pandemic, could lead to still higher prices and a cycle of harms for individuals, governments, and society as a whole.

Those harms include incomplete insurance coverage, both in terms of numbers of people covered and the generosity of that coverage, due to high prices that lead to high insurance premiums. Higher premiums have meant that many people who are not eligible for subsidies on the health insurance exchanges find insurance unaffordable. The Biden campaign proposals to extend subsidies to higher income groups are designed to help solve this problem but will not address its root causes. High premiums have also contributed to wage stagnation for US workers with employment-based health insurance and to higher cost-sharing, which has been shown to reduce access to necessary care.

In addition, higher health care costs put pressure on state and federal budgets. As Gee et al⁶ discuss, 12 states have not chosen to expand Medicaid to date, and a concern that even being responsible for 10% of the increased costs could be burdensome is one of the reasons cited for this choice. Frank and Neuman⁷ emphasize that the looming deficits in the Medicare Part A Trust Fund will also put pressure

on federal policy makers to find sources of new revenues or to cut benefits or payment rates. Perhaps even more important, as described by Venkatarami and colleagues,⁸ high health care prices contribute to limited budgets for other social goods like education and housing that could improve health outcomes, possibly even more than direct spending on health care.

Similarly, it is now clear that the US has spent an increasing amount of resources on health care, but spending on public health has been inadequate. Investments in surveillance officers and systems and in stockpiles of equipment and medications are less appealing ways to spend public resources than covering new drugs or services. The pandemic has revealed the shortcomings of the US public health infrastructure and illustrates that neglecting to reinvest in public health after a pandemic will more severely compromise the ability to respond effectively to the next public health crisis.⁹ Although none of the Viewpoints in this series focused on specific public health proposals, they should be part of every discussion of improving health and health care going forward. Public health policy must be central not only to health policy, but to economic policy and national security policy as well.

High health care prices might be less of a problem if the US health care system was uniformly delivering high-quality care and yielding high value. The US does prioritize health as a society and voters are reluctant to endorse solutions that limit access to the latest innovations in health care. However, a fundamental shortcoming in the US health care system is the tendency to create and perpetuate incentives to deliver higher-margin treatments and specialty care instead of primary care, preventive care, and public health. The central need to refine the focus on value was highlighted in many articles in the series.

Several Viewpoints in the Health Policy series provided worthy suggestions and policy recommendations that could help the US health care system recover from the current crises stronger. Berwick and Gilfillan¹⁰ call for speeding the cycle time of demonstrations under the Center for Medicare and Medicaid Innovation, Dafny⁴ suggests examining mergers and acquisitions more closely, and Chernew⁵ proposes implementing “backstop” prices in commercial markets.

Another important step will be using data and technology strategically. During the pandemic, the health care system rapidly adopted telemedicine in clinical care. Millions of people accessed readily available data dashboards that illustrated the course of the pandemic and the extent of infections in specific areas, and many used the information to demand better and more equal care. As described by Adler-Milstein,¹¹ a digital transformation in the US health care system could make it possible to continuously monitor and use real-time data to inform preparedness and population-level care planning. Such data systems also could be used to help address and reduce disparities and inequities in care and to improve health system transparency, including around prices. Moreover, these systems could save money and reduce the reporting and patient tracking burdens on health care centers, physicians, and other clinicians participating in value-based care; administrative costs are estimated by Kocher et al¹² at \$2500 per person per year.

Can commitments to improving health care coverage, financing, and organization be made in the midst of a pandemic and an affordability crisis? There are reasons to hope the answer is yes. The pandemic has substantially changed care patterns, shown the risks of fee-for-service payment and a reliance on

highly reimbursed surgical procedures, and revealed the need for a stronger public health infrastructure and greater preparedness. Health systems will be increasingly held accountable for ensuring delivery of high-value care and for addressing health equity issues in ways that do not rely on outdated models of care. No one could have imagined or would wish the current economic, societal, or health care challenges of the COVID-19 pandemic on a new administration or Congress. But all have hope that leaders can confront these crises as potential opportunities for developing solutions to address the ongoing major challenges in the US health care system.

Article Information

Corresponding Author: Melinda B. Buntin, PhD, Department of Health Policy, Vanderbilt University School of Medicine, 2525 West End Ave, Ste 1200, Nashville, TN 37203 (melinda.buntin@vumc.org).

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References

1. Bauchner H, Fontanarosa PB, Joynt Maddox K. Health care is a right, not a privilege: a new series on us health care and health policy. *JAMA*. 2021;325(3):227-228. doi:[10.1001/jama.2020.23915](https://doi.org/10.1001/jama.2020.23915)
2. Centers for Medicare & Medicaid Services. National health expenditures fact sheet. Modified December 16, 2020. Accessed March 10, 2021. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>
3. Colla C. Surprise billing-a flashpoint for major policy issues in health care. *JAMA*. 2021;325(8):715-716. doi:[10.1001/jama.2020.26779](https://doi.org/10.1001/jama.2020.26779)
4. Dafny L. Addressing consolidation in health care markets. *JAMA*. 2021;325(10):927-928.
5. Chernew ME, Pany MJ. Regulation of health care prices: the case for backstop price caps in commercial health care markets. *JAMA*. 2021;325(9):817-818. doi:[10.1001/jama.2020.26821](https://doi.org/10.1001/jama.2020.26821)
6. Gee RE, Shulkin D, Romm I. A blueprint for comprehensive Medicaid reform. *JAMA*. 2021;325(7):619-620. doi:[10.1001/jama.2021.0013](https://doi.org/10.1001/jama.2021.0013)
7. Frank RG, Neuman T. Addressing the risk of Medicare Trust Fund insolvency. *JAMA*. 2021;325(4):341-342. doi:[10.1001/jama.2020.26026](https://doi.org/10.1001/jama.2020.26026)

8. Venkataramani AS, O'Brien R, Tsai AC. Declining life expectancy in the United States: the need for social policy as health policy. *JAMA*. 2021;325(7):621-622. doi:[10.1001/jama.2020.26339](https://doi.org/10.1001/jama.2020.26339)
9. Narayan KM, Curran JW, Foege WH. The COVID-19 pandemic as an opportunity to ensure a more successful future for science and public health. *JAMA*. 2021;325(6):525–526.
10. Berwick DM, Gilfillan R. Reinventing the Center for Medicare and Medicaid Innovation. *JAMA*. Published April 6, 2021. doi:[10.1001/jama.2021.3203](https://doi.org/10.1001/jama.2021.3203)
11. Adler-Milstein J. From digitization to digital transformation: policy priorities for closing the gap. *JAMA*. 2021;325(8):717-718.
12. Kocher RP, Shah S, Navathe AS. Overcoming the market dominance of hospitals. *JAMA*. 2021;325(10):929-930.doi:[10.1001/jama.2021.0079](https://doi.org/10.1001/jama.2021.0079)