The Pandemic and the Healthcare System: Where do We Go from Here?
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One of my students, who is a nurse, described the final few moments in the life of one of her patients. In his 80s, he contracted COVID-19 at a small family gathering he believed to be safe. He was put on a ventilator for two weeks. A few days following its removal, he went into respiratory distress. He labored to breathe, gasping for every precious breath. It was clear he would not survive. He asked if he could say good-bye to his son, but visitors were not permitted in the hospital. The nurse FaceTimed his son from her phone. She wasn't successful in choking back her tears. They landed on the inside of the protective shield covering her face, blurring her view of his son's anguish. But she could hear him straining to contain his sobs, his voice cracking with helplessness. It was painful for her, but at the same time she was numb from all the sickness and death all around her. A moment into the call, the patient in the next ICU bed, also suffering from COVID-19, lapsed into cardiac arrest, triggering what hospitals call a "code." As part of the code team, the nurse was required to rush to him. She had to end the FaceTime call.

How does one keep going when no moment is free of urgency, when lives are taken in numbers so vast they defy comprehensibility? Could the magnitude of this suffering have been prevented? Since the pandemic hit, a sentiment in the public health community has been forming that the national response throughout 2020 was woefully inadequate, and it is likely that we experienced substantially more spread of the virus and deaths than we should have.

Reliable judgments about the degree to which a more effective response could have contained the extent of contagion and the death toll will take some time and sober analysis. But a tragic picture is taking shape, revealing that the impact on those working in the industry has been severe; a survey by Mental Health America (N.D.) reports that the work force is "Stressed out and stretched too thin: 93% of health care workers were experiencing stress, 86% reported experiencing anxiety, 77% reported frustration, 76% reported exhaustion and burnout, and 75% said they were overwhelmed."

The effect on hospitals has also been dramatic. For example, Research and Markets (2020) forecasts, that when all is said and done, hospitals will have lost $323 billion in 2020 due to COVID-19 and that Operating Room volumes will have declined by 35%, due largely from cancellations of elective surgeries and anxiety about going to a hospital for surgery generally during a pandemic. Hundreds of hospitals across the country, especially those serving rural communities, have a heightened risk of bankruptcy and closure. Those with limited financial reserves or which rely on non-patient care revenue sources, such as government subsidies and grants, are at greatest risk (Center for Healthcare Quality and Payment Reform, N.D.).

Indeed, the pandemic has exposed weaknesses and vulnerabilities in our healthcare system that have been there all along. Perhaps chief among them, and this relates to society more broadly, is the shameful inequity in our system, dramatically verified by the pandemic. Simply put: if you are Black, Brown, or poor, your chances of contracting COVID-19 and dying from it are higher than those of your white counterparts in middle- and higher-income brackets. This disparity didn't start with the pandemic. A recent study conducted by researchers at New York University examined life expectancy across 500

cities. They found that as racial and ethnic segregation in neighborhoods increased, so did the life expectancy gap (NYU Langone Health News Hub, 2019). Among the most glaring of such gaps was found in the Chicago suburbs of Streeterville and Englewood, just nine miles from one another. The average life expectancy in Streeterville, a relatively affluent white suburb is 90. Englewood, a poor African American community, has a life expectancy of 60 – a gap of thirty years! (Associated Press, 2019).

COVID-19 has shed a spotlight on the issue of the racial disparity that should make it impossible to ignore. Black people have died at a rate 1.7 times greater than white people (Peck, 2020). The Centers for Disease Control (CDC) found that Black, Hispanic, and Native American people were approximately four times as likely to be hospitalized for COVID-19 as white people (Chavez and Howard, 2020). In a late November 2020 Pew survey, "71% of Black Americans are likely to say they know someone who has been hospitalized or died as a result of Covid-19, compared with 61% of Hispanic, 49% of White and 48% of Asian-American adults" (Howard and Andrew, 2020).

Needless to say, these disparities are unsettling. Certainly, the problem extends beyond healthcare to socio-cultural and socio-economic underpinnings with deep historical roots that make it easier for some to access and enjoy the fruits of society while others are confined to the sidelines. If there is a silver lining to the pandemic – admittedly, a peculiar sentiment in light of the perverse price we have paid – it may be that we can no longer turn a blind eye to the disparities in healthcare. Fixing this national humiliation involves dismantling the barriers that have made it impossible for all to experience healthcare – *good quality healthcare* – as a basic human right.

But the pandemic uncovered other weaknesses in our healthcare system as well, weaknesses not unrelated to the uneven distribution and availability of care. These involve a failure to be fully – make that adequately – prepared for a broad-based health crisis like a pandemic; an inability to mobilize a coordinated response on a regional level, for example, in which resource sharing might occur; insufficient support for healthcare workers exposed to health risks and undue stress; a consolidation of hospital systems that has weakened governance at the local hospital level; and, of course, the enfeebling of the Affordable Care Act, slowing the pace of achieving universal coverage and diluting population health initiatives that, among other things, bring healthcare resources more directly into communities.

This is not meant to suggest that our healthcare system does not have many strengths. Like the healthcare systems of all countries, it has its assets as well as its limitations. All systems can be traced to national values, culture, and history. In order to explore where we may head to correct deficiencies that the pandemic has revealed should no longer be tolerable, it is best to start with a very brief chronicle.

How We Got Here

A starting point is almost arbitrary, but World War II largely accounts for the historical accident that is our healthcare system. As wages slowed or remained frozen during that period, health insurance became a popular enticement for employers to attract workers. In 1940, about 10% of workers had health insurance provided by their employers. By 1950, the number had skyrocketed to 50%. Thus, in just ten years, employer-based health insurance had become an institutionalized feature of our healthcare system.

By the time the late 1970s and early 1980s rolled around, the basic structures of the hybrid system of employer-based insurance and government programs, including Medicare and Medicaid, were in place. Much of the change that occurred after was built on those structures, including the Affordable Care Act, enacted in 2010.

In the late 1970s, and for much of the following decade, healthcare inflation was running high, often at multiples of the Consumer Price Index. For example, in 1982, a relatively typical year, the CPI was 3.2% while healthcare inflation was 11.7%. Accordingly, there was much pressure to control costs. As a result, in that same year, the federal government implemented a major policy change that would have sweeping implications for healthcare financing and delivery. The policy, *Diagnostic Related Groups*, was a Medicare initiative in which fixed fees were developed for roughly 500 diagnoses. This meant that hospitals could no longer easily pass along their costs for those procedures to the government, representing the first major shift from fee-for-service to prospective payment.

Hospitals had to respond by holding spending down. They did many things, like trying to reduce the length of time patients spent in hospitals and introducing new inventory models that limited how many supplies they would keep on hand. But of all the landscape changing activities that took place, the most significant was the realignment with hospitals seeking economies of scale through merger and acquisition. Today, the vast number of hospitals across the country are part of hospital systems. In 2018 alone there were 1,182 mergers and acquisitions, involving the exchange of over $120 billion of assets (Lagasse, 2019). The average transaction in 2018 exceeded $400 million and, by then, it wasn't just individual hospitals merging into hospital systems, but hospital systems merging with or being acquired by other hospital systems. The largest hospital systems in the country are vast enterprises. For example, the largest, HCA Healthcare, operates 214 hospitals, has over 30 million patient visits per year, and had a value of almost $47 billion in 2018, earning it a ranking of 67 on the Fortune 500 list (Fortune, 2018).

Healthcare System Characteristics that Impeded Preparedness for a Pandemic

The trends over the past fifty years have important implications for how the U.S. healthcare system met the challenge of the COVID-19 pandemic. Examining these markers can help explain how we have arrived in the current predicament. Broadly speaking, four conditions or characteristics of our system, natural outgrowths of those trends, may account for the healthcare system's less than stellar response to the pandemic: (1) unrestrained hospital system growth; (2) a dominant market-based culture; (3) lack of incentives for preparedness in the hospital sector; and (4) weakened structures for health crisis forecasting and planning.

First, the growth of hospital-based systems has occurred on a relatively unrestrained basis. For the most part, regulatory bodies with oversight responsibility, like the Federal Trade Commission, have approved virtually every merger and acquisition deal placed before them. Those proposing transactions have used three arguments to deflect and dispose of possible resistance: (1) the public will be better served by having a more comprehensive system in which greater coordination of care is possible; (2) market domination is not the goal; rather it is to provide services in a contiguous geographic region; and (3) communities will be better served by systems with greater size and reach. Incidentally, quality has not

been shown to improve as hospital systems enlarge (Frakt, 2019); but what does appear to increase are prices for providing care, due largely to reductions in competition (Abelson, 2018).

With system expansion, there has been something of a shift from the community-centric focus of independent hospitals to one of overall hospital system success; and such corporate success is a function of overall asset performance. This would be an expected consequence of hospital system expansion. To protect the system's interests, that is, to maximize its advantage in a competitive environment, market share growth and solidification are essential. After all, one's competitors would not be expected to sit still. Thus, building a comprehensive and complex corporation, one which integrates all levels of care – from the medical practice, to the outpatient center, to the diagnostic facility, to the hospital, to the rehab facility – is an essential means of keeping patients in the system and enlarging the patient base. In such a high stakes climate, competition supersedes coordination. That is, the relationships between and among hospital systems may be defined more by how they compete than by how they cooperate.

Second, a market-based culture has prevailed in healthcare. This means that all components of the system are expected to perform well financially. For example, a hospital system that spends a half a billion dollars a year on medical supplies will want to be assured that its suppliers have successful track records and durable business models. Moreover, as hospitals seek to manage their expense base, finding low-cost solutions for goods constitutes an important strategy; supply chains built on low-cost production and transportation models are most attractive. With many of the manufacturers of health-related products, like ventilators and personal protective equipment, based overseas, it is possible to get caught short in a crisis. Further, in keeping with the market-based culture, services that place a premium on return on investment will be promoted. Cardiac and orthopedic surgeries tend to offer the greatest profit margin. Infectious diseases, on the other hand, typically yield negligible financial benefits.

Third, in a market-centered system – one which promotes patient and resource accumulation, fortification of competitive advantages, and strengthened footholds in communities of strategic value – incentives for building resource inventories for potential use are in short supply. In this way, a preparedness mindset would incur a cost that does not align well with competition management. The public health perspective, that which focuses on detecting disease and managing its prevention and treatment, has not had as loud a voice in guiding hospital strategy.

Fourth, the Trump Administration did not consistently embrace priorities and recommendations from the scientific and health communities. The then-president of the United States acknowledged in a recorded interview with Bob Woodward that COVID-19 "moves rapidly and viciously" and that "If you're the wrong person and if it gets you, your life is pretty much over if you're in the wrong group. You know what I mean. It's a tough deal." And yet, in the same interview, the president presented a public communication strategy built on falsehoods with respect to the severity and scope of the pandemic, admitting that: "I always wanted to play it down" (Gangel, Stuart, and Warren, 2020).

Indeed, then-President Trump's dismissive position for preparing the nation for a health crisis predated the COVID-19 pandemic. In 2018, he downgraded the National Security Council Directorate for Global Health and Security and Biodefense, the group responsible for forecasting a pandemic and

orchestrating a national response. In a *Washington Post* op-ed, Beth Cameron (2020), the first director of the unit, equated the department to a "smoke alarm…all with the goal of avoiding a six-alarm fire."

History will judge our national leadership as it relates to the COVID-19 pandemic. Some distance will allow for a thoughtful, objective evaluation when the full extent of outcomes has been sorted out. Nonetheless, some things are clear. From the very beginning of the pandemic, the former president downplayed its severity, failed to galvanize support for the practice of proven mitigating protocols while chastising federal and state government officials who did, promoted unproven and potentially dangerous remedies, and touted administration achievements unsupported by any empirical measure.

Six Areas for Moving Forward

So, where do we go from here? Will we take an open, honest, and hard look at how we responded to the pandemic in a way that improves our capability for anticipating and managing a health crisis and which is free of obstructions to access for so many? Will we commit to making the necessary changes such that dignity and respect are not standard for some and unattainable luxuries for others? If we do, there are at least six areas we would be advised to address:

Create a more generous and inclusive health policy.

The good news is that if we look at the long history of health policy in this country, we see something of an evolution toward broader coverage, granting it to more and more groups. In 1965, with the passage of Medicare and Medicaid, health insurance was extended to the elderly and the poor. At various times since, coverage was extended to other groups, including children through various federal and state programs, With the Affordable Care Act, coverage was brought to millions more. Thus, over the past century, many groups – from workers to retirees to the elderly to the poor to children, and most recently to remaining groups, including those with pre-existing illnesses through the ACA – have become eligible for coverage.

The bad news is that progress has been largely glacial and inconsistent, often two steps forward, one back. Tens of millions remain uninsured and access to coverage doesn't neatly translate into convenient means for getting high quality and timely care. As long as health policy allows for such gaps, honoring the principle of health care being a right will elude us.

President Biden has indicated he will build on the Affordable Care Act by introducing a public option. This would add a federal plan to the mix of insurance programs. It is imperative that plans cover the ten benefits considered "essential" under the Affordable Care Act: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (Healthcare.gov, N.D.).

Embrace principles of "population health" and "community health."

In the traditional healthcare model, hospitals, medical practices, and other providers waited, for the most part, for patients to initiate contact and then respond to their health needs. In an emerging population health paradigm, providers reach into communities to gain a better understanding of factors that

influence the health of the residents and bring health resources more directly into the community. One CEO recently told me that this amounted to his hospital being defined more by its role in the community than by the physical building.

Bringing health services more fully into the community not only enhances access but allows for a greater understanding of how environment influences health, wellness, and illness. It provides opportunities for examining more fully how social determinants of health influence people's ability to obtain good quality care. Establishing networks of community-based clinics, staffed by people who look and sound like members of the community, helps dismantle the cultural divide, making visits to a provider not only more convenient, but possible.

A recent graduate of SUNY Empire State College's MBA in Healthcare Leadership program manages a population health program for the Montefiore Health System. They set up screening systems directly in various communities in the Bronx, including going directly into residents' homes. The purpose is to gain insight into factors that contribute to their health profile, including health literacy, economic stability, housing, substance abuse, violence, social connections, legal issues, transportation, and food insecurities. The focus on predisposition to health problems and the creation of health plans for community residents has had an appreciable impact on incidences of diabetes and heart disease as well as disease co-morbidities.

If we are to make headway on the disgraceful inequities of care, we cannot permit socio-economic factors that underlie health disparities to be obscured by other priorities that special interests attempt to convince us are more pressing.

Strengthen the focus on social determinants of health.
In the 1990s, as competition among hospitals was ramping up and as regulatory agencies were placing more emphasis on patient satisfaction, a wave of empathy and communication skills training for healthcare workers was set in motion. Sometimes it worked, sometimes it didn't. Hospitals that viewed patient satisfaction as dependent on a broad-based effort to strengthen communication experienced more success. This included revisiting the hiring criteria to be certain they could detect relevant skills; building communication into performance standards and evaluation criteria; ensuring that leadership and management were role models; dignifying the training by focusing on subjects like health literacy rather than approaching the training as though employees had been doing something wrong; exercising sensitivity to workplace stressors that could impair effective communication… and doing something about them; and conveying to employees that their satisfaction was as important as patient satisfaction.

Today, in recognition of the uneven distribution of and access to good quality care, hospitals across the country are implementing activities to sensitize employees to principles of equity, diversity, and inclusion. The empathy experience should prove instructive. The rush to do something, as occurred in many cases with the empathy training, just to do something, could backfire if employees believe the full measure of a solution is linked to a deficiency on their part.

Social determinants of health is a complex matter. Building an environment in which barriers can be overcome takes a lot of work and commitment. It includes ensuring that the decision-makers are

representative of the communities served, that members of communities are asked to contribute to the identification of their healthcare needs and play a role in devising solutions, and that understanding health literacy and its powerful role in influencing predisposition to engaging the healthcare system will occupy a key learning goal in the organization's educational activities.

Further, it would be ethically unreasonable to ask employees to behave toward patients in a way not reflected in management's behavior toward employees. Thus, ensuring that the workplace is a model of equity, diversity, and inclusion principles is foundational to a productive program of improvement. As such, compensation, advancement opportunities, and voice in decision-making should align with those values.

Enhance crisis planning and coordination across federal, regional, state, and local levels.
History is likely to judge the management of the pandemic throughout 2020 as a colossal failure of leadership; in addition to the former president downplaying the disease, the failure to mobilize a coordinated response between the federal and state governments will undoubtedly be viewed as fundamental to the disastrous effort. Aside from presidential failures, three factors account largely for the lack of more broad and robust approach to crisis planning. First, it's expensive; saving for a rainy day – storing massive amounts of PPE, ventilators, and so on – involves building inventory with no foreseeable payback. Second, in a market-based environment, competition supersedes coordination. Third, a sense of urgency depletes after a crisis, accounting in part for the weakening of a public health perspective in policy development.

This is not to suggest that coordination doesn't occur. Where it does, it is generally for common interests, such as policy advocacy, which, ironically, tends to promote the very ability to compete even more. Coordination also occurs around emergencies, for example, a plane crash or train collision, and most of the coordination involves distribution of patients across a few hospitals located near one another. But this type of coordination is for a specific, generally isolated event, not a pandemic.

Developing a more comprehensive, synchronized response across communities, regions, and states is vital. It needs to start with restoring the credibility, pre-eminence, and integrity of the scientific community and of agencies responsible for public health issues, like the CDC. Early signs from the Biden Administration are promising. Similarly, the National Security Council Directorate for Global Health and Security and Biodefense, which can oversee the development of a national plan for resource mobilization and coordination, should have its status and role upgraded. The reporting relationship in the White House would provide the political clout that was largely invisible during COVID-19.

The experience of 2020 should leave no misunderstanding about the importance of national leadership on this matter. Simply, in the face of a national health crisis, science should drive politics, not the other way around.

Institute stronger protections for healthcare workers.
In the fall of 2020, one of our MBA in Healthcare Leadership students, a nurse who works in the Operating Room, was reassigned to work in the ICU to care for COVID-19 patients. It is an entirely different clinical environment, requiring specialized training. She described it as walking into a new world. An ICU "buddy"

nurse was designated to provide basic information about how to care for the patients. The buddy nurse was overwhelmed with patients, so “training” consisted of quick shouts across a crowded nursing station about how to handle a procedure. At the end of their stressful shift – in which the OR nurse felt like she was working in the dark and the buddy nurse was feeling awful because of an inability to provide support – they saw each other across a hall, stared into one another’s eyes, and cried together, flooded by the sheer physical and emotional exhaustion. Words were not needed. They would do the same thing all over again the next day.

Burnout and worker shortages are on the rise. Over 20% of hospitals anticipate that during the pandemic they will experience critical shortages (McMinn and Simmons-Duffin, 2020). A complete plan for instituting a safer and more gratifying work environment would have many components, for example, taking proactive approaches in identifying and responding to burnout; implementing more generous plans for professional development; adjusting pay inequities; mandating and enforcing worker-patient ratios based on recommendations from relevant professional groups; strengthening inventories to ensure proper supplies of equipment; and allowing for a greater employee voice at board and governance levels. An uptick in interest in unionization among healthcare workers, which began shortly after the pandemic struck, can prove instrumental in mobilizing worker advocacy and advancing the prospects of achieving a safer and fairer work environment.

Re-empower local governing boards.

With the expansion of hospital-based systems, centralized corporate boards have largely replaced individual hospital boards as the primary drivers of goal development, direction, and strategy. This is not surprising. After all, the corporate giants have responsibility for billions of dollars of assets and, in some cases, treat individual hospitals as entries on a balance sheet. While corporate strategy is essential, what can get lost in the corporatization of the healthcare industry is the presence and influence of the individual hospital governing board.

Hospital boards are expected to consider stakeholder needs in crafting a policy and leadership framework for senior management. Traditionally, as representatives of the community served by the hospital, board members’ awareness of and sensitivity to local culture would enable them to ensure an enriching environment in which to work and in which care could be provided. This could become obscured in an ever more centralized governing model in which competition management is a prevailing priority. By no means does this suggest that patient care and employee welfare are not treated as important. But the order of priorities is influenced by where the board sits and the structural span of its organization. From a hospital employee perspective, a board seen as light years away from a member hospital’s workers may find it challenging to summon the credibility to demonstrate that its heart lies with them.

Reconstituting a local governance presence should be pursued in order to help employees feel as though their lives and working conditions are important, that the culture of the organization aligns with and supports their values, and that quality of patient care is not an empty slogan, but the core organizing principle of the institution.

Possibilities? Hope?

The six areas are interlinked. For example, a strengthened local governance presence may prove more capable of elevating the status of social determinants of health in hospital planning since they are closer to the communities served by the hospital. As such, they may be more inclined to exercise community outreach, knowing where health initiatives should be initiated. A more inclusive and generous national and state health policy should make it easier for all to obtain care, empowering those currently uninsured or underinsured to get care earlier when illness strikes and, ironically, when it costs less, creating a healthier population and at a lower expense. Greater worker protections lead to a more stable and satisfied work force, strengthening their predisposition to make headway on social determinants of health issues, not to mention the proven benefit on care outcomes. Certainly, there are a great many other areas we might consider – for example, in the realm of structural, cultural, legislative, economic, and political. But the six provide a starting point.

If necessity is the mother of invention, then we have an opportunity to recast our healthcare system in a way that makes it more responsive and more just. In normal times, political climates allow for just incremental change, tinkering around the edges. President Obama campaigned on and was able to usher the Affordable Care Act into law. But just barely. The public option proposal, which President Biden has been advocating, had to be jettisoned by President Obama in order to avoid losing the entire plan in a political atmosphere that would tolerate just so much change. Republicans have not ceased attacking the plan since and, had it not been for Senator John McCain thumbs-down vote, the ACA in its entirety would have been killed outright in 2017. Instead, it was watered down by legislative action.

Public opinion polls have shown that while a significant majority approved of the Affordable Care Act, a far smaller percentage approved of Obamacare. They are, of course, one and the same thing. Politics works by influencing perceptions.

I have a fantasy that one day the national discussion on healthcare can be held in a politics-free atmosphere. Reasoned debate will be the order of the day… ideas coming from all over will build on one another… disagreements will serve as the basis for dialogue and for achieving mutual understanding. Back in the real world, this is a pipedream. But the pandemic does provide an opportunity to reexamine underlying and deeply rooted assumptions about our healthcare system. If so, such an opportunity will be fleeting, for sure. But maybe, just maybe, if we seize the moment, the health and dignity of the American people – all the American people – will be at the heart of the health policy discussion. Imagine that!

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