The coronavirus disease 2019 (COVID-19) pandemic has laid bare many of the structural challenges of the US health care system. Although the US cannot be expected to perform at peak levels during infrequent crises, when the tide goes out on the health care system, many challenges become more visible. And now that all eyes are on these challenges, it is time to discuss them, together.

The first 45 days of the pandemic brought some obvious lessons. The US does not stockpile sufficient personal protective equipment, there are poor infection control protocols in many of US health care facilities, there is a lack of interoperability to quickly and easily share information, there are workforce shortages in key jobs such as respiratory therapists, there is a shaky supply chain of vital medications, there is a lack of humane end-of-life guidance for people dying alone from highly infectious diseases, and diagnostic testing capacities are incredibly poor. The list is actually longer and can get much more granular.

Health care workers, patients, and their families paid a price for these shortcomings from the first 45 days. National focus and investment in appropriate areas, process redesign, preparedness, data repositories, and clearer accountability can help fix these issues so they do not reoccur.

Emerging Structural Challenges

But as living with the pandemic continued, deeper and more critical structural challenges began to emerge. As millions of people began losing their jobs, stopped showing up at their physicians' offices, and delayed seeking health care, clinics, particularly small ones, were distressed and hospital systems began to run out of money. Millions of people lost their primary source of access to care. The US health care system stopped working for anyone except for the middlemen whose only function is supposed to be to facilitate care: the insurance companies.

And as much as the health care system failed, it failed some people even more—namely, the people it already fails miserably, Black individuals and people of color in particular. Older, sicker, and poorer people have been suffering the lion's share of illness and death, not just because they were most at risk to the effects of the virus but also because of deep inequities and racial bias that made them most at risk to shortcomings in the health care system.

Critical Changes

To address the US health care system's shortcomings, there are 3 critical changes that are needed. First, the US needs to move away from a system in which individuals pay insurance companies to one in which individuals pay clinicians, hospitals, and other institutions directly for the desired outcome. This will keep clinicians and medical institutions' income steady and equip them to meet patient needs better. Second, insurance should be tied to existence, not employment. When US workers lose or change jobs for whatever reason, they should not have to start over. Third, health equity and disparities should not be discussed as an afterthought, but ending the racism in health care delivery should be a part of the core design of the system.

How does the US achieve these critical changes? One important step is capitation: paying a set amount for each patient receiving care in a medical practice or institution, with a quality and outcome
component, as at least half if not all of a health care provider’s payment. All payers—including Medicare, Medicaid, and private insurers—should pay at the same rate. Intermediaries that are helpful in facilitating payment, coordinating care, or providing reinsurance, should get a small payment from the medical practices or institutions for those tasks, but not stand between the patient and the care provider. In good times and bad, clinicians and hospitals would be able to both stay afloat and invest in the core needs of their patient population, to keep their patients healthy. The vast majority of dollars from those payments should be required to be spent on prevention, diagnostics, and actual medical care.

Untethering health insurance from employment should be accomplished by eliminating the tax deductibility of health insurance for employers and instead by giving everyone in the US a subsidy to buy health care and insurance. The hundreds of billions in annual budget savings and payroll and corporate taxes could replace the funding from the employer subsidies that workers receive today. Health care should become as simple as picking a physician or care team or other organization offering health care. The Affordable Care Act’s 10 essential health benefits and progressive income subsidies should be a baseline, but the subsidies should be increased and extended to US residents earning middle and higher incomes. Artists, contractors, and temporary workers should get health care on the same basis as corporate executives.

Achieving health equity will be the hardest challenge and will require uncomfortable change for it to be real. Diversity and inclusion can no longer simply exist in one siloed department or be addressed in a single medical school lecture; they need to be integrated into every single thing every single day. Achieving health equity needs to transcend all aspects of problem solving, from the bedside to the boardroom. Gathering and reporting on outcomes by race and ethnicity to see where racism is affecting outcomes is a critical place to start.

With all-payer rate setting, access to care will broaden for everybody. However, it is important go well beyond that by bringing care differentially to communities that have a hard time accessing it. Home care and community-based care, personal care attendants, reimbursement of family caregivers, broadband and telemedicine, and significant increases in a health care workforce that looks like the community it serves are all part of the solution. Rewarding and penalizing care providers for reducing disparities is vital.

Does this simply describe a version of a single-payer system? Maybe, maybe not. Go beyond the label and ideological arguments and see that there are dozens of ways to make these changes, as well as many decisions still to be made—about reimbursement levels, outcomes measures, out-of-pocket costs, care coordination, supplemental benefits, and lots of other elements. The government cannot do this alone; innovative private sector companies can find a role enabling the system—if they add value.

These reforms would inevitably affect the many people whose jobs would change or be eliminated in a transformed health care system. These individuals should be confident that if they add value today—whether someone who studies data, focuses on improvement, or in any way supports the care process—they will adjust to more common sense ways of doing that. And if they do not add value to the care process, it would be hard to argue they are not just in the way.

Society wants a health care system focused on people but supported by institutions instead of one that is centered on institutions that people are forced to navigate. It should be one in which people are not worried about how changes in their life—pandemic-related or otherwise—could affect their ability to care for their families. It should be one in which clinicians’ relationships with patients and communities are at the core. And it should be one in which the people who have been ignored, left behind, and mistreated are central, maybe for the first time.

In times of crisis, good systems do not exacerbate challenges, they ameliorate them. That did not happen when the COVID-19 pandemic hit the US, and it shows major adjustments need to be made. Defining moments like this are supposed to spur change for the things that have long been broken. If the US cannot learn from the events of 2020 and make necessary changes, when will it?
