The Collision of COVID-19 and the U.S. Health System

Sue S. Bornstein, MD; Ryan D. Mire, MD; Eileen D. Barrett, MD, MPH; Darilyn V. Moyer, MD; and Thomas G. Cooney, MD

The coronavirus disease 2019 (COVID-19) pandemic is wreaking havoc and causing fear, illness, suffering, and death across the world. This outbreak lays bare the fault lines in our society and highlights that the United States could have been better prepared for the pandemic had we a more equitable and just health care system.

As leaders in the American College of Physicians (ACP), we have helped develop ACP's wide-ranging policies on health care in the United States. The College has adopted a "health in all policies" approach, integrating health considerations into policymaking across sectors to improve the health and health care of all communities and people, which we believe, if enacted, would have enabled the United States to more effectively respond to the COVID-19 pandemic. In January 2020, ACP released a series of far-reaching position papers on ACP's vision for the U.S. health care system (1). As background to these papers, ACP posed a question: What would a better health care system be like for all Americans? In response, we proposed ways to achieve improved access to care, decrease per capita health care costs, and reduce complexity of our health care system. Here, we focus on key recommendations from ACP's position papers that can advise how to act now and in the future in service to patients, our peers, and the profession.

UNIVERSAL COVERAGE AND ACCESS

Before the COVID-19 pandemic, at least 30 million Americans were uninsured and many more underinsured (2). Although most U.S. workers have employer-based insurance, those covered decreased from 67.3% in 1999 to 55.9% by 2017, while increasing deductibles and copays were adding to the financial burden in accessing care. (3) More than 36 million Americans have filed for unemployment since March 2020. For most, losing a job means losing employer-based health care. Those who lose coverage can purchase insurance, but this is often prohibitively expensive. The \$2 trillion CARES Act (Coronavirus Aid, Relief, and Economic Security Act) did not include insurance subsidies for the unemployed, mandates that companies receiving government assistance provide health care coverage for workers who get laid off, or requirements that Affordable Care Act exchanges reopen enrollment (4).

Equitable access to health care depends on having a robust primary care system. The pandemic highlights the need for increasing investment in primary care, which serves a particularly critical role during crises. Primary care provides a sentinel surveillance system, first-line response, and mitigation of the burden currently placed on our nation's overrun emergency departments and hospitals. Robust primary care with universal

coverage can be a tool for health justice that can reduce morbidity and mortality, particularly in currently and historically marginalized patient groups. The COVID-19 pandemic has underscored the adverse effects of our current system on primary care: In a recent survey of primary care practices, 76% reported severe or close-to-severe strain on their practice (5).

The American College of Physicians envisions a health care system where everyone has coverage for and access to the care they need, at a cost they and the country can afford.

To achieve this vision, the ACP recommends the following policies:

The American College of Physicians recommends that the United States transition to a system that achieves universal coverage with essential benefits and lower administrative costs.

a. Coverage should not be dependent on a person's place of residence, employment, health status, or income.

b. Coverage should ensure sufficient access to clinicians, hospitals, and other sources of care.

c. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private insurance.

The American College of Physicians supports greater investment in primary care and preventive health services, including support for the unique role played by internal medicine specialists in providing high-value primary, preventive, and comprehensive care of adult patients.

As described in the January 2020 ACP position papers, universal coverage would reinforce our increasingly underfunded safety net and ensure all Americans have accessible, affordable, and comprehensive health care. The continued trajectory of increasing per capita spending on U.S. health care threatens the stability of our current system when we can least afford it.

In comparison to countries with nationally coordinated systems of health care that have successfully limited spread of the virus, such as Australia, New Zealand, and Taiwan, the U.S. response to COVID-19 was delayed, uncoordinated, and less effective (6, 7). Methods employed by New Zealand and Taiwan, including tracking travel and contact history for every patient, timely mass testing, and early restriction of activity, could have been replicated in the United States if it had a robust

system for primary care and national coordination under a universal coverage model.

SOCIOECONOMIC INEQUALITIES AND RACE- AND ETHNICITY-BASED MARGINALIZATION

Prior pandemics disproportionately affected groups that have been marginalized and excluded on the basis of socioeconomic, race, and ethnicity. The COVID-19 pandemic is no exception. Across the United States, deaths from COVID-19 are disproportionately high in African-American, Latinx, and Native American communities (8, 9). These same groups have the highest rates of low health literacy (10). Racial and ethnic minorities make up a significant percentage of “essential workers” with a greater risk for exposure to the virus. Similarly, immigrants who work in places like meatpacking factories and the incarcerated population face higher risk. Social distancing is more difficult in areas with high population density, multigenerational households, or high reliance on public transit.

Public policies that relieve environmental, geographic, occupational, educational, and nutritional inequities must be implemented to reduce disparate health outcomes and engender trust in the health care system.

The American College of Physicians envisions a health system that ameliorates social factors that contribute to poor and inequitable health (social determinants); overcomes barriers to care for vulnerable and underserved populations; and ensures that no person is discriminated against based on characteristics of personal identity, including but not limited to race, ethnicity, religion, gender or gender identity, sex or sexual orientation, or national origin.

We believe more than ever that better is possible. The COVID-19 pandemic has further demonstrated that the status quo is unacceptable and strengthens our resolve to help shape a better health care system for all Americans. This pandemic has ripped the seams of the U.S. health care system wide open, thrusting front and center our health care inequities and injustices. The bigger challenge moving forward is how we can take the lessons learned from this time of great suffering and fear to create an equitable and just system of care for all.

From Texas Medical Home Initiative, Dallas, Texas (S.S.B.); Heritage Medical Associates, Nashville, Tennessee (R.D.M.);

University of New Mexico School of Medicine, Albuquerque, New Mexico (E.D.B.); American College of Physicians, Philadelphia, Pennsylvania (D.V.M.); and Oregon Health & Science University and Portland Veterans Affairs Medical Center, Portland, Oregon (T.G.C.).

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-1851.

Corresponding Author: Sue S. Bornstein, MD, 3111 Beverly Drive, Dallas, TX 75205.

Current author addresses and author contributions are available at Annals.org.

Ann Intern Med. doi:10.7326/M20-1851

References

1. Doherty R, Cooney TG, Mire RD, et al; Health and Public Policy Committee and Medical Practice and Quality Committee of the American College of Physicians. Envisioning a better U.S. health care system for all: a call to action by the American College of Physicians. *Ann Intern Med.* 2020;172:S3-S6. [PMID: 31958804] doi:10.7326/M19-2411
2. Gunja MZ, Collins SR. Who are the remaining uninsured and why do they lack coverage? Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2018. The Commonwealth Fund. 28 August 2019. Accessed at <https://bit.ly/3e9HRuU> on 10 April 2020.
3. Coverage at work: the share of nonelderly Americans with employer-based insurance rose modestly in recent years, but has declined markedly over the long term. Kaiser Family Foundation. 1 February 2019. Accessed at <https://bit.ly/2RkXMN5> on 10 April 2020.
4. Hohmann J. The Daily 202: Losing a job can also mean losing health coverage, adding to anxiety amid coronavirus pandemic. *Washington Post.* 3 April 2020. Accessed at <https://wapo.st/2JJAMdS> on 11 April 2020.
5. Lewis C, Seervai S, Shah T, et al. Primary Care and the COVID-19 Pandemic. Commonwealth Fund To the Point [blog]. Posted 22 April 2020. Accessed at <https://bit.ly/2X5hGOj> on 15 May 2020.
6. Nunn G. Coronavirus: How Australia's 'suppression' approach is rapidly flattening the curve. *The Independent.* 22 April 2020. Accessed at <https://bit.ly/366vdJH> on 15 May 2020.
7. Ing-Wen T. President of Taiwan: how my country prevented a major outbreak of COVID-19. *TIME.* 16 April 2020. Accessed at <https://bit.ly/2X4mdAC> on 15 May 2020.
8. Scott D. Covid-19's devastating toll on black and Latino Americans in one chart. *Vox.* 17 April 2020. Accessed at <https://bit.ly/2WDgFht> on 16 May 2020.
9. Klemko R. Coronavirus has been devastating for the Navajo Nation, and help for a complex fight has been slow. *Washington Post.* 16 May 2020. Accessed at <https://wapo.st/2WCXK6u> on 18 May 2020.
10. Wolf MS, Serper M, Opsasnick L, et al. Awareness, attitudes, and actions related to COVID-19 among adults with chronic conditions at the onset of the U.S. outbreak: A cross-sectional survey. *Ann Intern Med.* 2020. [PMID: 32271861] doi:10.7326/M20-1239

Current Author Addresses: Dr. Bornstein: 3111 Beverly Drive, Dallas, TX 75205.

Dr. Mire: 4230 Harding Road, Suite 601 East, Nashville, TN 37205.

Dr. Barrett: Department of Internal Medicine, University of New Mexico, 1 University of New Mexico, Albuquerque, NM 87131.

Dr. Moyer: American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.

Dr. Cooney: Department of Medicine OP30, 3181 SW Sam Jackson Park Road, Portland, OR 97239-3098.

Author Contributions: Conception and design: E. Barrett, S.S. Bornstein, T.G. Cooney, D.V. Moyer.

Drafting of the article: E. Barrett, S.S. Bornstein, T.G. Cooney, R.D. Mire, D.V. Moyer.

Critical revision for important intellectual content: E. Barrett, S.S. Bornstein, T.G. Cooney, R.D. Mire, D.V. Moyer.

Final approval of the article: E. Barrett, S.S. Bornstein, T.G. Cooney, R.D. Mire, D.V. Moyer.

Administrative, technical, or logistic support: S.S. Bornstein.

Collection and assembly of data: S.S. Bornstein, T.G. Cooney.