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What the Pandemic Taught Us: The Health Care System We Have Is Not the System We Hoped We Had

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What the Pandemic Taught Us: The Health Care System We Have Is Not the System We Hoped We Had

WILLIAM M. SAGE*

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I. INTRODUCTION

The United States spends nearly twice as much per capita on medical care as any other country.¹ The United States has the world’s most advanced biomedical technologies, sophisticated hospitals, and skilled health professionals.² The United States has a national public health body, the Centers for Disease Control and Prevention (CDC), that is generally considered the world’s leader in infectious disease detection and response.³ Nonetheless, the United States suffered among the world’s worst COVID-19 disease burdens and outcomes, inflicting largely avoidable harm on patients, health professionals, and the broader community.⁴

Why this happened is clearly important. But that it happened is itself significant. Criticisms of the U.S. health care system abound, but often have a Lake Wobegon character: The “health care system” may be bad, but my personal doctor is good.⁵ A silver lining of the pandemic experience is the

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¹ Nisha Kurani & Cynthia Cox, *What Drives Health Spending in the U.S. Compared to Other Countries*, HEALTH SYS. TRACKER (Sept. 25, 2020), <https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/> [<https://perma.cc/UY74-HJWA>].

² NAT’L RSCH. COUNCIL & INST. OF MED., U.S. HEALTH IN INTERNATIONAL PERSPECTIVE: SHORTER LIVES, POORER HEALTH 106 (Steven H. Woolf & Laudan Aron eds., 2013).

³ *CDC’s Global Health Partnerships*, CDC (May 9, 2017), <https://www.cdc.gov/globalhealth/partnerships.htm> [<https://perma.cc/WQ7P-EZRA>].

⁴ See *Mortality Analyses*, JOHNS HOPKINS UNIV. & MED.: CORONAVIRUS RSCH. CTR., <https://coronavirus.jhu.edu/data/mortality> [<https://perma.cc/L7V4-ZM4U>].

⁵ Alison Kodjak, *Many Dislike Health Care System but Are Pleased with Their Own Care*, NPR (Feb. 29, 2016), <https://www.npr.org/sections/health-shots/2016/02/29/468244777/many-dislike-health-care-system-but-are-pleased-with-their-own-care> [<https://perma.cc/AJP5-527V>].

possibility that Americans will finally recognize that, whether or not one's own doctor is in fact good, American health care is unreliable, wasteful, and unjust. Should this occur, the path forward should combine several issues of law and policy to which I have devoted much of my scholarly career. These include improving corporate governance, rethinking professional ethics and self-regulation, remaking health care delivery, and broadening competition policy—with the common objective of enhancing collective goals and obligations in U.S. health policy.

II. THE MISSING “MACRO”

The article in this volume by Professors Barak D. Richman and Steven L. Schwarcz on Macromedical Regulation tells an essential part of this story.⁶ Making useful analogies to the 2008 financial crisis that tipped the American economy into prolonged recession, they assert the importance of crafting systematic protections for interdependent health care organizations that mirror stabilizers that exist for the U.S. private banking system, rather than continuing to focus on assuring the quality and accessibility of individual facilities.⁷ I applaud their approach and overwhelmingly agree with their analysis and recommendations.

Unlike regulation of the financial system and its corporate components, however, expecting private actors to perform public duties is not a novel insight in health care.⁸ Our entire “system” has been premised on it, and we back it with taxpayer support. In a typical year, the United States spends roughly as much public money per capita on medical care as any other country, to which we add an equal amount of private spending.⁹

⁶ See generally Barak D. Richman & Steven L. Schwarcz, *Macromedical Regulation*, 82 OHIO ST. L.J. 727 (2021).

⁷ *Id.* at 728–29.

⁸ The financial regulatory literature also now routinely considers the public responsibilities of the corporate private sector. For an example that shortly precedes the Great Recession, see generally Donald C. Langevoort, *The Social Construction of Sarbanes-Oxley*, 105 MICH. L. REV. 1817 (2007) (highlighting the social expectations implicit in the regulatory and self-regulatory approaches taken by Congress in the Sarbanes-Oxley Act).

⁹ For specific comparisons among Organisation for Economic Cooperation and Development countries based on 2010 data, see DAVID SQUIRES, THE COMMONWEALTH FUND, MULTINATIONAL COMPARISONS OF HEALTH SYSTEMS DATA, 2012, at 3–5 (Nov. 2012), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_in_the_literature_2012_nov_pdf_2012_oecd_chartpack.pdf. [https://perma.cc/CGH4-CGC6]. Whether the United States is at the top in per capita public funding of health care, or just near the top, has varied in recent years. See, e.g., ROOSA TIKKANEN, THE COMMONWEALTH FUND, MULTINATIONAL COMPARISONS OF HEALTH SYSTEMS DATA, 2019, at 3 (Jan. 2020), https://www.commonwealthfund.org/sites/default/files/2020-01/Tikkanen_multinational_comparisons_hlt_sys_data_2019_01-30-2020.pdf [https://perma.cc/U4G4-SDMT]; ROOSA TIKKANEN, THE COMMONWEALTH FUND, MULTINATIONAL COMPARISONS OF

Government has empowered self-regulating health professions, supported the construction and operation of non-profit hospitals, funded the science that allows the private sector to patent lucrative biomedical technologies, subsidized health professions education and training, and financed health insurance coverage for all of the preceding elements while protecting “free choice” by multiple parties at multiple levels, including insurance, medical care provider, and treatment.¹⁰

The essence of the U.S. health care system is not based on any ideological distinction between profit-making companies and public agencies. It is that the United States has allowed and encouraged public duties in health care to be defined almost entirely by a casual extrapolation to the population level of the ethical obligations of individual physicians to individual patients.¹¹

For this reason, the focus by Richman and Schwarcz on using “macromedical regulation” to boost pandemic preparedness seems too modest. Although future pandemic threats are inevitable, the most important lessons for U.S. health policy from COVID-19 are almost certainly not about infectious disease. The most important lessons are about how the conceptualization of our health care system, expressed in part through its regulation and funding, limits its performance. As Richman and Schwarcz acknowledge, the market is already collectivizing some risks and therefore coordinating some responses: previously independent hospitals have consolidated into health systems, and independent physician-owned practices are being absorbed through employment relationships into large hospitals and national physician specialty groups.¹² Because physician-patient dyads still dominate how we think of health care, however, the system is simultaneously too consolidated (which raises prices and discourages innovation) and too fragmented (which increases vulnerability to inefficiency and injustice).

Collectivism is equally stunted by the framing of health reform, even oftentimes by progressives. The Patient Protection and Affordable Care Act (ACA), for example, ultimately presented a truncated version of universal

HEALTH SYSTEMS DATA, 2018, at 4 (Dec. 2018), https://www.commonwealthfund.org/sites/default/files/2018-12/Multinational%20Comparisons%20of%20Health%20Systems%20Data%202018_RTikkanen_final.pdf [<https://perma.cc/GQP6-3WNE>].

¹⁰ See ROBERT I. FIELD, *MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED FREE-MARKET HEALTH CARE* 24–25 (2014) (discussing the crucial role of public initiatives in private health care); Charles D. Weller, “Free Choice” as a Restraint of Trade in *American Health Care Delivery and Insurance*, 69 IOWA L. REV. 1351, 1356 (1984) (quoting AM. MED. ASS’N, ORGANIZED PAYMENTS FOR MEDICAL SERVICES 142 (1939)) (noting the potential for market power from unconstrained choice of physician).

¹¹ See generally William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008).

¹² E.g., CAROL K. KANE, AM. MED. ASS’N, POLICY RESEARCH PERSPECTIVES: UPDATED DATA ON PHYSICIAN PRACTICE ARRANGEMENTS 6 (2019), <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf> [<https://perma.cc/8ZD4-5XZD>].

coverage that offered consumerism without solidarity.¹³ This was stated clearly, if perhaps accidentally, in President Obama's Rose Garden remarks after the U.S. Supreme Court ruled in the ACA's favor in June 2015¹⁴:

And unlike Social Security or Medicare, a lot of Americans still don't know what Obamacare is beyond all the political noise in Washington. Across the country, there remain people who are directly benefitting from the law but don't even know it. And that's okay. There's no card that says "Obamacare" when you enroll. But that's by design, for this has never been a government takeover of health care, despite cries to the contrary. This reform remains what it's always been: a set of fairer rules and tougher protections that have made health care in America more affordable, more attainable, and more about you—the consumer, the American people.¹⁵

To the Obama administration, pragmatic health reform was an exercise in assuring the accessibility and affordability of individually selected health insurance, letting each American family choose or keep a physician and a health plan.¹⁶ No national identity was at stake; no shared responsibility was demanded.¹⁷ As I have written previously, there was no "Americare."¹⁸

The "macromedical" implications of COVID-19 are about adding principle to pragmatism and about defining in a principled fashion the collective investment and performance that the American public must demand of its health care system. In a Harvard Law School blog post offering advice to the Biden administration, I suggested the following:

From risk of harm to prevention of spread to ICU access to vaccination, the COVID-19 pandemic shows us that one cannot defend the ethics of the individual without defining the ethics of the group. Making the country healthier and less vulnerable to future threats is a communitarian project, linked

¹³ Solidarity, a central, celebrated aspect of health policy outside of the United States, is rarely cited in domestic reform proposals. See Alceste Santuari & William Sage, *Paradigms of Healthcare Systems, Law, and Regulation: A Transatlantic Conversation*, in THE OXFORD HANDBOOK OF COMPARATIVE HEALTH LAW 19, 56–57 (David Orentlicher & Tamara K. Hervey eds., 2021); William M. Sage, *Solidarity: Unfashionable, but Still American*, in CONNECTING AMERICAN VALUES WITH AMERICAN HEALTH CARE REFORM 10, 10–11 (Mary Crowley ed., 2009), https://www.thehastingscenter.org/wp-content/uploads/Connecting_American_Values.pdf [<https://perma.cc/T93L-M8WG>]; see also José Miola, *Putting the Morals Back into Medicine – Emphasizing the 'We' over the 'Me,'* 82 OHIO ST. L.J. 815, 818–19 (2021).

¹⁴ King v. Burwell, 135 S. Ct. 2480, 2496 (2015).

¹⁵ Remarks by the President on the Supreme Court's Ruling of the Affordable Care Act, 1 PUB. PAPERS 743, 744 (June 25, 2015).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ William M. Sage, *Why the Affordable Care Act Needs a Better Name: "Americare,"* 29 HEALTH AFFS. 1496, 1496–97 (2010).

inextricably to recognizing and redressing the injustices that impose risks on and withhold benefits from the poor and marginalized.¹⁹

In my view, moreover, the nation having empowered physicians to oversee its health care system in an ethical fashion, the medical profession must explicitly give the nation ethical permission to change it.

Admittedly, shifting the health care system in a consciously collective direction asks a lot of both the general public and the medical profession. Especially in our troubling and troubled times, with political discord, economic dislocation, and the looming threat of climate change. But it may prove beneficial to acknowledge and confront this challenge now, before trillions of additional dollars are misspent and millions of additional Americans suffer unjust health consequences.

III. EXPECTATIONS VERSUS THE SYSTEM WE HAVE

Public expectations of the U.S. pandemic response are straightforward to list. Detection and mitigation of COVID-19 spread should have been timely, with assets pre-positioned, supply chains verified, personnel trained and ready for deployment, and lines of communication tested.²⁰ It should have been effective, avoiding infection, morbidity, and mortality. It should have been efficient, with coordination among relevant actors and with planning updated as the pandemic evolved and knowledge grew. It should have been accessible, with testing, treatment, and prevention available widely without financial barriers or discrimination based on race, socioeconomic status, or geography. And it should have been transparent, with clear, honest messaging about known facts, statistical risks, and uncertainties.

It is no accident that these expectations mirror the attributes that the National Academy of Medicine has identified as essential to a high-performing health care system—that it be safe, effective, patient-centered, timely, efficient, and equitable.²¹ Unfortunately, in its comprehensive 2000 report on quality of care, the Academy (then Institute) of Medicine had buried the U.S. system rather than praise it, concluding that not one of the six criteria had been fully achieved.²²

¹⁹ William M. Sage, *Be a Transformational President, Mr. Biden: Launch a Commission to Create an Ethical Health Care System*, HARV. L. SCH. PETRIE-FLOM CTR.: BILL OF HEALTH (May 4, 2021), <https://blog.petrieflom.law.harvard.edu/2021/05/04/biden-commission-ethical-health-care/> [https://perma.cc/C6UE-XWPF].

²⁰ See Richman & Schwarcz, *supra* note 6, at 729–30.

²¹ NAT'L ACADS. OF SCIS., ENG'G, & MED., *THE FUTURE OF NURSING 2020–2030: CHARTING A PATH TO ACHIEVE HEALTH EQUITY* 275–76 (Mary K. Wakefield, David R. Williams, Suzanne Le Menestrel & Jennifer L. Flaubert eds., 2021), <https://www.nap.edu/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to> (on file with the *Ohio State Law Journal*).

²² INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 23–25 (Rona Briere ed., 2001).

A health care system that does not function particularly well under its accustomed conditions is not likely to excel when subjected to once-in-a-century stress in a public health emergency. Money would need to be better spent, with authority clearer and less parochial, and with frequent titration to achieve desired results. The delivery of individual health care would need to be integrated with population-level surveillance and intervention both within and across geographic areas. The health care workforce would need greater diversity, teamwork, and resilience. And shared principles of solidarity and equity would need to tie everything together for both health care providers and the public.

The beating heart of the U.S. health care system is its dependence on lavish revenues, which drives its information collection, its chains of authority, its organization, and its specialty and geographic distribution.²³ Cost control and objective performance are secondary goals.²⁴ Accordingly, the policy response to the pandemic tried to make the best of a bad system, such as by using federal recovery money to repay hospitals for lost income from shifts in patient demand and associated payer mix.²⁵ However, federal policy fell short of extreme cash infusions that, while wasteful, might have offset the delay and dissonance that beset the health care system in the early weeks of the pandemic. These might have included pre-negotiated, instantly triggerable billing codes for consultation, testing, and treatment in the event of a pandemic emergency, plus an increase under such circumstances of Medicare and Medicaid reimbursements to match private insurance benchmarks. The actual federal response also made counterproductive concessions to existing but dysfunctional power structures, such as overemphasizing the ability of prominent academic health systems and other private hospitals to obtain supplies, deliver care, and protect communities, which invited fraud and abuse from untested suppliers and discriminated against poorer communities of color.²⁶

The tendency in the United States to “medicalize” public health preparedness, place it under decentralized physician control, and cast public cooperation in terms of individual doctor-patient relationships is longstanding.²⁷ When the 1986 Chernobyl reactor failure threatened a regional if not global health disaster from nuclear accidents, the most visible U.S. commentator was a physician, Robert Gale, who urged greater investment in bone marrow

²³ See COMM. FOR A RESPONSIBLE FED. BUDGET, AMERICAN HEALTH CARE: HEALTH SPENDING AND THE FEDERAL BUDGET 1 (May 2018).

²⁴ See *id.* at 2.

²⁵ CARES Act Provider Relief Fund, HHS, <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html> [<https://perma.cc/YL5F-82U3>].

²⁶ See Leonard E. Egede & Rebekah J. Walker, *Structural Racism, Social Risk Factors, and Covid-19—A Dangerous Convergence for Black Americans*, NEW ENG. J. MED. (Sept. 7, 2020), <https://www.nejm.org/doi/pdf/10.1056/NEJMp2023616?articleTools=true> [<https://perma.cc/H557-7VKC>].

²⁷ See Richman & Schwarcz, *supra* note 6, at 729–30.

transplantation programs to treat radiation-induced cancers.²⁸ When fears of the Ebola virus were spreading across the United States in 2014 because of media sensationalism and political posturing, the public was urged by government to “see your doctor” for symptoms suggesting infection.²⁹ Had any significant number of Ebola cases reached the United States, this was advice likely to yield avoidable chaos, as few physicians have expertise in containing extremely deadly, highly contagious pathogens and even fewer physician offices are equipped to receive and isolate such patients safely.³⁰

IV. POLICY LESSONS LEARNED

While COVID-19 is not yet behind us, and the pandemic policy playbook therefore is not yet fully revised, the first pandemic year offered several lessons for policy development in health and health care. As noted above, the analysis by Richman and Schwarcz is consistent with most of these points, although they downplay the need to substitute direct government provision of health-related services for similar private activities.³¹

First, financing most health care organizations mainly through elective surgical procedures and specialty care paid by private insurance is foolish. It leaves smaller providers and their employees vulnerable to business shutdowns or diversions for public safety or to preserve scarce supplies and puts even larger providers in financial jeopardy if payer mix shifts quickly.³² As Richman and Schwarcz observe, a national health crisis is a time when private health care providers require stability and coordination and when skilled personnel deserve financial security and psychosocial support.³³ Memorably, the physician executive leading one of New York City’s major academic hospitals complained

²⁸ See Anne C. Roark, *Chernobyl ‘Hero’: Dr. Gale—Medical Maverick*, L.A. TIMES (May 5, 1988), <https://www.latimes.com/archives/la-xpm-1988-05-05-mn-3615-story.html> [<https://perma.cc/LZ7A-FN93>].

²⁹ See Tara Kirk Sell et al., *Media Messages and Perception of Risk for Ebola Virus Infection, United States*, 23 EMERGING INFECTIOUS DISEASES J. 108, 108 (2017).

³⁰ See *Here’s the Johns Hopkins Study President Trump Referenced in His Coronavirus News Conference*, JOHNS HOPKINS UNIV. (Feb. 27, 2020), <https://hub.jhu.edu/2020/02/27/trump-johns-hopkins-study-pandemic-coronaviruscovid-19-649-em0-art1-dtd-health/> [<https://perma.cc/4AGB-VYGM>].

³¹ See Richman & Schwarcz, *supra* note 6, at 772.

³² “Payer mix” refers to the balance of privately insured, Medicare, Medicaid, and uninsured patients treated by a hospital or medical practice. David A. Frenz, *What’s Your Payer Mix?*, TODAY’S HOSPITALIST (Mar. 2020), <https://www.todayshospitalist.com/insurer-payer-mix/> [<https://perma.cc/DX7P-BHYL>]. Private insurers typically “reimburse” (pay) providers considerably more than Medicare would, and Medicaid reimbursement is even lower. See *id.* COVID-19 shifted payer mix away from private reimbursement in the short term and probably in the long term as well. GLENN MELNICK & SUSAN MAERKI, CAL. HEALTH CARE FOUND., THE FINANCIAL IMPACT OF COVID-19 ON CALIFORNIA HOSPITALS 11 (June 2020), <https://www.chcf.org/wp-content/uploads/2020/06/FinancialImpactCOVID19CAHospitals.pdf> [<https://perma.cc/L82J-JCVH>].

³³ See Richman & Schwarcz, *supra* note 6, at 730–32.

in spring 2020 that the pandemic was flooding his facility with Medicare and Medicaid patients, even though it was entirely predictable that the old and the poor would be, as they usually are, at greatest risk from any novel health threat.³⁴ Dependence on private reimbursement for elective services also perpetuates one of the core failings of the U.S. system, which is that management of billings and revenue typically receives greater attention from health care providers than management of costs and operations.³⁵

Second, expecting private health care organizations to perform public health functions is unrealistic even if it is more politically (fiscally) acceptable because it avoids explicit taxation and direct public employment.³⁶ Under “normal” conditions, competition among increasingly consolidated hospitals and physicians emphasizes non-price dimensions and defers to professional standards, in large part because private insurers tend to act as network administrators and claims processors for self-funded employers and government programs rather than buying for their own account in active marketplaces.³⁷ The COVID-19 pandemic showed that “competing” private hospitals often spent more for scarce resources in a time of emergency while getting less for their money, and they proved challenging to audit and monitor when they did receive public funds.³⁸ Explicitly governmental importation, production, inventory, and distribution mechanisms—such as the Strategic National Stockpile and the Defense Production Act—turned out to require better planning and investment, plus greater political will to assert collective interests.³⁹ Profound failures in ramping up COVID-19 testing, lack of community engagement in many areas sufficient to overcome political bias or manipulation, and gaps in public education that continue to prevent vaccine uptake also demonstrated that an effective public health response likely requires a larger, more empowered, proved trustworthy public workforce—including public health nurses, social workers, community health workers, and key civic leaders.

³⁴ See generally Sarah Kliff, *Hospitals Knew How to Make Money. Then Coronavirus Happened.*, N.Y. TIMES (May 15, 2020), <https://www.nytimes.com/2020/05/15/us/hospitals-revenue-coronavirus.html> [https://perma.cc/CD5F-93Z3].

³⁵ See Sean Nicholson & David A. Asch, *Hospitals Need Cash. Health Insurers Have It.*, HARV. BUS. REV. (Mar. 25, 2020), <https://hbr.org/2020/03/hospitals-need-cash-health-insurers-have-it> [https://perma.cc/8WHR-BCWY].

³⁶ Whether costs of social programs appear explicitly as taxes and spending on government budgets has acquired critical political and practice importance in recent decades. For an overview with respect to health reform, see generally William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J.L. MED. & ETHICS 434, 434–35 (2020) (discussing budgetary policy in healthcare reform).

³⁷ See Richman & Schwarcz, *supra* note 6, at 765–66.

³⁸ Clary Estes, *States Are Being Forced into Bidding Wars to Get Medical Equipment to Combat Coronavirus*, FORBES (Mar. 28, 2020), <https://www.forbes.com/sites/claryestes/2020/03/28/states-have-are-being-forced-into-bidding-wars-to-get-medical-equipment-to-combat-coronavirus/?sh=48b9d0221cde> [https://perma.cc/JZS5-6JBR].

³⁹ See *id.*

Third, many health care laws and regulations are outdated, are too protective of physicians' professional privilege, and should not be reinstated after the pandemic emergency ends.⁴⁰ These include state professional licensing provisions and other restrictions on non-physician (advanced practice nurse, pharmacist, registered nurse) practice that reduce access to geographically accessible, high quality, cost-effective care.⁴¹ Similarly at risk of post-pandemic restoration are insurance coverage and payment laws that disadvantage non-physician services or care provided virtually through telehealth, teleconsultation, and remote patient monitoring.⁴² Many of these laws were relaxed or amended on an emergency basis because of stay-at-home orders, moratoria on in-person delivery of elective medical services, and the need to re-deploy trained personnel rapidly across geographies as COVID-19 infections waxed and waned.⁴³ But the political power of the medical profession is deeply entrenched, and the desire among cash-strapped health care organizations with large labor forces to resume traditional operations is strong.⁴⁴ Backsliding in both practice norms and governing laws is therefore a serious risk that perpetuates existing inefficiencies and inequities as well as increasing vulnerability to future threats.

Fourth, neglecting "long-term care" costs lives.⁴⁵ The dominance of acute care in U.S. health spending renders skilled nursing, post-acute, and congregate care settings nearly invisible to policymakers and the public despite an aging population, rising chronic disease burdens, and worrisome trends in dementia and progressive cognitive decline.⁴⁶ Rapid spread of COVID-19 infection between staff and residents, with significant resident mortality, exposed the reality that long-term care is underfunded, understaffed, and poorly regulated.⁴⁷ Medical and policy research on this experience shows the perils of high staff

⁴⁰ See generally William M. Sage, *Fracking Health Care: How to Safely De-Medicalize America and Recover Trapped Value for Its People*, 11 N.Y.U. J.L. & LIBERTY 635 (2017) (explaining the need for legal reform).

⁴¹ See, e.g., Donnie L. Bell & Mitchell H. Katz, *Modernize Medical Licensing, and Credentialing, Too—Lessons from the COVID-19 Pandemic*, 181 JAMA INTERNAL MED. 312, 312–14 (2021); NAT'L ACADS. OF SCIS., ENG'G, & MED., *supra* note 21, at 363–64.

⁴² See Reed Abelson, *Is Telemedicine Here to Stay?*, N.Y. TIMES (Aug. 3, 2020), <https://www.nytimes.com/2020/08/03/health/covid-telemedicine-congress.html> [<https://perma.cc/53SR-H4UU>].

⁴³ See Bell & Katz, *supra* note 41, at 312–13.

⁴⁴ See, e.g., Lyle Muller, *Pandemic Spikes in Rural States, Where Small Hospitals Are Already in Financial Distress*, REVEAL NEWS (Oct. 16, 2020), <https://revealnews.org/article/pandemic-spikes-in-rural-states-where-small-hospitals-are-already-in-financial-distress/> [<https://perma.cc/8GSQ-UL5J>].

⁴⁵ NAT'L ACADS. OF SCIS, ENG'G, & MED., REDUCING THE IMPACT OF DEMENTIA IN AMERICA: A DECADAL SURVEY OF THE BEHAVIORAL AND SOCIAL SCIENCES 24, 180–81 (2021), <https://www.nap.edu/catalog/26175/reducing-the-impact-of-dementia-in-america-a-decadal-survey> (on file with the *Ohio State Law Journal*).

⁴⁶ *Id.* at 7–8, 153–54, 180–81, 187–88.

⁴⁷ *Id.* at 24.

turnover in larger facilities, as well as the challenges of requiring COVID-19 vaccination among those caring for vulnerable seniors and the disabled.⁴⁸ It is critical that this work receive prominence in pandemic-related media coverage and help inform policy change.

Fifth, “Health Justice” needs to be at the core of future U.S. health reform, a fact made clearer by the coincidence of attention to both health and race in 2020.⁴⁹ Throughout the pandemic, America’s “haves” did far better than its “have-nots,” including BIPOC populations, poor rural areas, and immigrant communities.⁵⁰ This applied equally to the health care providers that serve “have-not” communities;⁵¹ in New York City, for example, public hospitals and their patients suffered much greater privation and much worse consequences than was the case for prestigious private facilities.⁵² Among other things, the pandemic exposed the structural racism that had long been embedded in supposedly objective, science-driven prioritization of patients according to potential clinical benefit.⁵³ Chronic conditions and disabilities often reflect social failures, not personal choices;⁵⁴ communities with high rates of COVID-induced respiratory failure as the result of multi-generational discrimination therefore should not be denied lifesaving services under “crisis standards of

⁴⁸ Matt Richtel & Reed Abelson, *Nursing Homes Confront New Covid Outbreaks amid Calls for Staff Vaccination Mandates*, N.Y. TIMES (Aug. 10, 2021), <https://www.nytimes.com/2021/08/04/health/nursing-homes-vaccine-delta-covid.html> [<https://perma.cc/Y63H-JZFP>].

⁴⁹ See Jessica L. Roberts, *The Health Justice Potential of Macromedical Regulation*, 82 OHIO ST. L.J. 845, 849–52 (2021); see also Wendy Netter Epstein, *The Healthcare System Misnomer*, 82 OHIO ST. L.J. 779, 783–85 (2021) (arguing that targeting preventative healthcare interventions towards disadvantaged populations is one of the best ways to impact health outcomes). See generally ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, *ESSENTIALS OF HEALTH JUSTICE: A PRIMER* (2019) (describing Health Justice); DAYNA BOWEN MATTHEW, *JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE* (2015) (discussing the impact of health care inequalities on people of color); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public’s Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2016) (proposing a health justice model as a replacement to the current patient rights model for exploring healthcare quality and access).

⁵⁰ See Don Bambino Geno Tai, Aditya Shah, Chyke A. Doubeni, Irene G. Sia & Mark L. Wieland, *The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States*, 72 CLINICAL INFECTIOUS DISEASES 705, 705 (2021).

⁵¹ See Muller, *supra* note 44.

⁵² Brian M. Rosenthal, Joseph Goldstein, Sharon Otterman & Sheri Fink, *Why Surviving the Virus Might Come Down to Which Hospital Admits You*, N.Y. TIMES (Dec. 25, 2020), <https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html> [<https://perma.cc/4KTG-C2TT>].

⁵³ See Ibram X. Kendi, *Stop Blaming Black People for Dying of the Coronavirus*, ATLANTIC (Apr. 14, 2020), <https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946/> [<https://perma.cc/J7XM-VHJA>].

⁵⁴ See RACHEL REBOUCHÉ & SCOTT BURRIS, *The Social Determinants of Health*, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 1097, 1097–98 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

care” or other systems of prognosis-based rationing.⁵⁵ The pandemic experience has also reminded policymakers that the laws that matter most to health are usually not those one thinks of as “health law,” but rather the laws that help provide economic security, education, jobs, and housing; that improve policing and criminal justice; and that protect basic civil rights from racism and disenfranchisement.

V. CONCLUSION: FROM ETHICS TO ACTION

Richman and Schwarcz frame “macromedical regulation” as a coordinated alternative to regulating single hospitals and individual physicians that could anticipate and counter systematic risks to the nation’s health such as another viral pandemic.⁵⁶ But the problem runs deeper than that. It is not merely that the United States regulates health care primarily at the individual level; it is that the United States conceptualizes the nation’s health as the product of millions of interactions between physicians and their patients. From mask resistance to vaccine hesitancy, the American experience with COVID-19 shows that tension between individual choice and the collective interest is an endemic problem in U.S. public policy, which the dyadic, physician-dominated approach to health policy accentuates.

I would therefore expand and restate the goals of “macromedical regulation.” It is not particularly about dealing better with another pandemic, and it is only indirectly about preventing one. It is mainly about valuing collective health and well-being and about investing wisely in it—including by addressing social problems that bear on health without medicalizing them.⁵⁷ That is only partially a regulatory project. It is also a managerial project, one that may be harder to accomplish if pandemic-induced financial stresses on health care organizations relegate corporate visionaries to the background while pragmatists clean house and make payroll. And it is a civics project, requiring good faith engagement by those holding different views despite partisan acrimony.⁵⁸

⁵⁵ See Egede & Walker, *supra* note 26; INST. OF MED., CRISIS STANDARDS OF CARE: A TOOLKIT FOR INDICATORS AND TRIGGERS 11 (Dan Hanfling, John L. Hick & Clare Stroud eds., 2013), <https://doi.org/10.17226/18338> (on file with the *Ohio State Law Journal*).

⁵⁶ Richman & Schwarcz, *supra* note 6, at 776.

⁵⁷ See generally ELIZABETH H. BRADLEY & LAUREN A. TAYLOR, THE AMERICAN HEALTH CARE PARADOX: WHY SPENDING MORE IS GETTING US LESS (2013) (discussing relative lack of social investment in the United States); RICHARD (BUZ) COOPER, POVERTY AND THE MYTHS OF HEALTH CARE REFORM (2016) (arguing that poverty, not clinical uncertainty, explains geographic variation in health care spending); Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001–2014*, 315 JAMA 1750 (2016) (examining the geography and socioeconomics of longevity).

⁵⁸ The defense of democracy requires an even more challenging but necessary exercise in civics education. See EDUCATING FOR AM. DEMOCRACY, EXCELLENCE IN HISTORY AND CIVICS FOR ALL LEARNERS 8 (Mar. 2021), <https://www.educatingforamericandemocracy.org>

Most of all, I would argue, it is a project for the health professions. Physicians can make significant progress in reorienting U.S. health care toward collective goals, but only if their professional ethics acknowledges its importance. For that reason, I would urge the creation of a new Presidential Commission on Medical Ethics.⁵⁹ Its charge would include to explain how unethical the current system has become in its wastefulness and injustice; to support social investment in health, even when that favors non-medical over medical approaches; to recognize and reverse the biases that perpetuate racism and other forms of discrimination in the exercise of professional judgment; and to advocate for benefits to communities and populations as strongly as for the well-being of individual patients, including by confronting problems such as climate change and mass incarceration that fall outside the usual “lanes” of medical advocacy.⁶⁰ One might call this “macromedical ethics.”

/wp-content/uploads/2021/02/Educating-for-American-Democracy-Report-Excellence-in-History-and-Civics-for-All-Learners.pdf [https://perma.cc/8XLW-CBJ2].

⁵⁹ For information on previous commissions, see *U.S. Bioethics Commissions*, BIOETHICS RSCH. LIBR., <https://bioethics.georgetown.edu/library-materials/digital-collections/us-bioethics-commissions/> [https://perma.cc/458C-QPJZ].

⁶⁰ For a similar view of physicians’ ethical obligations in today’s world, see Donald M. Berwick, *The Moral Determinants of Health*, 324 JAMA 225, 225–26 (2020).