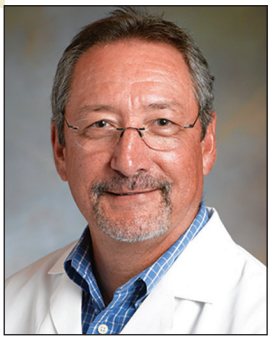


Time for Health Care Reform: A Call for Moral Clarity, Ingenuity, and a Willingness to Try

Edward T. Chory, MD

As I retired in January 2020 after a 40-year surgical career, the American College of Physicians (ACP) published a supplement to the *Annals of Internal Medicine* endorsing health care reform and suggesting a single-payer model. In it, the case was described clearly and with some urgency:

> The U.S. health care system is gravely ill, and the symptoms are many: Costs are too high, many people lack affordable coverage, incentives for hospitals and physicians are misaligned with patients' interests, primary care and public health are undervalued, too much is spent on administration at the expense of patient care, and vulnerable individuals face daunting barriers to care. Health care expenses are the leading cause of private citizen bankruptcies in the United States.[1]

Further, this supplement describes a system that "fosters barriers to care for and discrimination against vulnerable individuals." The supplement concludes by stating:

> The ACP rejects the view that the status quo is acceptable, or that it is too politically difficult to achieve needed change. Dr. Atul Gawande wrote, "Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try." ... We urge others to join us.[1]

The buildup to the 2020 election was getting started, with Bernie Sanders beating the drum of Medicare for All. I attended a University of Pennsylvania Leonard Davis Institute of Health Economics conference in February to hear keynote speaker Paul Starr, MD, who won the Pulitzer Prize in 1984 for his magnum opus, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry.* What I heard him say was that Medicare for All was not politically feasible. I was crushed. If ever the time was right, it was 2020.

The graphic representation in Fig. 1, comparing both health care expenditures and longevity before the COVID pandemic, makes the need for reform obvious.

Almost all would agree change is needed. Yet we're hampered by disagreement about whether incremental change versus wholesale overhaul is warranted. Margo Sanger-Katz did a fine job simplifying the case with her analogy of health care as an old house in a 2019 *New York Times* article. Her premise: is our health care system a fixer upper, or should we tear it down and rebuild?[2]

In many ways, our health care system saps the competitiveness and efficiency of our economy, not to mention of our patients, many of whom need us most. Now we are nearly three years into a pandemic that has left more than one million Americans dead. This infectious disease crisis has exposed many shortcomings with our American health care "system." In fact, one can make the argument that our situation is now even worse than that described by reformers who in 2020 suggested dramatic change.

The longer we wait, the higher the price we may have to pay. It is no secret that costs are rising, and even those within a more robust system, such as in Canada and the United Kingdom, are making hard decisions, including rationing. Yet we in medicine can do things now, including changing how we practice, reforming our addiction to high-tech intervention, and valuing low-tech prevention. Serious work can be undertaken to engage our communities to alter the social determinates of disease. I hope every clinician takes a long look into the mirror and tries to remember why they practice medicine and how best to serve their patients. Our system may be wasteful and unjust, but surely we have not forgotten our priorities.

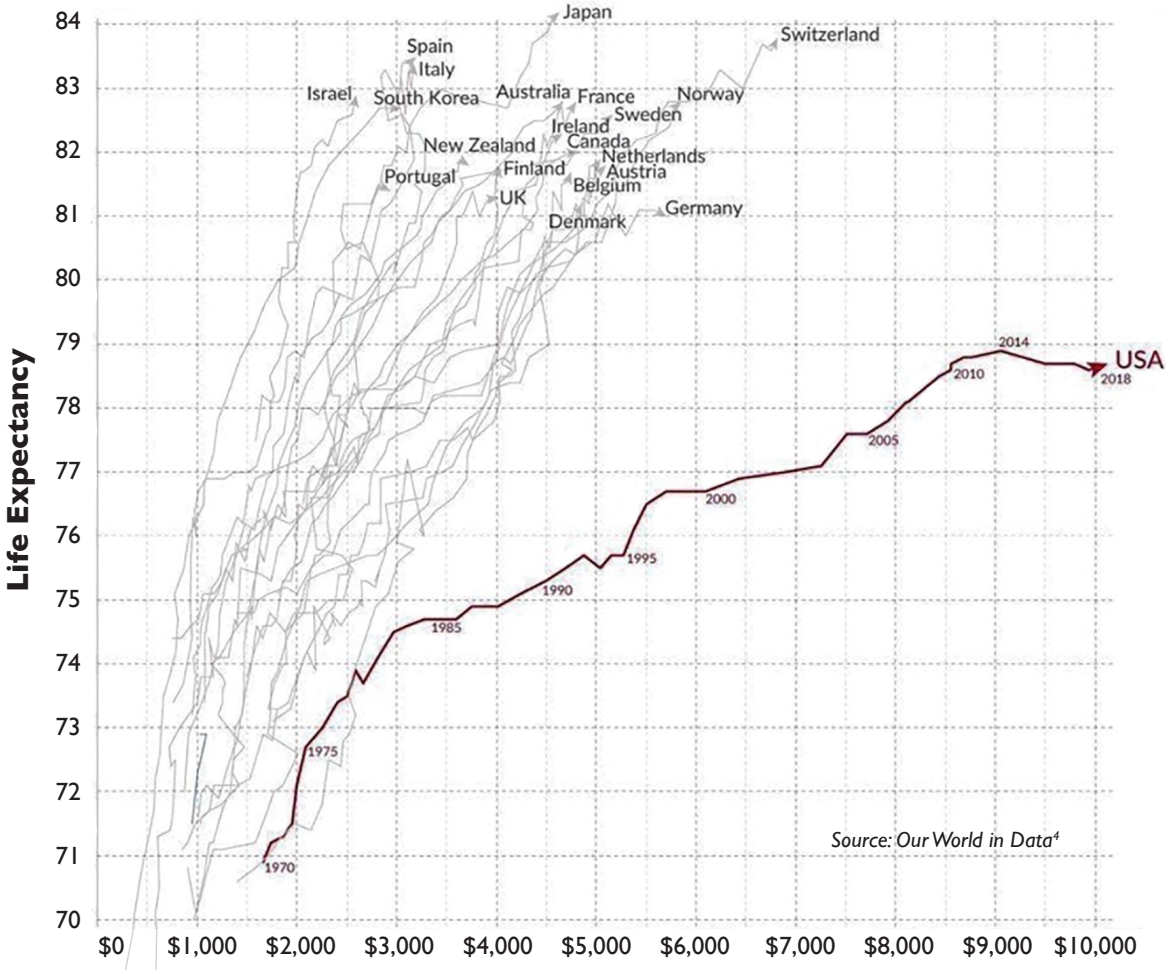
Further, we must engage and urge Congress that it is long past the time to take meaningful legislative action. The irony of calling for government-run health care is not lost on me; certainly, there is a risk that inefficient bureaucracy would invite criticism, but the administrative bloat and waste in our current way of providing care is worse. The Congressional Budget Office's most recent analysis reveals that Medicare for All would result in savings.[3] In turn, that savings could be directed to areas we would deem important, such as in our communities to benefit quality of life and augment those social determinants of disease.

Missing from the debate as we make efforts to im-

prove our current health care structure is consideration of options other than expanding Obamacare or Medicare for All. Switzerland, Germany, and Taiwan provide universal coverage and high-quality care with hybrid systems that involve highly regulated private insurance. We need to expand the discussion to understand and consider these types of solutions — but first we must face the fact that our current system of providing health care is too expensive, inequitable, and not providing the care we all need and deserve.

We can do so much better. We need to join the ACP in following Dr. Gawande's direction: "It takes moral clarity. It takes ingenuity. And above all, it takes a willingness to try."

Fig. 1. **Life Expectancy vs. Health Expenditure, 1970-2018**



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