

COVID-19 and the Case for Medical Management and Primary Care

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Abstract

Hospitals and health systems suffer an over-reliance on elective surgeries to remain profitable. As a result, systems report record losses, while demand for emergency room, hospital, and intensive care beds have surged. Studies have admitted that many surgeries are unnecessary, and physician leaders admit that profit plays a role in driving such needless cost and risk. Most diseases are better managed with medications and lifestyle changes. But it pays more to replace a knee than to prevent that replacement. We must bring surgical and medical value closer in-line. Communities of color are suffering disproportionately from coronavirus. The social determinants of health that lead to higher concentrations of hypertension and diabetes can be mitigated by investment in primary care. Such investment has been proven to decrease cost and increase quality of life. However, the United States spends 50% less on primary care, than other developed countries. While showing promise, telehealth is not a panacea. It relies on continued reimbursement parity, and there remains a digital divide. Any meaningful fix will draw the ire from those who profit from such a profligate system. If we want to improve quality, access and equity, while avoiding unnecessary hospitalizations, risky surgeries, and runaway costs, we must invest in primary care.

Keywords

access to care, health economics, prevention, primary care, underserved communities

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Introduction

This pandemic has laid bare horrific cracks and chasms in our fragmented healthcare system. For years, U.S. Healthcare has plodded along in a predominately piece-meal, for-profit fashion, yielding a system with pervasive dysfunction characterized by high cost, and poor outcomes. Indeed U.S. healthcare is now a 3.6 trillion dollar industry constituting almost a fifth of our Gross Domestic Product.¹ Those 3.6 trillion dollars are made off the backs of doctors and patients, in 15 and 30 minutes appointment slots, with time only to deal with the “most important” 1-2 issues, tabling the rest for the next truncated visit.

American adults, 50% of whom admit to skipping medications,² and 40% of whom are obese,³ bear the burden for most of America’s healthcare woes. The rise of lifestyle comorbidities, and diseases of despair keep premiums high, hospitals full, and the pockets of Big PhRMA lined.

COVID-19 has held the mirror up to our broken system. It has revealed an over reliance on risky surgeries, persistent gross health disparities, and profiteering at the expense of

prevention, wrapped in the illusion of humanism. From this scourge we have an opportunity to materialize the exceptionalism our nation deserves, by creating a system that supports health, and reduces harm for patients and populations.

The Over-Reliance on Elective Surgeries

Hospitals and health systems rely on elective surgeries to stay profitable. The suspension of elective surgery has resulted in furloughs and layoffs across the industry.⁴ The American Hospital Association estimates a \$200 billion

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loss, nationwide, from March through June of 2020.⁵ In April alone, 1.4 million healthcare jobs disappeared.⁶ Record losses mounted as demand for emergency room, hospital, and intensive care beds skyrocketed. It is confounding that you could fill a hospital with sick COVID-19 patients and lose money. It is confounding until you grasp that medical management and “real value” quality metrics, are woefully undervalued.

On average, only 29% of hospital admissions are surgical, but surgeries compose 48% of hospital revenue.⁷ The overvaluing of procedures has two significant downstream effects.

First, because procedures pay more, doctors and systems are more apt to do them, regardless of whether people need it. An American College of Cardiology funded study estimates that 12% of all cardiac stents were flat out unnecessary, and 30% had unclear need. Similarly, studies⁸ have estimated that over 17% of back surgeries are unwarranted. Indeed, leaders in orthopedics from Stanford to Dartmouth have cited the role of financial incentives in driving unnecessary surgeries.^{8,9} By hook or by crook, revenue producing procedures get done despite long term costs in real dollars, and worse, risk to patient safety.

Second, is the undervaluing of outpatient medical management. To date, among the most common causes for both hospitalization and death in America revolve around heart and lung disease.^{10,11} Decades of research indicates that lifestyle changes (diet, exercise, smoking cessation) and medical management (pills and inhalers), prevent hospitalizations and surgeries for these diseases, while prolonging life.^{12,13} But the work to manage these conditions is under-valued and under-paid. So chronic conditions persist and thrive, while we debate length-of-stay and re-admission rates.

The Fix: Medical-Surgical Near-Parity

If we value the management of disease, and the prevention of risky surgery; the reimbursement for medical management must be brought closer in line with the reimbursement for surgical management. While there is value in replacing a hip, there should also be value in preventing the need to have that hip replaced in the first place. The overhead of running an operating room must be considered. But the reimbursement gap between medical and surgical management drives risk and cost through an over-reliance on unnecessary surgeries, at the expense of the medical management and prevention. If chronic disease is the scourge of the 21st century, then we should prioritize its prevention and treatment.

Dramatic Healthcare Disparities

The coronavirus has brought a near century-old problem into stark relief; many cannot afford or access healthcare. This burden has fallen disproportionately on minority communities. In Louisiana, blacks make up only 32% of the

population but comprise 70% of COVID-19 deaths. In Michigan, blacks account for 14% of the population, but 41% of fatalities.¹⁴ In San Francisco, latinos make up 35% of the population but 80% of cases, while in Virginia, latinos compose 49% of cases while only 10% of the population.¹⁵ Why are communities of color dying at such higher rates? The answer is multifactorial, but there are at least two clear reasons.

First, we know that people with certain pre-existing conditions like hypertension, diabetes, and obesity are more vulnerable to infections like COVID-19.¹⁶ Unfortunately, these chronic conditions are more prevalent in communities of color. For example, diabetes affects 12.6% of blacks, 11.8% of hispanics, but only 7.1% of whites.¹⁷ Likewise, hypertension affects 43.5% of blacks, 33% of hispanics, but only 27.5% of whites.¹⁸

Second, communities of color disproportionately lack access to healthy living and healthcare. If you do not have access to healthy food, safe places to exercise, and a job with health insurance; hypertension and diabetes become statistical inevitabilities. While redressing the Social Determinants of Health remains paramount, these comorbidities can be mitigated by increasing access to primary care.¹⁹

Telehealth

Telehealth has been shown to improve access and outcomes, from sub-specialty support to mental health.²⁰ Until this pandemic, these advances were consigned to rural communities by regulation.²⁰ The advent of COVID-19 reiterated the need to expand telehealth to all communities, including the urban, suburban, and especially those of color. Accordingly, the Center for Medicare and Medicaid Services changed their regulations, expanding access, granting reimbursement parity for tele-visits, and allowing physicians to treat across state lines.²¹ This regulatory pivot was fundamental in telehealth's success,²¹ portending improved access for mental health and chronic disease management.

However, telehealth is not a panacea. Physicians in San Francisco noted a digital divide—a cohort of patients who lacked the infrastructure or technological know-how to “log on.”²² Any continuation of telehealth will rely on payers acknowledging parity between office and tele-visits. And there are some things, such as a physical exam or point-of-care testing, that require a physical office. Our fractured, fee-for-service system was ill equipped to make such a fast and vital pivot, resulting in physician office closures, exacerbating wait times and further limiting options.²³

The Fix: Primary Care

Studies have consistently shown that resource investment into primary care improves health,¹⁹ and saves money.^{24,25} Despite these overwhelming benefits, primary care is not

valued in the U.S. While the developed world spends 14% of healthcare dollars on primary care, we spend less than half as much (5.8%-7%).^{26,27} You can guess the results. Twenty-eight percent of Americans suffer from multiple chronic conditions, versus only 17.5% in other developed countries.²⁸ Forty percent of Americans are obese, compared to 21% in other developed countries.²⁸ And the rates of hospitalizations for preventable conditions such as hypertension and diabetes are 33% higher in the US, compared to other developed countries.²⁸

So why do we not have better primary care? Because we do not value it. When doctors could spend the same time training, but get paid 50% more doing another specialty, they do not line up for primary care. When we do not allocate money for the psychologists, nutritionists, and social workers critical to its success, health systems do not invest in primary care. When we pay for injections, instead of paying doctors to spend time talking with patients, prevention and management become afterthoughts. Indeed, the few physicians trying to treat patients holistically, are being forced to see more patients, with fewer resources, consequently suffering an epidemic of depression, anxiety, and burnout.²⁹

The reallocation of funds may be brutal for some, but the math is simple. We can either pay for prevention and management, or we can pay for expensive procedures to Band-Aid the complications of preventable end-stage disease. We can invest in population health, improving access and equity, or we can pay for the sick, communities of color, rural communities, and the poor to suffer and die at disproportionate, yet preventable rates. Even those that may be content with the status quo, must realize that higher premiums and tax dollars are going to preventable hospital visits instead of improving schools, roads, and parks.

Like other developed nations, we must double investment in primary care. For recruitment and retention, we must pay primary care doctors more. We must pay them to spend time with their patients, to talk about healthy living, prevention, and disease management. We must pay them more to work in poor and underserved communities, not less. We must pay for the psychologists, nutritionists and case workers who aid in the treatment of lifestyle comorbidities, diseases of despair, and Social Determinants of Health. We can debate cost, but we must not forget, the product itself is defective. And the real fix starts with primary care. It will save lives, and money.

Conclusion

America herself has a chronic condition—the inability to invest now, for what will save us later. The collapse of masks, gowns and gloves was the hallmark of our hubris. Rather than invest in public health, supply chain resiliency,

and disaster preparedness, our margin-obsessed system folded within days after the rumor of pandemic.

Politically popular debates on cost only capture half the problem. “Medicare for All,” or private payer competition, will only insure that everyone has access to the same pile of problems: a fundamentally defective product. Healthcare is a 3.6 trillion dollar economy, that makes up a fifth of our Gross Domestic Product and employs between 1 and 2 out of every 10 people.³⁰ We are kidding ourselves if we think such a leviathan will go gently into that good night. The reallocation of funds will raise the ire of those who benefit from such an inefficient and profligate system. However, reorienting our system towards outpatient medical management, primary care, and prevention, will put us on the path to improve health, equity, and control costs.

COVID-19 continues to spotlight our broken system, as it rampages through states with higher concentrations of comorbidities, resulting in dwindling ventilators and intensive care beds. These failures portray, embarrassing and absurd, huge pockets of preventable suffering, death, and run-away cost. If we want to survive without furloughs and firings, to save our poor, our old, and our vulnerable, the answer is obvious. Invest in primary care. Pay for doctors to spend time with patients and to do the cognitive work to keep them healthy. Pay for the therapists, nutritionists, and case workers who bridge the gaps in our broken system. Incentivize prevention and medical management, rather than expensive, preventable, and often unnecessary surgeries. Anything short of that is all hat, and no cattle.

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