

A Q&A WITH DONALD M. BERWICK, MD, MPP

Hopes, Worries for US Health Care in Wake of COVID-19

Interview by Allison Inserro

To mark the 25th anniversary of The American Journal of Managed Care® (AJMC®), each issue in 2020 will include a special feature: an interview with a thought leader in the world of health care and medicine. The June issue features a conversation with Donald M. Berwick, MD, MPP, president emeritus and senior fellow at the Institute for Healthcare Improvement and former administrator of CMS.

AJMC®: It's our 25th anniversary, and we had originally planned to talk about the Affordable Care Act and other related topics, then the pandemic happened. I noticed that you've been out front the past few months talking about the gaps and inequities that coronavirus disease 2019 (COVID-19) has exposed, and so I'm wondering about your hopes and fears for health care access and affordability in the wake of this crisis. *Healthcare Communications, LLC*

DON BERWICK: What COVID-19 has revealed, as you said, about the lack of secure health care insurance coverage in this country, and the enormous burden of disparities, especially racial and socioeconomic disparities, is no surprise. It's just a very vivid reminder of what we've been living with for far too long. My hope is that we would finally confront this and work hard to end these disparities. That involves really investing in the well-being of people, of disadvantaged people, people [of color], people in poverty, people in marginalized communities. They get hit hard, and only when we commit to compassionate and effective social policies will we end this embarrassment. It's a tragic continuing problem in America, and it isn't just health care. We're talking here about disparities in education and housing and food security. And this is going to take a really strong social policy to redress. It's also going to take redistribution of public policies in which we ask the wealthy to contribute a greater share of their wealth to redressing these problems of poverty and inequity. The other piece of this that affects everybody, not just the poor, is insecurity in health insurance coverage. We have people who are losing their jobs, scrambling to find a way to get health insurance coverage, and many are failing. The rates of uninsurance are rising. And even [some] people who have insurance are finding out that their insurance policies are ineffective, that they're junk policies. And we need, again, public policy that addresses my own view, which is that health care is a human right. Coverage should be universal. The best

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way to do that is with public coverage, national health insurance of some form, but at a minimum, we need to make, one way or another, a guarantee to every American that they can have health insurance that they can afford and that will cover them when they need it. My hope is that we wake up to these issues, [but] I just don't know if we will. My fear is that we won't [and that the situation] will regress back into the inequity and greed and sense of division that has afflicted this country for decades now.

AJMC®: I was reading the column you wrote that was published in *JAMA* ["To Isaiah"],¹ and I think maybe what you're saying is that it's not enough to get payers to invest in social determinants of health, for example; it really has to go beyond what payers can do.

BERWICK: Yes—it's 2 parts. One is that we need everyone to be able to get health care when they need it, and we don't do that now. We have a very fragile and incomplete health care insurance system that leaves people out. And that's sad. When people get sick, they ought to be able to get care. And they ought to be able to get the preventive care that they need to keep from getting sick. But the bigger picture that you're referring to in that essay is that we have to look at why we get ill. What kills us in America? It isn't health care. Health care is a repair shop. The actual causes lie in conditions in communities and society—the foods we eat, our patterns of

exercise, and structural racism and violence and housing shortages and homelessness and the kind of unfairness in a society in which the disparities in wealth are phenomenally large, and the rich get richer. That disparity, that unfairness, that inequity, is a deep cause of illness. So, if we want to be a healthy America, we have to invest in these social determinants, in reversing the things that actually make us sick and improving the things that keep us healthy. It can't just be done within the health care system or within the health care insurance system; this has to do with social and economic policies.

We need public policy that ends homelessness, that ends hunger, that ends the insecurities people feel in their lives. And we have to work on very special populations who are particularly vulnerable: incarcerated people, Alaska Natives and American Indians, people in isolated communities, rural communities, which need a lot of robust support. So the problems we have need to be addressed through health care, but they can't be solved only through health care, and that's what you read about in that piece.

AJMC®: Something you haven't mentioned yet is waste: You're one of the leading researchers and scholars on waste in the health care system.² Do you think that if we move to a universal system, or to Medicare for All, that would help eliminate the massive waste problem that you've documented?

BERWICK: Yes, the [problems] overlap. I mean, the frequent claim that we can't afford health insurance for everyone is pure nonsense. We're spending nearly twice as much as the next most expensive country. We have well-documented evidence of waste in our system, administrative hassles that just pour money down the drain, pricing nonsense where pharma companies or drug or device manufacturers or even hospitals raise prices to levels that cannot be justified. We have problems with fraud that need to be dealt with through strict enforcement; we have problems of inappropriate care, ineffective care that can't help people and just keeps the machines going and the tests going, [which happens] because we have a payment system that pays for that. And the idea that we can't afford to give every American all the care they want and need is simply incorrect. It's not based in the evidence. So we do need a national agenda to make health care far more efficient on behalf of patients. And remember, a lot of health care costs today are paid out of pocket, in co-payments and deductibles and by uninsured people, uninsured processes. So, you know, saving money by reducing waste helps individuals directly as well as helping governments and businesses. One thing we need to strictly avoid is any thought of rationing care, withholding care: We don't need to do that. We can give all the care people want and need if we really attend to waste as our target.

AJMC®: We've seen plans in the past couple of months to attack the virus with the involvement of private contracts and private business relationships to help speed things along. Are you concerned that in the effort to move things faster, and in maybe lowering the regulation bar, that a new source of waste might develop?

BERWICK: Well, your question has 2 or 3 points. The first is that in terms of public health and health care, we need public-private partnerships and there can be good ones. We need sound partnering between the public sector and the private sector, with diligence. That [kind of partnering is] good, but it also opens the door to abuse that we cannot allow. Profiteering and greed in the private sector hurt everyone, and they are widespread. I am in favor of controls, including, if necessary, price controls, that keep greed out of the picture. With respect to pace, COVID-19 is so serious that we've increased the tempo of innovation in the public and private sectors, exploring all sorts of new drugs and new therapies, new vaccines. I am glad that we're going fast on it, but we cannot lose the discipline of science. We have to make sure that proper evaluation and scientific scrutiny are applied to everything that we subject patients to. If we go over that line, if we allow myth and salesmanship and profiteering to control what happens, patients will pay a very high price, both in their health and in money. So we have to pair the activation of the private health part of the health system with strict adherence to science. That's crucial.

AJMC®: Are you hopeful that some of the innovations that have occurred, whether it's a faster possible timeline to a vaccine or treatment, or even something like telehealth, can be applied to other diseases or other populations?

BERWICK: Yes, COVID-19 is rapidly bringing us some very good innovations, and one of them is telehealth. Again, we have to make sure that telehealth is scrutinized, that we understand what it looks like when it's done responsibly, and that we know how to maintain quality. But much of the progress we're making in telehealth, very fast, is good for patients, good for families, good for the economy. I also think that we will be seeing faster progress, I hope, toward vaccines and antiviral treatments. Again, these have to be subjected to science, but we're seeing a kind of energy that is exciting and almost unprecedented. This is also happening at the clinical level; the amount of information that's speeding around in our clinical journals and our scientific community, between scientists and clinicians, is rising very quickly. I serve on the Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats, convened by the National Academies of Sciences, Engineering, and Medicine. And it's stunning how quickly that very disciplined process in the National Academies has moved ahead and offered badly needed guidance to the country. That's an example of pace and tempo that I think is good to learn and to keep as long as we keep science in the foreground. ■

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