Eighteen months after SARS-CoV-2 arrived in the US, the coronavirus continues to affect every aspect of society. The health effects of the pandemic have been enormous—and unfortunately, the economic implications have been as well. Overall employment is still 7.6 million workers short of prepandemic forecasts, and economic output remains below the expected trend.

One of the major economic effects of the virus has been experienced by the health care sector. In 2020, health care spending was down relative to 2019, the first time this has occurred since at least 1960. Relative to prepandemic forecasts, the drop in spending was roughly $150 billion, about 5% of personal medical spending. Health care spending rose modestly in the first 5 months of 2021, but not back to prepandemic forecasts, let alone enough to fill in the hole from 2020. If the pattern through May 2021 continues through the rest of the year, the shortfall in 2021 could be another $150 billion.

Different sectors of the health system have been affected by the spending reduction to different degrees. Dental spending is down the most (−12% from January 2020 through May 2021). Nursing home spending (−5%) and physician spending (−2%) declined as well. Other components of care—hospitals (1%), prescription drugs (2%), and home health care (1%)—rose marginally.

Health care businesses dealt with the spending reduction by reducing employment. In April 2020, at the height of the pandemic, health care employment was down nearly 10%. Employment recovered somewhat but still remains 3% below prepandemic levels.

The reduction in health care employment is a sign of a “normal” industry. When business sales fall, firms lay off workers. Health care has not traditionally experienced that because demand for such care was steady; no matter if the economy was in expansion or recession, people sought care from physicians.

That era may be coming to an end. Although such layoffs are sad in some ways, it is a mistake to think about health care as a jobs program. Health care should only employ as many people as are needed to adequately care for patients.

What Happened to the Deferred Care?

Several aspects of the effects of COVID-19 on health care are particularly troubling. First, it seems that many patients are not seeking the services they deferred last spring and summer. Service use decreased markedly during the pandemic, including preventive services, physician visits, and non–COVID-19 hospital admissions. The question in economists’ minds was how much of this foregone care would reappear. So far, very little of it has. Even when it appeared that widespread vaccination would finally end the COVID-19 isolation, there was no rush to the ambulatory surgery center.

There are 2 types of goods: necessities and luxuries. People typically pay the rent in good times and bad. But a dinner out depends on how much money is leftover. Is it possible that people now see health care as akin to a coffee shop latte? If so, one worries about how patients will decide which services merit the expense and which fall short.
How Fast Can the Health Sector Contract?

A key question for clinicians and health care facilities is about the dislocation that might occur if revenues continue to be low. Employment reductions are not a complete response to low spending growth. Capital is fixed in the short term, and capital costs cannot be deferred. Building rents must be paid even if only half the space is occupied.

Downsizing health care would be welcome. Hospitals should get smaller, and more care should occur elsewhere—in urgent care centers, ambulatory surgery centers, and at home. But this adjustment takes time, and leads to losses in the short term.

Partly as a result of these fixed costs, many clinicians and hospitals pushed for higher prices going into 2021. There was a modest growth in health care prices in February and March of this year, and insurers went along, to a degree. But the price increases were temporary; health care inflation dropped back down in the summer.

The implication of high fixed costs and modest price increases could be a flight of smaller clinicians and groups into larger entities. In Massachusetts, the largest independent physician group recently reached an agreement to be acquired by Optum Health, a subsidiary of UnitedHealth Group, which already employs 5% of US physicians. Not surprisingly, that physician group had a lot of capital that was unused during the pandemic. Other physicians will seek safety in hospital ownership or as part of bigger associations.

Large health care groups have pluses and minuses. Some big organizations are better at care coordination than smaller groups, and are also better able to adjust to risk-based contracts, which many insurers are pushing to clinicians and health care entities that need extra cash. However, large care groups have traditionally excelled at raising prices and upcoding. It would not be surprising if fights over price increases between insurers and health care organizations become a key topic later this year and into 2022. Such a fight does nothing to benefit patients, however.

The economic hope is that the COVID-19 crisis can turn into the COVID-19 glide path. COVID-19 could be the spark that helps health care become smaller, more efficient, and cheaper. But for this to happen, governments, insurers, and health care professionals all need to work together so that the post-COVID-19 health care sector is an improvement over what came before.

Several principles should guide such actions. First, payment must continue to move away from fee-for-service reimbursement and should do so rapidly. Even before the pandemic, it was clear that payment structures based on fee-for-service reimbursement were harmful to patients. The pandemic shows that they are financially toxic for practices as well. Moving primary care physicians and health systems into global payment arrangements can reduce the variability in operating margins associated with future fluctuations in demand.

Second, reducing the overhead of medical care is essential. Responding to financial shortfalls by reducing administrative staff is a far better strategy than cutting salaries or laying off clinical staff. This can only happen if efforts are made to automate the nonclinical operations of health care practices, such as billing and prior authorization. For example, plans could make better use of “gold card” programs for prior authorization (a process in which a payer exempts clinicians who have had consistently high rates of approval for prior authorizations). Some currently required billing supplements could also be waived (as they were at the start of the COVID-19 pandemic) with the understanding that they will not come back if a simpler system can be agreed upon in the next few months.

Third, every effort must be taken to test alternatives to traditional expensive medical care settings. Telemedicine seems to have a solid toehold in medical care, thanks to the pandemic. Would a hospital-at-home program also be valuable? Is home health care safer than long-term care for those with long-term physical or cognitive impairment? With appropriate testing and evaluation, it may be possible to cut out some of the costliest aspects of medical care while simultaneously improving patient health and well-being. That type of silver lining would be a rare, good outcome of the COVID-19 pandemic.
REFERENCES