Moving Patient Care Forward in the Biden Era

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When Joseph Biden is inaugurated as the 46th president of the United States on January 20, 2021, the chaos of the Trump era should eventually begin to fade and the formidable task of controlling and ending the coronavirus disease 2019 (COVID-19) pandemic must move forward in earnest. The speed and effectiveness of the response is likely to define the Biden era.

COVID-19 has dwarfed the myriad of other health care challenges, and removing its threat, which has paralyzed the country since March 2020, will determine whether the new administration will be able to restore trust in the competence of the US government with regard to science and public health.

The response to COVID-19 will also influence whether Democrats and Republicans in the 117th Congress can find sufficient common ground to work with the Biden administration to address other pressing health policy issues. The long list includes the continuing effects of systemic racism on health inequities; an underfunded public health system; the future of the Affordable Care Act, health insurance for the approximately 29 million nonelderly individuals in the US who remain uninsured; and the high costs of prescription drugs. However, there are some steps that the Biden administration can take without waiting for Congress, such as resuming a leadership role in global public health by promptly rejoining the World Health Organization and spearheading the international effort to address climate change.

When Biden takes office, more than 400 000 people in the US will have died from COVID-19, with no definite end in sight to the tragic number of new cases and deaths. It is a national disgrace that with only 4% of the world’s population, the US accounts for nearly 20% of all COVID-19 deaths. There is a disturbing disconnect between the heroic efforts of physicians, nurses, and other health care professionals to save lives, and the practical difficulties of mobilizing widespread political and public support for common-sense actions to prevent new cases and deaths. The pandemic has made glaringly clear the risks to the nation of an inadequate public health infrastructure that would be incapable of mounting a speedy and well-coordinated national response to the next pandemic.

Making progress against the pandemic will require strong federal leadership and the empowerment of career federal scientists and public health officials at the US Food and Drug Administration, the Centers for Disease Control and Prevention, and other agencies. For the foreseeable future, organized and efficient systems to not only distribute vaccines, but also to administer millions of immunizations daily, will be necessary to prevent new infections. The continuing measures will also include the consistent, correct, and universal wearing of face masks, physical distancing, and the avoidance of crowds and gatherings.

Beyond the COVID-19 pandemic, an overarching concern about the health care system is that the US spends 25% more per capita than the next highest spending country, but it underperforms on many important metrics, such as infant and maternal mortality rates. Emanuel and colleagues recently reported on a comparison of health outcomes between privileged US citizens and average residents of other developed countries. Although wealthier White US citizens often had better health outcomes than average US citizens, the study suggested that they often fared worse than average residents in many other countries that have national health systems and spend much less per capita than the US. The implication is that even if all US citizens had the same health outcomes as privileged White citizens, health indicators would still fall short of those in many other countries. And despite the trillions of dollars spent on health care, the US is the only country among developed nations that does not provide health care to all of its citizens, a shameful situation highlighted by the challenges of responding to the COVID-19 pandemic. We have a system of too much (often unnecessary) health care for many and not enough necessary health care for many others.

During the Trump era, the rate of growth of health care spending has slowed, but national health expenditures are still increasing. In 2015, health care spending was $3.2 trillion, or $9930 per person, and accounted for 17.4% of gross domestic product; by 2019, health care spending had increased to $3.8 trillion, or $11582 per person, and accounted for 17.7% of gross domestic product. Total retail prescription drug spending increased from $1014 per person in 2015 to $1128 in 2019. The path forward is for policy makers and politicians to collaborate to advance health and health care, to improve insurance coverage and curb costs, and to end the ongoing series of legal challenges to the Affordable Care Act. There are several health policy areas ripe for immediate bipartisan reform efforts, beginning with the existing Medicare program and including forging ahead with value-based payment for care and lowering the cost of physician-administered drugs, especially high-cost biopharmaceuticals.
A silver lining of the pandemic is that it provided an impetus for both political parties to move beyond partisan differences and work toward a more accessible and equitable health care system. As physicians, we know that when they are sick, people of all political persuasions want the same things: to get well, to be treated with dignity and respect, and to not be bankrupted by the process.

Another silver lining would be improvements in health care based on the lessons of COVID-19. The explosion in the use of telemedicine and virtual visits on the basis of safety from COVID-19 has shown that many appointments can be completed without going to an office, which saves administrative expense and time. Tablet computers have allowed hospitalized patients to communicate with family members when they have been unable to have visitors. Even when visiting is again safer, tablet computers should help patients and care teams to communicate with family members and friends who are too far away to visit in person.

The pandemic should also spur efforts to modernize medical licensing and credentialing. As recently discussed in JAMA Internal Medicine,\(^{1,14}\) the response to COVID-19 showed how the current US system of state licensure and hospital-based credentialing precluded the rapid hiring and deployment of physicians, across and even within state lines, impeding the response to the pandemic. Finally, we can hope that the technologies that led to COVID-19 rapid testing, messenger RNA-based vaccines, and other outstanding scientific achievements during the pandemic can be marshaled to improve testing, treatment, and prevention of other viral diseases.

In 2020, the COVID-19 pandemic has defined our lives. Not surprisingly, it has been the focus of attention for medical journals as well. In 2020, JAMA Internal Medicine received 6636 manuscripts, including 4523 research manuscripts, compared with a total of 3536 manuscripts in 2019—an increase of 87.7%. From May to December, about half of all the submitted manuscripts were related to COVID-19. Of the 10 most discussed articles of 2020, as assessed by Altmetric attention scores, 9 were about COVID-19.\(^{15}\) Although it has been a privilege to promptly provide medical professionals and the public with reliable information, the pandemic is only 1 of the many urgent issues on which readers should be better informed. In 2021, we will continue to seek research and opinion articles that advance the interests of patients, clinical practice, and the delivery of health care. We welcome your suggestions and contributions.

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REFERENCES

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