

Healthcare as a Public Service

Redesigning U.S. Healthcare with Health and Equity at the Center

by Dana Brown

As the healthcare “system” of the world’s wealthiest country is teetering, if not close to collapse, the pressing need for transformative solutions is obvious. Scaling publicly owned healthcare to serve all would be just that—a way to take healthcare from a source of private profit, mass suffering, and financial ruin, and make it a public good.

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hat might healthcare look like if the profit motive were removed from the provision of care altogether? If healthcare were designed as a public service, what possibilities would exist for health equity, health system resilience, and reduced costs? The multiple crises of our current healthcare sector, laid bare by COVID-19, should move us to ask deeper questions about how our investments into the healthcare sector should be employed to maximize the health and well-being of our people and economy.

There are, sadly, few bright spots in a system that has allowed more than one in five hundred Americans to die due to COVID-19.¹ Many readers may be surprised to learn that one of the few highlights in healthcare performance during the pandemic comes not from the nation’s richest hospital systems or biggest names in medicine but from the poorly understood and often maligned Veterans Health Administration (VHA).



The COVID-19 pandemic has brutally exposed the weaknesses of the nation's fragmented, inequitable, and extraordinarily expensive healthcare system.

The VHA—the country's only fully public, integrated healthcare system—has a lot to tell us about how a national healthcare service for the United States might operate, and not just for its performance amid COVID-19. Indeed, combined with other public healthcare institutions, it could prove to be a critical institution to achieving health justice.

While the new is often fetishized, sometimes the most effective and feasible models are not new; they just need dusting off so that we can see them for what they are. Healthcare as a public service is one such model, and the VHA could help jump-start a revival of this model today.

U.S. HEALTHCARE IN CRISIS

The COVID-19 pandemic has brutally exposed the weaknesses of the nation's fragmented, inequitable, and extraordinarily expensive healthcare system. In the early days of the pandemic, as revenue from elective procedures cratered, many health systems furloughed staff, cut their hours, or reduced pay, even as demand for emergency care due to COVID-19 exploded. Many hospitals resorted to rationing care, and some shuttered altogether. Increasingly, we are witnessing the collapse of U.S. healthcare, as multiple crises—including lack of rural hospitals, shortages of physicians, and overpriced treatments—collide.²

Hard though it may be to believe, today healthcare consumes almost one fifth of the entire U.S. economy. This is far more than most other advanced economies, even as health outcomes fail to match this extraordinary expenditure.³ Life expectancy in the United States has been declining for years, and existing health inequities have only been exacerbated by the pandemic. To do better requires changing how the nation finances, administers, and allocates healthcare resources.

The VHA's pandemic experience provides some valuable lessons. When COVID-19 hit, the VHA, rather than

contracting, expanded to meet needs. It opened its doors to accept hundreds of nonveteran patients and sent staff to assist in non-VA hospitals and nursing homes. By September 2021, it had provided nearly a million pieces of personal protective equipment to non-VA facilities and sent personnel to more than fifty states and territories to assist local authorities and health systems.⁴

The department moved swiftly to protect its workers and patients, restricting nonessential visitors at facilities, screening returning soldiers, and offering telehealth options nationwide for both medical and mental health services. It also used its novel tele-ICU (intensive care unit) program to help alleviate the pressure on overtaxed ICUs. VA-run nursing homes fared so well that the VA was asked to take over some state-level Veterans Homes from the private, for-profit companies experiencing crises.⁵

In this time of extraordinary challenges for the healthcare sector, what can this tale of two health systems teach us?

HEALTHCARE AS A PUBLIC SERVICE

The VHA operates like a Beveridge-style health system. Beveridge, for the uninitiated, refers to the British economist William Henry Beveridge, author of the famed Beveridge Report during World War II that set the foundations for what would in the United Kingdom become that nation's enormously popular National Health System.⁶

In such a system, both the payer and provider are public: Funding for the VHA, for example, is appropriated by Congress; VHA personnel are salaried public employees; and the hospitals, clinics, and equipment used to serve patients are publicly owned. Like the United Kingdom, Spain, New Zealand, Cuba, Hong Kong, and much of Scandinavia employ this model for virtually their entire healthcare sector.⁷ Rather than seeking to maximize profit and allocate resources based on ability to pay, these systems run like public services.

Without the constraints of market imperatives, Beveridge-style systems are free to adopt public-interest missions. For example, the VHA's principal mission is to care for the

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nation’s veterans, while one of the missions (called its “Fourth Mission”) of its parent agency, the Veterans Administration (VA), is to improve the nation’s emergency preparedness and serve as a backup to the rest of the healthcare sector during emergencies.

While many of these healthcare systems have suffered times of severe underfunding and privatization attempts, their popularity with both patients and healthcare workers has generally endured over time. Even Brexiteers recognized the potency of the U.K.’s National Health Service (NHS) as a totemic expression of British values when they pledged that leaving the European Union would mean an extra £350 million a week for the NHS—a pledge that was emblazoned on the side of their campaign bus.

There are likewise valid criticisms of the VHA. It has certainly not always been managed in the best interest of its patients or staff.⁸ Persisting geographic variations in the availability and accessibility of some of its services disadvantage some groups of veterans over others.⁹ Chronic underfunding coupled with increasing demands by Congress and the executive branch have contributed to critical staffing shortages and unmet goals to modernize its infrastructure.¹⁰ But despite these challenges, the VHA has delivered impressive improvements in recent decades and—most important—health outcomes consistently equal to or better than those in the private sector.¹¹

The public nature of the VHA does not, by default, make it the perfect health system. But because it is free of the imperatives of profit seeking, the VHA can create space for other imperatives—for example, centering patients’ needs, training and retaining a highly skilled and effective healthcare workforce, and advancing the science of medicine. Also, as a single integrated system, the VHA can manage its shared assets across multiple sites and move both staff and supplies from one geographic location to another more easily than private-sector competitors. This ability to steward resources for the collective good is particularly useful in times of emergency or unexpected strain—such as a supply chain failure—on the healthcare sector.

PUBLIC HEALTHCARE, AMERICAN-STYLE

Building a Beveridge-style health system for all based on the VHA—a kind of “VA for all”—would transform the economics of U.S. healthcare by removing extractive profit seeking from health insurance, the provision of care, and the procurement of medical supplies. It would also drastically reduce political capture by the healthcare industry, thus removing one of the key obstacles to such long-sought reforms as Medicare for All and enabling the government to negotiate drug prices with pharmaceutical companies.

How could a “VA for all”—style system benefit payers, providers, and patients alike?

First, scaling the VHA would increase the efficiency of healthcare spending through strictly evidence-based care, reduced duplication in testing and procedures, and far lower prescription prices. Moreover, the VHA model relies on a foundation of comprehensive primary and preventative care services. These “first dollar” investments reduce demand for more costly care later. For example, a 2018 study of dual-eligible veterans showed that veterans who relied on the VA for their healthcare saw fewer emergency department visits and hospitalizations than those using private-sector care.¹²

Together, these features would make establishing universal health insurance coverage—a key goal of Medicare for All—less costly. Although the VHA serves patients who are, on average, older and sicker than the overall population, it achieves better results at a lower average per-patient cost than Medicare.

A VA Commission on Care study found that if 60 percent of VHA patients were to start seeking care in the private sector, costs to the VA for their care would quadruple.¹³ Rather than privatizing veterans’ care, the real cost savings for the country lies in bringing more patients under the care of the VHA, particularly as the overall patient population in the United

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States is on average younger and healthier than the average current VHA patient.¹⁴

Second, patients would experience better and more equitable outcomes from the kinds of integrated services provided by the VHA. The VHA's "whole health" model starts with primary care teams that include a physician, a nurse serving as the care manager, a clinical associate, and an administrative clerk. Based on the individual needs of each veteran, and in consultation with them, other providers such as mental health professionals, pharmacists, and social workers may be added to that team to ensure all aspects of the patients' health and well-being are understood, addressed, and monitored. This type of coordinated and individualized care is unavailable to most patients in the private sector, despite the importance of care coordination in reducing misdiagnoses and improving patient safety and outcomes.¹⁵

Multiple studies show this is working in practice. A 2018 Dartmouth College study compared performance between VHA hospitals and private hospitals across the country and found that in fourteen out of fifteen metrics, the VHA care fared "significantly better" than private hospitals.¹⁶ A 2010 systematic review of all studies from 1990 to 2009 comparing the quality of medical and other nonsurgical care in VA and non-VA settings found that studies "almost always demonstrated that the VA performed *better* than non-VA comparison groups" (emphasis added).¹⁷

Lastly, workers would benefit from a fully public healthcare system like a VA for All. The public sector has long done a better job of employing women and people of color than the private sector.

Already, the VHA's workforce is salaried and almost entirely unionized. For nonclinical staff, VHA jobs offer more stability and better benefits than many private sector healthcare administration jobs, which tend to be based on at-will

contracts. And clinical staff can focus on patient care, since they do not have to build a practice, recruit patients, or bill multiple insurers. Research and training opportunities abound for staff inside the VHA. Because the institution plays such a large role in training the U.S. healthcare workforce, it has explicit career ladders; and, as it engages in significant amounts of in-house research, clinical staff can also easily engage in ongoing research and both further their own careers and their scientific field.

TOWARD A VA FOR ALL

Currently, around nine hundred hospitals across every state outside the VA system are on the verge of shutting down due to financial losses.¹⁸ Even before the pandemic, the United States had fewer hospital beds per one thousand residents than many other high-income countries.¹⁹ If cash-strapped hospitals have no incentive to stay open, where do the patients seek care? Where do the jobs go? And how is the broader local and regional economy expected to recover? Some will undoubtedly be purchased by large health systems, consolidating their economic and political power. But many will close—leaving critical gaps in access to care.

We could empower the VHA to acquire and administer many of these hospitals. These acquisitions would not only ensure that communities can access affordable, high-quality healthcare but also help to preserve local community economies.

The VHA could also be tasked to work with Federally Qualified Health Centers (FQHCs), which provide comprehensive primary care to low-income and medically underserved populations and receive support from across the political spectrum. Both could be scaled in a public–public partnership to achieve access to quality primary, secondary, and tertiary healthcare services for all, regardless of income or geography.

Like VHA patients, the FQHC patients experience more chronic health conditions than the overall U.S. population. Yet the health outcomes of FQHCs rival those of the private sector.²⁰ Numerous studies suggest that FQHCs are associated with lower total per-patient costs to Medicare and Medicaid, as well as economic benefits to the local communities

in which they operate, through job creation and purchasing.²¹ Moreover, primary care is associated with more equitable health outcomes than specialty care.²² Thus, expanding the network of FQHCs and linking them to other public healthcare infrastructure like that provided by the VHA could both advance health equity goals and contribute to overall health system savings.

Additionally, FQHCs offer a model for democratized governance of healthcare services and responsiveness to local community needs due to their “consumer board” structure. By federal mandate, 51 percent of each board must come from the patient population served by the health center in terms of demographics, and “of the nonpatient health center board members, no more than one-half may derive more than 10% of their annual income from the health care industry.”²³

TRANSFORMATION, NOT REFORMATION

As the healthcare “system” of the world’s wealthiest country is teetering, if not close to collapse, the pressing need for transformative solutions is obvious. Scaling publicly owned healthcare to serve all would be just that—a way to take healthcare from a source of private profit, mass suffering, and financial ruin, and make it a public good.

Leveraging healthcare investments to actually improve the health and well-being of our people, our communities, and our economy is eminently possible. The models for how to do it already exist. Building on the successes of the VHA and FQHCs offers a path to delivering better healthcare at lower cost, with greater stability for our healthcare workforce.



As patients and healthcare workers know, sometimes the body can heal itself—but only if nutrients it takes in are feeding the body’s essential organs rather than a cancer or pernicious bacteria. Sometimes a tumor must be excised—and tissue must be irradiated—to stop a malignant growth. But with the proper support and care, a body can transform itself, develop new habits and abilities, and return to a state of health and well-being.

Likewise, the U.S. healthcare system needs major surgery before it can heal. The malignancy of profit seeking must be cut out, so that life-giving resources may flow where they are most needed. Only then can the dream of healthcare as a human right be truly realized.

NOTES

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