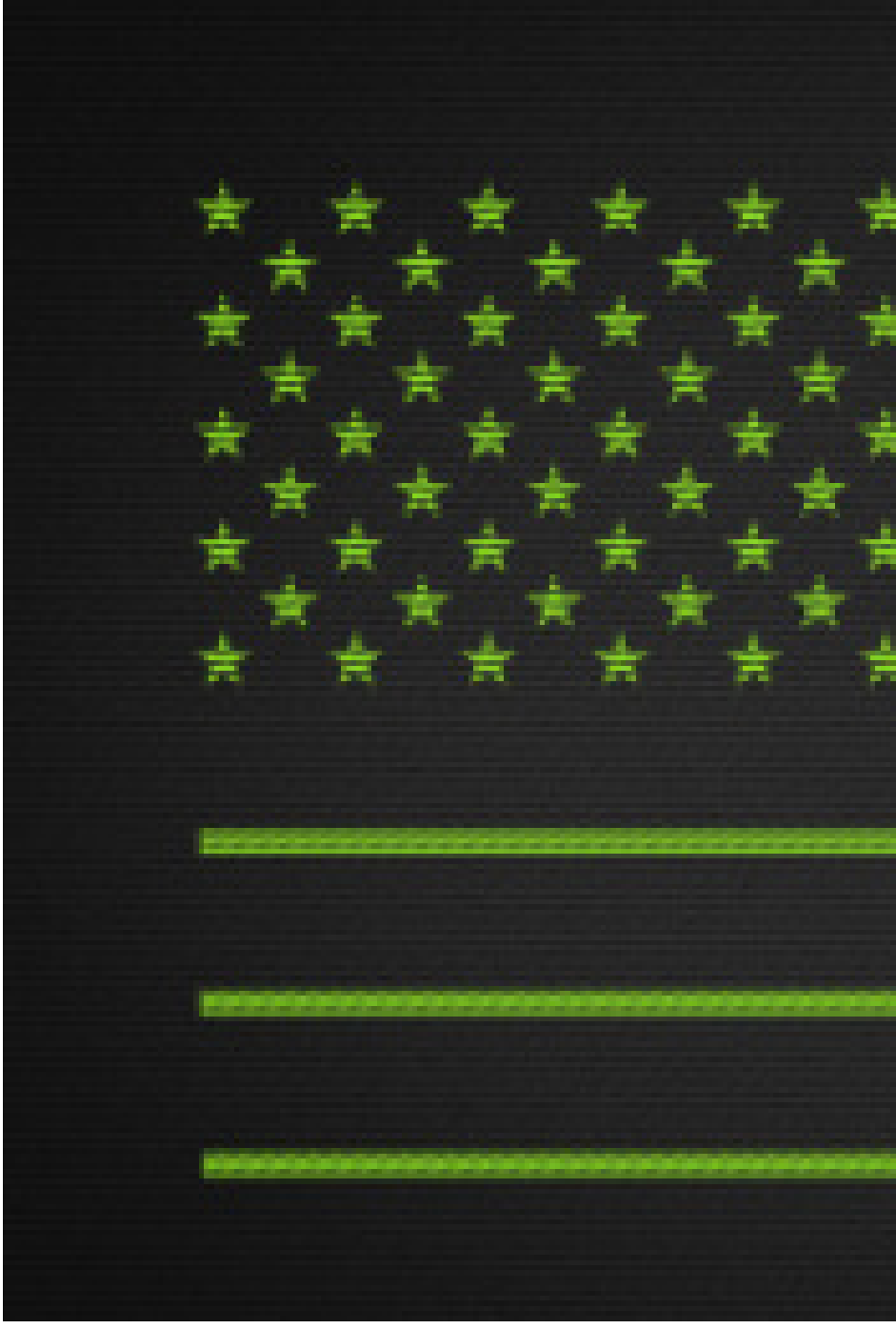


# Monitoring Vital Signs in the US

The US healthcare model is suffering COVID-related side effects, says Brunswick's **RAUL DAMAS.** That creates significant risks, but it could also bring some benefits.

HEALTHCARE IS DIFFERENT.

That's what we've said for decades when anyone attempted to apply the traditional laws of supply and demand to healthcare consumption.

People can't simply choose when to obtain healthcare, like they choose when to buy a phone or car, the reasoning goes. If you're sick, you need to see a doctor. There's no time to shop around, and there's no price we as a society won't pay for care.

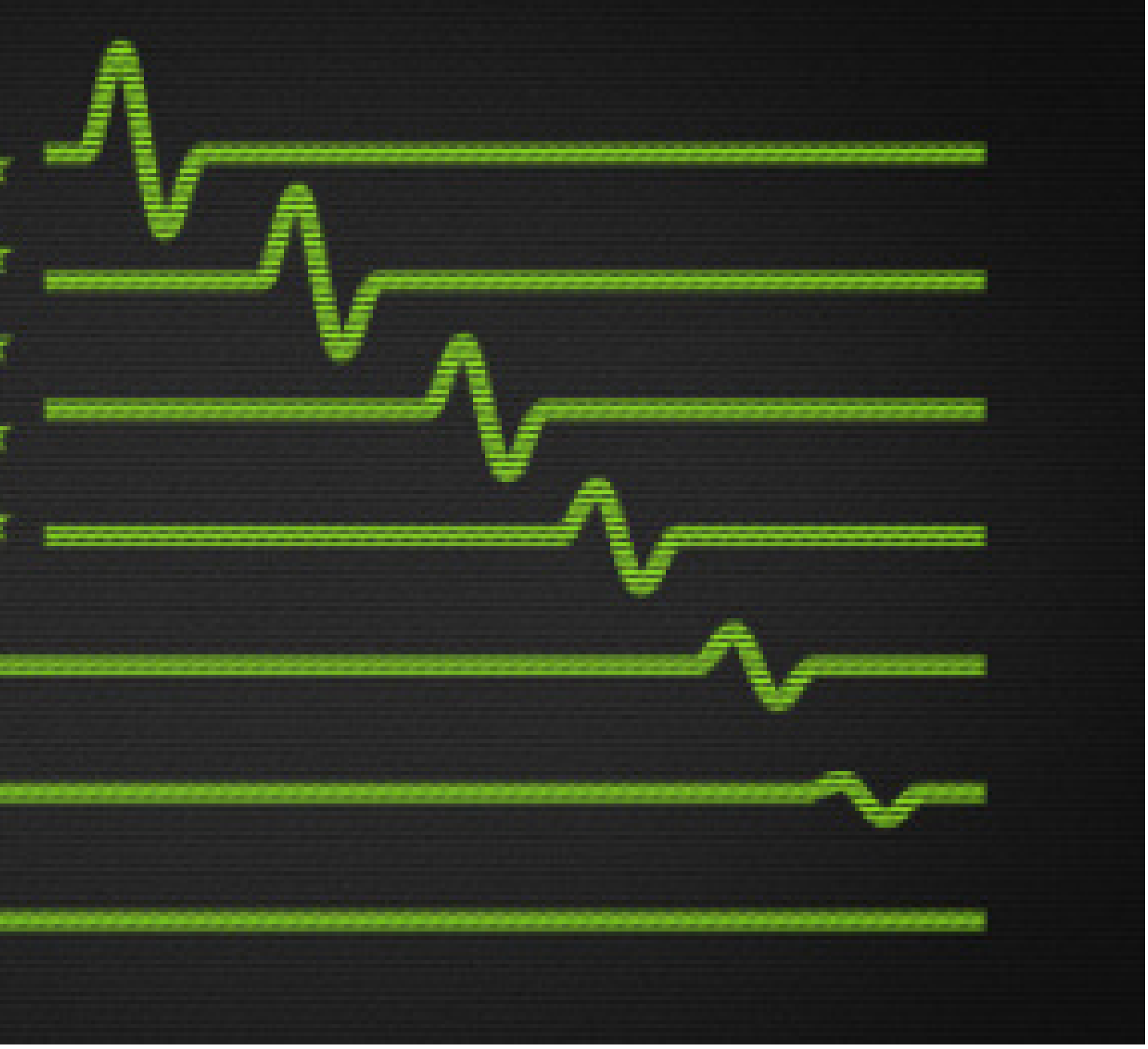
But what if that's wrong—or at least not entirely right? What if healthcare demand is more elastic than we thought? What if some types of healthcare consumption are as discretionary as regular consumer purchases?

For several months, the US has been running an unprecedented and previously unthinkable experiment that may help us understand just how much of healthcare spending is essential and which parts of our healthcare budget we could safely reduce.

The first sign this experiment was under way was in the first-quarter GDP report, which indicated that a decline in healthcare services represented nearly half (47 percent) of the economic contraction—the greatest on record since 2008. Interestingly, consumer data shows this steep decline began before the lockdowns were initiated, meaning that people were proactively taking steps to reduce their risk, including by limiting their consumption of healthcare services. The increased "cost" of healthcare, in terms of increased risk, reduced public demand.

The Bureau of Labor Statistics employment report echoed that finding, noting that healthcare service segment of the economy declined by 1.6 million jobs in March and April and resumed only slow growth after that.

This is notable because past economic recoveries have been driven in large part by increases in healthcare employment and spending. As additional context, the US spends more on healthcare per person



than any other developed nation, but it achieves comparable health outcomes to the lower-spending countries. Naturally, a better understanding of how much excess spending is attributable to care that may be unnecessary or safely postponed would have significant economic implications.

In a recent op-ed in the New York Times, cardiologist Sandeep Jauhar suggests that unnecessary healthcare strains both individuals and our health system, particularly Medicare and Medicaid. He cites a Kaiser Family Foundation poll that found nearly half of households polled, 48 percent, said that they had skipped or postponed medical care because of the virus. Yet only 11 percent of those who skipped care reported that someone's medical condition in the household worsened during that time. "Perhaps," Dr. Jauhar writes, "Americans don't require the volume of care that their doctors are used to providing."

### BY THE NUMBERS

The declines in preventative care in recent months are dramatic, and there is little debate that there will be significant negative repercussions for individuals who've avoided or been unable to obtain essential healthcare services. Even as states begin reopening and elective surgeries resume, the fear of contracting coronavirus in a clinic or hospital remains for many Americans. A report published by the American Cancer Society indicates that nearly one in four cancer patients delayed their care as a result of the pandemic, pushing back in-person appointments, surgery, imaging and other surveys. Similar studies by

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ILLUSTRATION: EDMON DE HARO

Epic Health Research Network show a sharp decline in preventive cancer screenings in April relative to pre-COVID times, with average weekly screenings for cervical, colon and breast cancer decreasing by 94 percent, 86 percent and 94 percent, respectively, compared to pre-pandemic averages.

A report by the CDC shows that emergency visits increased almost exclusively for coronavirus-related illnesses (respiratory distress, pneumonia not caused by tuberculosis, exposure to infection disease), while decreasing for almost every type of injury or ailment.

Studies suggest that, as a result of these changes in healthcare consumer behavior, a number of chronic illnesses will be diagnosed at later stages with a much more severe prognosis. Labs across the country are seeing significant drops in treatment for life-threatening illnesses—the American College of Cardiology experienced a 38 percent decrease in patients being treated for the heart condition STEMI, associated with a 30-day mortality rate of around 10 percent.

The drop-in treatments directly correlates to the high number of individuals delaying care until the situation is dire. Evidence shows that a large percentage of individuals who have experienced severe heart attacks either ignored earlier symptoms or endured the symptoms over the past four months. In the first three weeks of April, the US saw 2,000 more deaths than normal from cases associated to heart attacks.

## THE SYSTEM RESPONDS

While patient behavior has undergone a significant change, our health system has been struggling to keep pace, adapt and return to some semblance of normalcy. Even as states have begun to reopen, few expect the demand for non-COVID health services to resume pre-pandemic levels anytime soon. As of this writing, the virus continues to spread across the country, keeping healthcare system executives and regulators unbalanced and wary about any rapid resumption of traditional operations.

Nevertheless, physicians and hospitals are working to convince potential patients that it is safe to return to the clinic, as they may experience significant health consequences unrelated to the virus if they continue to forego necessary care. To serve these patients, hospitals already experiencing unprecedented financial strain are investing in costly safety protocols, including purchasing additional PPE for healthcare workers, managing waiting rooms at lower capacity, and increasing testing for COVID-19.

Telehealth and remote monitoring have also stepped in to fill this gap in care. Both have experienced tremendous growth throughout the pandemic, yet neither has counterbalanced the drops in in-person visits, particularly in terms of revenue. The AHA estimates that US nonfederal hospitals are expected to lose around $161.4 billion in revenue between March and June 2020 from cancelled elective and non-elective surgeries, outpatient treatment and reduced urgent care rates. Facilities are already being forced to close, reduce services they can offer or take other extraordinary measures to stay afloat.

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The urgent care sector has also seen extraordinary volatility. Patient volumes declined by nearly 80 percent at the start of the pandemic but have now increased in some regions to levels higher than what they would normally be in the summer months, when respiratory illness, which drives a significant amount of urgent care volume, is relatively low. This spike has been driven predominantly by patients seeking COVID-19 tests. An important question that urgent care operators are considering is whether these lower-margin testing services ultimately replace other services their traditional patients sought, leaving a busier but less profitable industry.

As the virus continues to spread across the US, not only will the healthcare sector continue evolving and adapting, but so will patient behavior. Many patients will continue to view the risk of contracting coronavirus at a clinic as greater than the risk of their chronic illness or pain remaining unaddressed.

## A DELICATE BALANCE

This evidence raises important questions to which we'll be learning the answers in the months and years to come. What were the consequences of these delayed diagnoses and foregone treatments? Which types of individuals and patients suffered the worst outcomes, and which avoided any negative consequences as a result of their reduced interaction with our healthcare system? What types of care once considered essential by patients and physicians will now be seen as optional?

Dr. Jauhau suggests that perhaps without access to doctors, people appear to be taking more responsibility for their own health, noting that a "vast majority of patients seem to have fared better than what most doctors expected." This is an optimistic view, but perhaps the long-term data will support it, at least in certain circumstances.

One certainty is that this extraordinary moment in history will generate a trove of health outcomes data upon which public health experts and policymakers can base future plans. It's critical that they do so. This experiment comes at a terribly high price, and it would be a shame if we didn't learn from it. ◆

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