Charting a New Path for Health Care Reform

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Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence, and Erin C. Fuse Brown, *Health Reform Reconstruction*, __ **U.C. Davis L. Rev.** __ (forthcoming, 2022), available at SSRN.

Since the 1960s, debates over health reform in the United States have focused on expanding access to health care, improving its quality, and lowering its costs. In their forthcoming article, *Health Reform Reconstruction*, Professors Lindsay Wiley, Elizabeth McCuskey, Matthew Lawrence, and Erin Fuse Brown argue that this so-called “iron triangle” framework has led to an unjust health care system by marginalizing equity, solidarity, and public health concerns. Building on their prior work, the authors call for a new set of principles to guide health care reform that centers around health justice. The Article also identifies legally and logistically entrenched fixtures of the U.S. health system and shows how they have structurally constrained health reform and undermined social justice goals. This provocative Article is a must-read for those interested in health reform, and the authors’ reframing of the issues pushes stakeholders to ask whether reform proposals will reinforce these problematic fixtures or dismantle them (albeit partially), thereby moving us closer to a more just health care system.

The Article is organized around four lessons that the authors pull from the U.S. health care system’s deficient and inequitable response to the COVID-19 pandemic. Part I presents the first lesson ? “that health care reform requires new principles rooted in solidarity, equity, and justice.” (P. 5.) The authors argue that the pandemic has revealed weaknesses in our health care system that have increased COVID-19’s public health and economic harms, such as failing to fairly allocate, adequately supply, and constrain prices for COVID testing, treatment, and vaccines. The pandemic’s disproportionate impact on low-income, Black and Brown communities also has made highly visible the health care system’s failure to reduce long-standing disparities in health. In addition, the pandemic highlighted our interdependence across racial and socio-economic lines. The authors argue that evaluations of future health reforms therefore should be guided by three core criteria ? anti-subordination, equitable distribution, and community empowerment ? criteria often overlooked or marginalized by the iron triangle framework. Specifically, they believe we should ask whether reforms (1) dismantle or reinforce structural racism, economic injustice, and other forces of social subordination; (2) ensure the just distribution of the burdens and benefits of public investments in health care and public health; and (3) allow for decision-making processes that give recognition to and empower subordinated groups that too often are excluded from collective self-determination.

Part II focuses on the second lesson the authors pull from the pandemic ? that health reform has been structurally constrained by four fixtures of the U.S. health care system that impede solidarity and egalitarian justice ? namely, individualism, fiscal fragmentation, federalism, and privatization. The authors provide a detailed discussion of how each of these fixtures is legally and logistically entrenched in our health care system and the ways in which they have undermined our COVID-19 public health response. For example, given the health care system’s orientation toward treating individual patients, coronavirus testing was used simply as a diagnostic tool in caring for individuals rather than also supporting disease surveillance programs. The authors also explain how fiscal fragmentation that spreads costs and benefits across patients, employers, public and private payors, and providers impeded the public health response by producing a mismatch between those who would benefit from public health interventions and those asked to pay for them.

The Article’s third lesson is that these four fixtures contribute to racial and socioeconomic disparities in the burden of disease. Part III describes the fixtures’ racists foundations and how they continue to perpetuate socioeconomic inequality. In linking key structural components of our health care system to racism and subordination, the authors

remind us that health reforms that reinforce these fixtures further cement structural inequalities in health care. A key illustrative example discussed by the authors is the Affordable Care Act (ACA). While many have hailed the ACA for expanding access ? a pillar of the iron triangle ? the authors explain how Medicaid expansion further entrenched the country's two-tiered health care system, with reduced access to care for Medicaid's disproportionately minority and low-income beneficiaries given the program's lower payment rates to providers.

In Part IV, the authors discuss their final lesson ? that health reforms needs "a reconstruction in ethos, centered on health justice criteria." (P. 56.) The authors believe a single-payer health care system would advance health justice and population health by disassembling the four fixtures. However, they rightly recognize that these fixtures are structural impediments to far-reaching reforms. In deference to this reality, they argue for confrontational incrementalism, or incremental reforms that lay the groundwork for future transformation of the health care system by displacing the fixtures. Accordingly, evaluations of proposed reforms would not simply consider their impact on cost, quality, and access, but would primarily focus on whether they further health justice by confronting the entrenched fixtures. Policymakers and scholars committed to a more just health care system should consider adopting confrontational incrementalism as a method for achieving this goal.

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