









Ten health policy challenges for the next 10 years

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Abstract

Health policies and associated research initiatives are constantly evolving and changing. In recent years, there has been a dizzying increase in research on emerging topics such as the implications of changing public and private health payment models, the global impact of pandemics, novel initiatives to tackle the persistence of health inequities, broad efforts to reduce the impact of climate change, the emergence of novel technologies such as whole-genome sequencing and artificial intelligence, and the increase in consumer-directed care. This evolution demands future-thinking research to meet the needs of policymakers in translating science into policy. In this paper, the *Health Affairs Scholar* editorial team describes “ten health policy challenges for the next 10 years.” Each of the ten assertions describes the challenges and steps that can be taken to address those challenges. We focus on issues that are traditionally studied by health services researchers such as cost, access, and quality, but then examine emerging and intersectional topics: equity, income, and justice; technology, pharmaceuticals, markets, and innovation; population health; and global health.

Key word: health policy.

Cost, access, and quality

Thinking beyond the insurance card: How do systemic barriers affect access to care and what we can do about it?

Despite reaching an all-time low uninsurance rate in 2022,¹ a growing realization has started to set in across the United States that handing out insurance cards does not serve as the final step in the goal of increasing the health of all Americans. Indeed, enrolling individuals into health coverage is only meaningful if they can access the medical care they need, and if they can do so in a timely manner. Yet, the problems of connecting patients with care are widespread and multifaceted. For example, today's insurance products are overwhelmingly managed-care arrangements that restrict

consumers' choice of providers. As a result, consumers have to navigate provider networks that may be inadequate due to their restrictiveness.² Moreover, the provider directories offered to consumers by carriers are often highly inaccurate and may include thousands of “phantom” or “ghost” providers.^{3,4} The maldistribution of medical providers as well as local and national shortages in some specialties further exacerbate this problem.⁵ Many Americans, particularly those traditionally marginalized by the medical system, also lack the confidence and trust in the medical profession to provide appropriate and effective care and avoid or delay care as a result.⁶ In addition, expanding health coverage to more Americans in the wake of the Affordable Care Act has not solved the underlying high-cost problem the US health care system faces.⁷ As a result, even many insured Americans, particularly elderly,

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Black, and Hispanic adults, and those with lower incomes, continue to face financial barriers to care because of out-of-pocket payments.⁸

Research focusing on the experience of consumers as well as the implications on the lives of consumers impacted by these challenges is a crucial next step. Researchers should be engaging these issues from a variety of viewpoints as well as methodological approaches to better understand the effects on individuals, their health, their finances, and their broader life experiences. Moreover, future research should also remain focused on providing the information needed to policymakers to improve consumers' lives.

At the same time, researchers should be willing to take a broader look at consumer experiences beyond the explicit focus on the health care field as many barriers are reflective of broader societal issues. Systemic and structural racism continues to also impose substantial barriers for many non-White Americans needing access to care and contributes to widening existing health disparities.⁹ The coronavirus disease 2019 (COVID-19) pandemic as well as the ongoing opioid epidemic only increased these barriers, particularly for children.¹⁰ Moreover, many individuals lack the means of transportation as well as other resources to access medical care when needed.¹¹ Government policies, like the enforcement of immigration restrictions via interior border checkpoints, only further exacerbate these challenges.¹²

There may be great value in expanding traditional definitions and conceptions of health-related research to develop a better understanding of the challenges consumers face in accessing care. Moreover, research should particularly focus on traditionally marginalized populations because these populations may face access challenges above and beyond those experienced by other groups. Importantly, research should be mindful to include the perspectives of these populations not only in terms of the focus of the research but also the unique methodological approaches that may be required to conduct meaningful and policy-relevant research.¹³

New health care over-the-counter products: What will be required to meet consumer needs?

The market for over-the-counter (OTC) health products continues to expand dramatically.¹⁴ This increase is not only for products that have been on the market for decades, such as nutritional supplements, but also for new categories of products, such as online eye exams and prescription glasses, direct-to-consumer genetic and other types of screening tests such as those for COVID-19 infection, and online pharmacies. These trends are changing the relationship between consumers and health care in significant ways, just as other paradigm-shifting changes, such as ride-sharing apps, radically changed transportation habits and the traditional taxi industry.

A prime example of the advantages—and challenges—of the move to OTC health products is the recent US Food and Drug Administration (FDA) approval of the marketing of OTC hearing aids. There is a huge unmet need for affordable and accessible hearing device products as statistics show that the majority of individuals who would benefit from hearing aids do not use them.¹⁵ This need is particularly acute in marginalized and geographically inaccessible communities, given the high cost of traditional hearing aids. Moreover,

Medicare does not provide coverage for them and neither do many Medicaid programs.¹⁶ However, there were widespread concerns about whether OTC hearing aids were appropriate, and thus passage of the relevant Congressional acts and FDA approvals took many years.

Rapid and timely research is urgently needed on the implications of OTC products for consumers and providers that includes their unique perspectives. For example, it will be important to assess whether OTC hearing aids truly provide greater access to meet a pressing population health need or whether consumers get lost in a bewildering maze of products and are unable to choose and appropriately use the best device for them. The historical provider model, which relies on audiologists to work directly with consumers to choose and purchase traditional hearing aids, will have to evolve to address the OTC market. Research also needs to consider the many stakeholders that will play a role in successful implementation of OTC products, including payers and industry, and the complex practice and policy environment within which these products will be marketed.

Intersections with health care: equity, income, and justice

Safety-net programs: Why do we make it so hard for families to receive social safety-net benefits?

It is increasingly recognized that social factors like poverty and housing are key determinants of health. Yet, the United States dedicates a smaller percentage of its Gross Domestic Product (GDP) to social spending on families than the average Organization for Economic Co-operation and Development (OECD) country (0.6% vs. 2.1% in 2019).¹⁷ Despite having a much higher GDP per capita, the United States has a lower life expectancy and higher infant mortality than other high-income countries.¹⁸ Part of this discrepancy is that safety-net policies in the United States are less generous than those in other countries; for example, the United States is the only high-income country not to provide paid family leave to new parents and is among the only countries not to provide a basic income benefit for families with children (like the 2021 expanded child tax credit).

Another major understudied component of this problem is that it is challenging for economically disadvantaged families to access the benefits for which they are eligible.¹⁹ For example, the largest US poverty alleviation program—the earned income tax credit (EITC)—has well-known positive health effects, yet it is administered through the tax system, a notoriously bureaucratic system that is more difficult to navigate for the most vulnerable families who would benefit the most from the EITC.²⁰ In fact, most US safety-net programs require their own individual application processes, requiring cash- and time-strapped households to complete redundant paperwork and often attend in-person interviews, and to do so on a regular basis to recertify frequently.

A small but growing literature is focused on understanding and addressing low take-up of social safety-net programs to address health equity.²¹ Yet, there is much work to be done to understand how to tackle the different facets of the problem, including streamlining multiple applications in the face of a fragmented and siloed safety-net system, scaling up small interventions that have been shown to be successful, and partnering with state and federal agencies to simplify eligibility

requirements and reduce administrative burdens. The rapid pace of policymaking to improve access to safety-net programs during COVID-19 demonstrated that governments and practitioners have the capacity to work quickly in this space²²—for example, reducing the churn of Medicaid benefit receipt among eligible families through the continuous enrollment provision. The possibility for innovation in this space makes this topic a critical emerging area of program development and evaluation to address health equity.

Ensuring access to care for patients with limited ability to pay: What are the unintended impacts of poorly targeted support for the health care safety net?

All countries, regardless of their specific health payment approach, must consider how patients can equitably access care. Even countries with publicly funded systems have gaps in access. For example, although the United Kingdom has the world's largest government-run and -funded health care system, a recent survey found that one in eight adults paid for private insurance because waits were too long.²³

These issues are particularly acute in the United States, with its complex mix of private and public insurance programs. Despite historic expansions of public and private coverage under the Affordable Care Act, many patients cannot afford care in the US health care system. Uninsured or underinsured patients rely on the health care safety net, a crucially important, yet loosely organized collection of public and private providers willing to provide unreimbursed care, or uncompensated care.²⁴ An analysis from 2015–2017 suggests that the annual dollar value of uncompensated care totaled over \$42 billion.²⁵ To offset the cost of uncompensated care, federal and state governments provide support to safety-net providers in a variety of forms such as Disproportionate Share Hospital (DSH) payments, Section 330, grants to community health centers, Veterans Affairs funding, and the 340B drug discount program. The estimated annual dollar value of this support is \$34 billion, leaving a sizeable amount of unsubsidized uncompensated care.²⁵

How safety-net providers share the burden of unsubsidized uncompensated care is an important question that has received insufficient attention in the research literature despite its importance sustaining the safety net. There is often a poor match between safety-net funding and the burden of uncompensated care, and thus providers with significant uninsured and low-income insured populations sustain high amounts of uncompensated care relative to their budgets, while the subsidies that others receive may exceed their uncompensated care costs.²⁶ Recent work demonstrates that the eligibility criteria used to allocate Medicare disproportionate-share hospital payments and 340B drug discounts undersubsidizes hospitals with significant uncompensated care burdens,²⁶ and that a significant proportion of hospitals receiving Medicaid DSH do not meet reasonable definitions of safety-net status.²⁷

With better targeting, policymakers can strengthen the safety net and therefore also improve access to care for the uninsured and low-income insured patients who rely on it. Better matching support to unsubsidized, uncompensated care burden can facilitate safety-net hospitals' investments

in technology and services,²⁸ improve quality of care, improve financial outcomes,^{29,30} and possibly improve health equity³¹ and achieve critical public health goals.³²

Policymakers have shown interest in improving the targeting of support for safety-net providers.³³ However, existing research suggests that identifying better allocation methods will be challenging as there is no single definition of what constitutes a safety-net provider³⁴ and definitions can dramatically affect the characteristics of recipient hospitals.³⁵

Are structural inequities hampering hospitals' ability to address social determinants of health?

Hospitals and health systems have the potential to play a significant role in addressing health inequities in the communities they serve. This is particularly true among low-income communities of color that face some of the starkest disparities in health care coverage, access, and clinical outcomes. Central to these efforts is meaningful engagement and partnerships³⁶ to address social determinants of health with local communities that health systems serve.

Emerging evidence, however, raises substantial concern that structural inequities may hamper the ability of safety-net hospitals, which disproportionately serve low-income and racially/ethnically minoritized populations, to address their patients' and communities' social needs.³⁷ These inequities are, in part, driven by structurally discriminant factors³⁸ at the core of our current hospital financing system.

Our current hospital reimbursement system³⁹ effectively assigns a lower dollar amount for the care of low-income, Black, and Latino people, given their disproportionate enrollment in insurance plans like Medicaid, which reimburse hospitals less. And while DSH payments are intended to subsidize these hospitals' care of underinsured patients, the current allocation of DSH payments may structurally disadvantage certain communities,³¹ with fewer dollars flowing into low-income communities of color.

Another potential driver is related to the hospital non-profit status system,³⁸ which exempts hospitals from paying local, state, and federal taxes if they demonstrate that they are providing a benefit to their community. Given that there is little to no oversight of tax-exempt charitable status,³⁸ nonprofit hospitals are often operating virtually indistinguishable from for-profit hospitals, and their mission is to maximize profits, which are re-invested in the health system, including the use of tax savings for their own employees' and administrators' benefit, and not for the benefit of their community.

Moving forward, if the aim is to improve health equity, policymakers must consider strategies that directly target structural inequities that stem from our current hospital financing system, including consideration of further regulation to ensure fair reimbursement for the care of low-income people of color and appropriate allocation of funds meant to meet the needs of socially vulnerable communities. Research is needed that evaluates the impact of interventions or policies that may better align the reimbursement of health care services with the needs of the community, including more fair distribution of community-benefit support to at-risk communities.

Health care technology, pharmaceuticals, markets, and innovation

With mergers of insurers and pharmacy chains and growth of online generic retailers, can community pharmacies survive?

Pharmacies play a crucial role in the provision of medications and patient-centered medication management services, as demonstrated in the COVID-19 pandemic. Pharmacy accessibility is indispensable for equity in health care access, as pharmacies can reach individuals who do not interact with other health care providers.⁴⁰ Pharmacy access is jeopardized by the increasing trend in pharmacy closures observed in the past few years. But why are pharmacies closing?

Pharmacists have limited opportunities to bill for their services as they have not been granted provider status, which precludes them from billing Medicare Part B. As a result, the business model of community pharmacies relies on the dispensing of prescription drugs. One reason behind pharmacy closures is the declining reimbursement rates associated with the consolidation of the pharmaceutical benefit management industry.⁴¹ Another reason is the exclusion of pharmacies from the preferred networks of major health plans.⁴² The exclusion from preferred networks predominantly affects independent pharmacies and has been catalyzed by the vertical integration of insurers with pharmacy chains, as insurers incentivize patients through lower cost-sharing to fill prescriptions in their own pharmacies.

In the past year, two online entities have made the headlines for disrupting the pharmacy market. Mark Cuban founded an online generic retailer, Mark Cuban Cost Plus Drug Company, which dispenses generic drugs at acquisition cost and a markup, which are lower than insurance copayments. As another example, in January 2023, Amazon announced that it would dispense fifty top-selling generic drugs for \$5 per month to its Prime members. With pharmaceutical benefit managers increasingly pushing pharmacies' margins, and Mark Cuban Cost Plus Drug Company and Amazon dispensing generics, can we expect community pharmacies to stay in business just to administer only other prescriptions and vaccines?

The changing pharmaceutical reimbursement landscape calls for robust research that assesses the implications of these changes. Such research should evaluate the impact of pharmaceutical benefit manager consolidation, vertical integration of insurers and pharmacy chains, increasing restrictiveness of pharmacy networks, uptake of mail order, and entry of online generic retailers on the financial sustainability of community pharmacies.

The private equity “takeover” of health care: What does it mean?

Private equity investment into health care accelerated rapidly over the last decade and shows no signs of slowing down. Private equity firms now play a meaningful role across the health care industry, from hospitals and nursing homes to physician practices and dental clinics to biotechnology, medical devices, and information technology. This infusion of capital offers the potential for investments that may improve patient care and generate economies of scale, but private equity's focus on short-term profits and efficiency also raises concerns about patient harms and higher costs.

Numerous news stories have identified examples of fraudulent activity,⁴³ overtreatment,⁴⁴ aggressive billing practices,⁴⁵ and widespread use of noncompete and nondisclosure agreements associated with private equity-owned facilities and medical groups. Also, recent empirical evidence suggests that private equity acquisitions of medical practices lead to higher prices and, perhaps more concerning, that their acquisitions of nursing homes tend to increase mortality rates.^{46–48} The future is likely to bring the further consolidation of many physician specialties by private equity firms and expanded investments in primary care, behavioral health, and specialty practices with significant exposure to value-based payment models. Inevitably, this investment will bring with it both pros and cons.

The trillion-dollar question is how legislators and regulators should respond to private equity's “takeover” of health care. One school of thought is that a presumption of patient harm should accompany private equity acquisitions in health care and that lawmakers, therefore, should enact roadblocks to such acquisition through stronger corporate practice of medicine rules or similar means. Others argue that lawmakers should instead focus on weeding out the market failures and payment loopholes that private equity (and other acquirers) can exploit, such as laws regulating surprise billing, the Federal Trade Commission's decision to prohibit noncompetes, and stronger antitrust and fraud enforcement.

Not enough is known, though, about private equity's net effects on quality of care and patient experience. More research—qualitative, descriptive, and empirical—is needed to help policymakers, providers, and patients understand the effects of and respond to this growing trend. The research community is forced to play catch-up as private equity continues to expand into new arenas of health care.

The road ahead for health policies on genomic testing and precision medicine: Much accomplished but what remains to be addressed?

On June 26, 2000, two key leaders of the mapping of the human genome—Francis Collins and Craig Venter—stood with the US President Bill Clinton in the White House as he announced: “With this profound new knowledge, humankind is on the verge of gaining immense, new power to heal. Genome science will have a real impact on all our lives—and even more, on the lives of our children. It will revolutionize the diagnosis, prevention, and treatment of most, if not all, human diseases.”⁴⁹

Over two decades later, genomic testing and the general field of “precision medicine”—which uses information about a person's genome and advanced computing tools for data aggregation to precisely target prevention, diagnosis, and treatment—have made great advances. Genomic testing is routinely used in a range of clinical scenarios, including cancer risk screening for *BRCA1/2*, noninvasive prenatal testing for fetal anomalies, and genomic sequencing of tumors to target effective treatments and to diagnose rare diseases in newborns.⁵⁰

Yet, much more health policy research is needed, both on existing uses of genomics and those that are emerging. Although much has been accomplished, much more must be done if genomics will indeed “revolutionize” health care. Questions remain about the economic and societal value of using genomics compared with other approaches, the impact on families of the

identification of genetic variations that are inherited, the ethics of identifying the possibility of future disease in newborns and even fetuses, access to testing for underserved populations and the lack of genomic data from non-White populations, the often-contradictory preferences of individuals versus society for genomic information, balancing innovation with affordability, regulatory conundrums, and gaps in antidiscrimination legislation. And although many countries worldwide have genomic testing availability and government initiatives to develop genomic databases and programs, there is little understanding of how approaches and policies compare across countries.⁵¹

Population health

“Nothing about us without us”: How can patient engagement contribute to meaningful health policy research?

Several global initiatives have emerged to recognize the value of patient-centered care. For example, over a decade ago, the US Congress created the Patient-Centered Outcomes Research Institute (PCORI) to “conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions.”⁵² In Canada, provincial governments have adopted health legislation based on a broad public consultation process, “Putting People First,”⁵³ which established principles in the law that expanded efforts to engage the public in health policy, and the Strategy for Patient-Oriented Research was launched nationally by the Canadian Institutes of Health Research to address the gap in research getting “knowledge into action.”⁵⁴ In the United Kingdom, with a long history of patient engagement, the National Institute for Health and Clinical Excellence (NICE) has invited patient and public participation to consider issues related to social value judgments in assessments and the development of guidance and quality standards on social care based partly on patient preferences.⁵⁵

Health care delivery and health policy change that does not actively engage patients is no longer acceptable. With the ongoing challenges facing health care systems, patient engagement in health policy research to inform health policy changes will become increasingly important to the delivery of effective and financially sustainable health care to an aging population with complex chronic care needs.⁵⁶ In the Information Age of Medicine,⁵⁷ patients are now empowered to be partners in not only their care but also how health care is delivered and the policies governing its delivery. Patient engagement has been defined as “active, meaningful and collaborative interaction between patients and researchers across all stages where decision-making is guided by patients’ contributions as partners recognizing their specific experiences, values and expertise.”⁵⁸ Tokenism or symbolic efforts to have patient representation on governance and advisory committees are not the same as meaningful patient engagement.

The slogan “Nothing about us without us” was used originally to reflect the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy.⁵⁹ The United Nations used this phrase in 2004 as the theme for the International Day of Persons with Disabilities,⁶⁰ and more recently, this statement has been used in the context of patients and health care. It highlights the importance of engaging

patients to adhere to the principles of justice, equity, diversity, and inclusion in countering systemic discrimination.

The potential benefits of meaningful patient engagement working as “part of the team”—both in their own care and in health policy research—are significant.⁶¹ It has been demonstrated that patients who are “activated” achieve better outcomes and their care is less costly.^{62,63} Aligning health care policy to respond to what matters to patients and their priorities has enormous potential to increase informed decisions about health policy to improve patient-centered care.

There are tremendous opportunities to effectively and meaningfully engage patients to advance patient-centered care at all levels of knowledge mobilization. An innovative approach to how patient engagement can create new roles and relationships within health systems to impact health research and health policy is the partnership with patients in the Strategy for Patient Oriented Research Chronic Disease Networks (SPOR). As an example, in the IMAGINE SPOR Network of gastroenterology centers across Canada, patients are involved in a wide range of roles.⁶⁴ Patients are included at all levels of governance of the network as co-leads for the core projects and the cross-cutting themes. As part of the Patient Engagement theme, patients can be involved in an advisory role to the research program, and in providing input to internal study materials, testing data-collection tools, and participating in national committees overseeing the network. As part of the capacity-building efforts in patient-oriented research, some patients undertake intensive 1-year training in patient experience research in the Patient and Community Engagement Research Programme (PaCER) university certificate program and as patient research partner graduates and subsequently engage in clinical and scientific knowledge mobilization activities to inform health system change and health policy.^{65,66} In these ways, patients, as patient research partners, help bridge the gap between patient experience and knowledge implementation in the health care system.

Global health

Building a truly global perspective: How can researchers contribute?

Recent phenomena have made apparent the interconnectedness of our global community; what happens in one country touches us all, whether the spread of COVID-19 infection and of technologies to combat it, or crises from wars to climate change and their humanitarian consequences. Global health policy research is a particular gap in the scientific literature,⁶⁷ despite the richness of experience across the world. Researchers and policymakers everywhere can learn from Rwanda’s community health insurance program or Turkey’s health system reforms. However, the public health and health policy literature has long been dominated by authors and perspectives from high-income countries: over 80% of the world’s population lives in low- and middle-income countries (LMICs),⁶⁸ yet authors from LMICs are underrepresented in the scientific literature, particularly in meaningful authorship roles.^{69–71} Publications about LMICs, and with LMIC-affiliated authors, are increasing—but progress has been slowest for low-income countries⁶⁹ and female authors remain underrepresented.⁷² These inequities in publishing have echoes in other imbalances seen across global health

and health policy research, such as in the financing for global health research,⁷³ boards and commissions focused on global health issues,^{74,75} and representation at scientific conferences⁷⁶ and journal editorial boards.^{77,78}

Research must be accessible to a global audience. By conceptualizing ourselves as a truly global community and removing the spatial connotations of “global health,” we can move toward research that is equitable and reflexive⁷⁹—that is, critically reflective upon the scientific enterprise and how knowledge is produced. Efforts are needed to disseminate high-quality science across the globe and respectfully engage and amplify international expertise and local voices. To achieve this, we need models for sustainable and equitable publishing models into the future.

Contribution statement

L.A., J.F., S.F.H., R.H., I.H., C.M., and S.N. contributed equally.

Supplementary material

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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