

## The Future of Healthcare: Five COVID-Era Trends and Developments

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**The beginning of a new year is historically a time to make lists and contemplate the future.** This is typically true for hospital and health system leadership and governing boards. Often, this is when turnover is most likely to occur on boards, prompting the need for educating new board members, electing new officers, filling out committee memberships, and developing or revisiting strategic and capital plans.

This need to plan is especially urgent for public hospital board members, who often spend less time in board meetings than their private hospital counterparts pondering future challenges and opportunities. As I wrote in a Special Commentary in The Governance Institute’s biennial survey, “There have been many important changes in the health industry. It is essential for public hospital governing boards to keep abreast of these changes to govern effectively.” I also pointed out that The Governance Institute’s research continued to show that “public hospital governance has not evolved rapidly enough to keep pace with industry trends and reforms” in areas like strategic planning and board member education.<sup>1</sup>

Several years ago, I helped conduct a survey of the “best governance practices” of nine high-performing public and non-profit hospital systems. We found that a majority of the surveyed boards spent over 25 percent of their meeting time on “strategic

1 Larry S. Gage, “Peak Effectiveness for Government-Sponsored Hospitals & Health Systems Begins with Governance,” Special Commentary, The Governance Institute’s 2019 Biennial Survey; see new survey for updated research: Kathryn Peisert and Kayla Wagner, *Advancing Governance for a New Future of Healthcare*, The Governance Institute’s 2021 Biennial Survey of Hospitals and Healthcare Systems.

## → Key Board Takeaways

Public hospital governing boards have improved their ability to take advantage of governance best practices, but such boards still lag behind many of their private sector peers in paying adequate attention to board member education and strategic challenges and opportunities for the future. This situation has been exacerbated by the ongoing impact of the pandemic, and its repeated surges, which have understandably demanded the full attention of public hospital administrative and clinical leadership and have (at least for now) eroded their ability to focus on planning for the future. Boards of public hospitals need to maintain a strong, strategic, and future-focused perspective by doing the following:

- Educate themselves about the trends and developments that are likely to shape future strategic plans.
- Focus on what the workforce crisis means for the post-pandemic future, when many aspects of the current situation are likely to persist.
- Consider how the dramatic expansion of remote diagnosis and treatment alternatives through telehealth and other technologies, as well as reimbursement for these services, will impact strategic and capital decisions.
- Stay updated on genetic medicine achievements. While controversial, the genie is not going to be put back in the bottle; the impact of these new biomedical tools will be profound and will generate substantial opportunities for hospitals and health systems that are prepared to take advantage of them.
- Develop an understanding of AI, including how it is progressing and investments in AI that may be beneficial for the organization. Board members should take note that there is already considerable support for AI's ability to transform healthcare and the way doctors and hospitals operate.
- Collaborate with clinical and administrative leadership to counter the waves of erroneous and unscientific public health misinformation that is being propagated on the Internet and in other forums.

growth and competition,” with three systems spending more than 50 percent.<sup>2</sup> We concluded that “enough time needs to be dedicated to these topics for in-depth discussions,” but too often, this is not the case with public hospital governing boards.<sup>3</sup>

This situation still exists for many public hospitals. At the same time, the devastating disruptions of the ongoing pandemic—now entering its third year—has diverted the attention of public hospital administrative and clinical leadership away from anticipating the challenges and opportunities of the future. It is therefore more important than ever for public hospital board members to step up and fill this gap for the hospitals and systems they govern.

This article highlights five current trends and developments that are going to require board members’ attention.<sup>4</sup> These developments may potentially have a profound effect on public hospitals in the future.

## 1. The Great Burnout of the Hospital Workforce

The erosion during the pandemic of the hospital workforce through resignation, illness, and sheer burnout raises profound and ominous concerns that are likely to affect public hospitals well into the future.

Last year, I wrote about the behavioral health crisis facing public hospitals.<sup>5</sup> I outlined a number of elements that have been brewing for many years, including historic patterns of deinstitutionalization, the growing opioid epidemic, under-reimbursement, and a range of legal, regulatory, and reimbursement barriers. These elements, when aligned with the anxiety and insecurity brought on by the pandemic, have resulted in a crisis of major proportions for public hospitals. These factors are all still with us

2 Larry S. Gage, Donald E. Casey, M.D., Ethan Norris, and James A. Rice, Ph.D., “Best Practices in Health System Governance: Summary of Evidence-Based Literature Search and Peer System Survey,” September 2016, unpublished client report; public version available upon request with client permission from the author at [larry.gage@alston.com](mailto:larry.gage@alston.com).

3 The Governance Institute recommends that boards spend more than half of meeting time during most board meetings discussing strategic issues.

4 This article provides newly developing trends. To view additional issues the author has recently addressed in other Governance Institute articles, see Larry S. Gage, “Preparing for Leaner Times Ahead: The Role of the Public Hospital Governing Board,” *Public Focus*, The Governance Institute, December 2018; Larry S. Gage, “Rethinking the Governance of Public University Teaching Hospitals,” *BoardRoom Press*, The Governance Institute, February 2020; Larry S. Gage, “The Growing Behavioral Health Crisis: A Perfect Storm for Public Hospitals,” *Public Focus*, The Governance Institute, May 2021.

5 *Ibid.*

today, and as we prepare to enter the third year of the pandemic, the behavioral health crisis has been greatly exacerbated by our concern for the mental health and well-being of our healthcare workers themselves.

For nearly two years, our essential health workers have been appropriately considered heroes, caring for wave after wave of people suffering from COVID-19. As I write this, our workers have watched over 935,000 die from the virus in the U.S. Though the omicron variant may produce somewhat milder disease than the delta variant, it is so much more contagious that both patients and the workers themselves are infected in greater numbers than ever. This has led to chronic understaffing and full hospitals, and to skyrocketing costs for temporary nurses and other staff.<sup>6</sup> By some estimates, nearly 20 percent of healthcare workers have quit since the pandemic began.<sup>7</sup>

Some observers think these estimates may be overstated, and that the resignation of many healthcare workers may be “part of a broader economic trend such as workers leaving all industries.” One economist said in a recent article, “All health employment is down only 2.7 percent compared to pre-pandemic and most of that is in nursing homes...there is no data to support an oft-repeated claim that one in five workers has quit the field.” And a recent Kaiser Family Foundation study maintained that hospital employment in the last quarter of 2021 was about 2 percent lower than February 2020 levels and about 4 percent lower than prior projections for December 2021.<sup>8</sup>

At the same time, these findings largely predate the fierce and vertical rise of infections and admissions due to the far more contagious omicron variant. And there is no question that this is taking a fearsome additional toll on the hospital workforce, both in terms of caring for hundreds of thousands of new patients and experiencing a dramatic increase in infections themselves. And lurking beneath the surface is a profound and possibly permanent erosion of mental health on the part of overworked people in understaffed hospitals.

The problem is made worse by the fact that medical professionals often put off seeking help. About 62 percent of healthcare workers have said that COVID-19 has

6 On January 24, 2022, 197 members of Congress co-signed a letter to Jeffrey Zients, the White House COVID-19 Response Team Coordinator, urging various branches of the federal government to investigate nurse staffing agencies for price-gouging during the pandemic.

7 “Inside the Health Care Worker Crisis,” *The New York Times*, January 19, 2022; See also Annie Gowen, “A Breaking Point on the Frontline,” *The Washington Post*, December 30, 2021.

8 Dan Diamond, “Hospitals’ Latest Pandemic Shortage: Staff,” *The Washington Post*, December 31, 2021.

had a negative impact on their mental health, according to a *Washington Post*/Kaiser Family Foundation poll from March 2021, but only about 13 percent had received mental health services or medication because of the stigma attached.”<sup>9</sup>

As a Minnesota hospital official put it in a recent op-ed column: “Even before the pandemic, physicians had twice the risk of burnout as the general population and had an estimated 40 percent rate of depression and suicidality. Now, 60 to 75 percent of clinicians experience symptoms related to depression, sleep disorders, and PTSD. The numbers are likely higher in nurses.”<sup>10</sup>

## 2. Virtual Health Is Here to Stay

Telemedicine has been with us for years, but its use has greatly expanded during the pandemic. For the last two years, hospitals and health systems have called upon telehealth to improve access and the quality of care for their patients. Third-party payers—and Medicare and Medicaid in particular—have expanded reimbursement. State licensing entities have also loosened regulatory requirements for various kinds of telehealth, and remote or virtual digital care, to facilitate and expand the use of these services.<sup>11</sup>

Regulators and Congress are now debating the continuation of pandemic-related telehealth services, but there is little doubt among observers that many of the new or expanded services, and the easing of regulatory requirements making them possible, will be made permanent. In some respects, this is because the real revolution in remote or virtual healthcare goes way beyond what we have historically known as “telemedicine” to include a wide range of diagnostics, treatments, and patient monitoring capabilities that now can be effectively provided on a remote basis.

The results have substantially benefited rural providers, but remote or virtual medicine can also be a game changer for public hospitals, providing access to specialized diagnostics and services that could otherwise be too costly to provide in person. Expanded telehealth can also provide reasonably priced ways to monitor and

9 Ashley Kirzinger, et al., “[Kaiser Family Foundation/The Washington Post Frontline Health Care Workers Survey](#),” April 6, 2021.

10 Sarah N. Cross, “Hospitals Are Running Low on Yet Another Resource: Hope,” *The Washington Post*, January 9, 2022.

11 Wyatt Koma, Juliette Cubanski, and Tricia Neuman, “[Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future](#),” Kaiser Family Foundation, May 19, 2021.

stay in communication with the vulnerable patients that are disproportionately part of the patient population at many public hospitals.

Current and projected uses of telehealth or virtual medicine include some that will help public hospitals alleviate ER overcrowding, improve access for vulnerable populations, and provide specialty services more equitably across the full range of patients and payers.

One area in which vulnerable patient populations are already benefiting from the more effective use of remote diagnostics and treatments is in monitoring patients in both pre- and post-hospital settings—and not all the findings point to the need for high-tech solutions. One new study by BJC HealthCare and the Washington University School of Medicine’s Healthcare Innovation Lab found that Black and underserved populations would prefer to use the telephone to connect with care providers in a remote patient monitoring (RPM) program. The research team tracked roughly 7,600 participants in an RPM program for COVID-19 treatment. They found that Black enrollees preferred using the telephone over an mHealth app by a margin of 68 to 44 percent, as did those from less disadvantaged neighborhoods vs. those in better-off areas (59 to 43 percent). Researchers found that the availability of a telephone option “appears to have bridged an engagement gap for Black patients...Failure to bridge this gap might have worsened disparities between Black patients and other patients that already exist due to structural injustices (e.g., housing discrimination and limited public transportation) that limit access to primary care, nutritious food, and exercise.”<sup>12</sup>

The American Medical Association (AMA) surveyed physicians on the subject of telehealth and found that “physicians want virtual care to continue as long as key concerns are addressed. Doctors are enthusiastic when a solution helps them better care for patients or reduces administrative burdens.” Four key concerns physicians consistently express when evaluating digital solutions are:<sup>13</sup>

1. Does it work and have an evidence base?
2. Will they receive fair payment?
3. What liability and privacy concerns are there?
4. How will the change be implemented and managed?

12 Eric Wicklund, “[Value Seen in Diverse Digital Engagement Strategy](#),” Healthleaders Media, January 19, 2022.

13 Tanya Albert Henry, “[3 Key Insights to Understand Telehealth’s Value, and Its Future](#),” AMA, January 17, 2022.

The AMA found that improved access is one of telehealth’s major advantages. Technology gave patients greater access to care during COVID-19. It also increased their access to specialists and behavioral health professionals.<sup>14</sup>

While the pandemic required emergency departments to rely on digital technology, a recent commentary in *The New England Journal of Medicine Catalyst* proposed that telemedicine should be extended beyond the realm of the pandemic and become further integrated into emergency medicine.<sup>15</sup> The authors suggested that the COVID-19 pandemic offers “an opportunity to rethink the role of emergency departments and emergency physicians, and to create new care options that remove traditional barriers to effective emergency care” and offered new strategies on how emergency rooms can use telemedicine to their benefit. For example, digital technologies have the capability to evaluate a patient with extremity injuries in a virtual emergency department instead of an in-person emergency room. Digital technology can also schedule outpatient diagnostic testing, allow paramedics to evaluate patients with more serious injuries at home while consulting with a physician by phone or video, support in-person care, and help healthcare providers address health disparities in communities.<sup>16</sup>

Other recent studies reported by the AMA have pointed to a range of other applications for telehealth, virtual health, and remote patient monitoring, including in the areas of allergies, asthma, immunology, ophthalmology, and substance abuse disorder, among others.<sup>17</sup> Related case studies (at both public and private hospitals) include complex care coordination, telepsychiatry, improved hypertension control, and teleneurology and telestroke programs.

There are still barriers to overcome in expanding telehealth and virtual care, including adequate bandwidth in some areas of the country and a way to measure the value of (and appropriately reimburse for) telehealth. The ongoing rollout of high-speed Internet in rural areas, coupled with the potential of 5G cellular technology to transmit higher volumes of data at greater speeds, will further enhance the benefits of telehealth.

14 *Ibid.*

15 Judd E. Hollander and Rahul Sharma, “[The Availablists: Emergency Care without the Emergency Department](#),” *New England Journal of Medicine Catalyst*, December 21, 2021.

16 Naomi Diaz, “[Viewpoint: Telemedicine Will be Vital for Future of Emergency Medicine](#),” *Becker’s Hospital Review*, January 14, 2022.

17 [Return on Health: Moving Beyond Dollars and Cents in Realizing the Value of Virtual Care](#), American Medical Association, May 2021.

### 3. Artificial Intelligence

Related to the recent growth in telehealth and virtual or remote medicine technologies is the increasing sophistication and effectiveness of artificial intelligence (AI) and machine learning (ML). While AI and ML are by no means perfect, and not without controversy, we are constantly gaining a better understanding of the rapidly growing number of things machines can do better than humans.

The benefits of AI are becoming especially clear in medicine and healthcare, where AI and ML are being found to outperform humans in diagnosing many different kinds of diseases and conditions. Board members should keep up to date about the progress and promise of AI and ML. In public hospitals in particular, AI has the potential to improve efficiency, reduce costs, and increase the quality of care provided in crowded emergency rooms and for vulnerable patient populations.

*The New York Times* recently reviewed a new book on AI by an unlikely trio of authors: former Secretary of State Henry Kissinger, former Google CEO Eric Schmidt, and Professor Daniel Huttonlocher, a computer scientist who is the dean of the Schwarzman College of Computing at the Massachusetts Institute of Technology (arguably the only AI expert among the three).<sup>18</sup> The review summarizes the book's premise as "someday all of our least favorite chores, including complex cognitive ones like managing global supply chains, will be outsourced to machines." One of its recurring themes is "that although today's AI systems can be clunky and erratic at times, they are getting better fast, and will soon match or surpass human proficiency in a number of important tasks, solving problems in ways no human would have thought to solve them." At that point, the authors maintain that AI will "transform all realms of human experience."

This perhaps overstates the reality of AI's current status in some areas, and there are some observers in the healthcare community who believe that AI still has a way to go before fulfilling some of the predictions being made.<sup>19</sup> However, there is already considerable evidence of AI's future ability to transform the way doctors diagnose and treat many diseases and conditions.

18 Kevin Roose, "A Robot Wrote This Book Review," *The New York Times*, December 12, 2021. The book in question is called *The Age of AI and Our Human Future*, published by Little, Brown and Company, November 2021.

19 Andis Robeznieks, "Why Talk of AI's Transforming Health Care is Premature," AMA, January 5, 2022.



Take the not-so-simple matter of obtaining an accurate and timely diagnosis of diabetic retinopathy (DR)—an eye disease caused by diabetes that disproportionately afflicts lower income and minority patients. There is substantial scientific evidence that early diagnosis and timely treatment can prevent most visual loss from DR.<sup>20</sup> Traditionally, DR screening has been performed by specially trained graders studying photographs of the eye, often remotely through telemedicine. However, the diagnostic accuracy of this method has been questioned, and obtaining a diagnosis often takes several days. More recently, AI researchers at the University of Iowa and elsewhere have developed deep-learning AI algorithms that are increasingly believed to outperform human screeners, while also cutting the time necessary to obtain a result from several days to several hours (or less). Since the equipment needed in a doctor’s office or public hospital clinic is fairly minimal and inexpensive, “such AI systems have been demonstrated to lower cost, improve diagnostic accuracy, and increase patient access to DR screening.”<sup>21</sup>

Apart from machine-learning diagnostics, AI will have numerous other benefits in the health system of the future. While the recent growth of more traditional information systems, such as increasingly sophisticated electronic medical records (EMRs), has outpaced the utility of AI in the hospital, a recent report found “immense upside” in bringing AI-driven clinical decision support tools to the patient’s bedside.<sup>22</sup> The report found that “organizations have already invested significant time, effort, and money into establishing the EMR, and every moment more potentially actionable clinical and patient data is added. The report suggests that hospitals and health systems need to include clinical AI in their future clinical strategies because it has the potential to:

- Improve patient outcomes
- Maximize the EMR to its full extent
- Augment physician decision making to help reduce burdens
- Increase care equity
- Allow health systems to take on more risk confidently

20 Andrzej Grzybowski, et al., “Artificial Intelligence for Diabetic Retinopathy Screening: A Review,” *Eye*, September 5, 2019.

21 *Ibid.*

22 “5 Reasons Why Every Health System Needs AI At the Bedside in 2022,” *Becker’s Hospital Review* (in collaboration with BAYESIAN HEALTH), September 27, 2021.

## 4. The Wonders of Genetic Medicine

Perhaps the greatest scientific achievement directly attributable to the pandemic was the development of a new family of anti-viral vaccines based on the use of molecules called messenger RNA. The use of this new biomedical technology resulted in the development of new, highly effective vaccines against SARS-CoV-2, the virus that causes COVID-19, in less than one year by multiple companies.

COVID vaccines have now been administered to over a billion people worldwide, but there is still considerable work to do, especially as the virus continues to mutate and lead to successive surges that disproportionately affect the unvaccinated. It is important for public hospital board members to join with their clinical and administrative leadership to educate the public, especially because some of the vulnerable patient populations disproportionately served by public hospitals have proved to be susceptible to fear and misinformation about the vaccines.

One of the arguments made by anti-vaxxers is that the vaccines were developed too rapidly and have not yet been fully tested. While the rapid development of the vaccine has indeed been a remarkable breakthrough, it was dependent on many years of research in various fields. A recent article in *The New York Times* pointed out that the vaccines were possible only because of long-standing efforts in three major areas:

- The discovery of mRNA, the genetic molecule that helps cells make proteins, in the 1950s was the first step, leading to the ability of scientists many years later to use mRNA to direct cells to make tiny pieces of viruses that would strengthen the immune system.<sup>23</sup>
- The second effort led to the development of gene therapy—the modification of genes to treat diseases—by Canadian biotech researchers.
- The third effort involved the federally funded initiative in the 1990s to develop a vaccine against HIV.

While a vaccine against HIV has so far eluded scientists due to the complexity of the virus that causes AIDS, this effort prompted scientists to focus on the spikes on the HIV viruses that allowed them to invade cells. In early 2020, these different strands of research came together. The spike of the COVID virus was encoded in mRNA molecules. Those molecules were wrapped in a protective layer of fat and poured into small glass vials. When the shots went in arms less than a year later recipients cells

23 Gina Kolata and Benjamin Mueller, “Decades of Discoveries Before ‘Miraculous’ Sprint to a Vaccine,” *The New York Times*, January 16, 2022.

responded by producing proteins that resembled the spikes and that trained the body to attack the coronavirus.<sup>24</sup>

The scientists who ultimately developed the vaccine for coronavirus knew that if it proved effective, they could pave the way for other new shots against diseases as varied as the common cold, flu, and cancer, and even against that most elusive virus, HIV. Even with multiple variants, the vaccines have proved remarkably resilient at defending against severe illness and death, and the mRNA technologies should allow companies to adapt the vaccines quickly to protect against new variants.

This is potentially one of many disruptive technologies that are likely to spring from genetic medicine. As futurist Amy Webb said in a recent interview, “At the moment if someone came up with a universal flu vaccine that was mRNA based it would be problematic for a whole bunch of companies that have made their money on the current model. From medical records firms to doctors’ offices to CVS, a whole business ecosystem. Some of synthetic biology will cause future problems for today’s business models. The model will have to adapt just as we will.”<sup>25</sup>

Just how potentially disruptive (and at the same time beneficial) this biological revolution will be has been demonstrated in recent weeks by developments in the field of organ transplantation, and in particular, in the development of successful techniques for transplanting genetically altered organs—such as a kidney or heart—from pigs into humans.<sup>26</sup>

Despite critics of genetic manipulation in a range of areas (including agriculture as well as medicine), the implications of these developments in genomic health and synthetic biology for the patient populations most likely to be served in public hospitals cannot be overstated. Often the result of diabetes or high blood pressure, kidney disease is most common in older adults but it disproportionately effects people of color, women, and those with less education and lower incomes. And more than half a million Americans have end-stage renal disease and depend on dialysis. The most effective treatment for end-stage renal disease is a transplant, but the wait for a kidney transplant can be long. More than 90,000 people were on waiting lists for a kidney as

24 *Ibid.*

25 Stephen Zeitchik, “An Interview with Futurist Amy Webb,” *The Washington Post*, January 16, 2022.

26 Roni Caryn Rabin, “Genetically Engineered Pig Hearts and Kidneys Being Transplanted into Humans,” *The New York Times*, January 21, 2022.

of last summer, but fewer than 25,000 transplants are done in the United States each year. More than a dozen people on the waiting list die each day.<sup>27</sup>

## 5. The Decline of Public Health—and the Need to Fix It in a Hurry

Advances in public health over the last 150 years have arguably contributed more to the health, well-being, productivity, and life expectancy of Americans than any other single factor. Antibiotics, vaccines, clean water, the virtual eradication, at least in our country, of a range of diseases that once were considered scourges, from polio to smallpox to measles—all of these have played as important a role in our health system in the past as the new technologies outlined in this article promise to do in the future.

It is thus all the more disturbing that the pandemic has revealed gaping holes in our public health safety net, not least of which is a substantial erosion of public confidence (bordering for many on outright hostility) towards our public health infrastructure. COVID-19 did not necessarily cause these problems. They have been brewing for some time, through a combination of underfunding, Internet misinformation, and attacks on the system by politicians who cynically question long-proven tenets of scientific fact and seek to feed public fears for purely political gains.

To a certain extent, the frustrating level of fear and confusion in some segments of the public has been made worse by the failure of public health officials to communicate clearly and accurately. The current omicron surge has been said to represent one of the greatest public health challenges not only of the pandemic but also of our lifetime. In a recent column in *The Washington Post*, physicians (and past Presidential advisors) Michael Osterholm and Zeke Emanuel cite a variety of factors contributing to the current crisis.<sup>28</sup> One example they cite is the politicization of masking policies, which flies in the face of scientific information but which has likely been caused in part by inadequate or confusing information about masks. They conclude that “Public health messaging is essential not only on the benefit of masking but also on what constitutes effective masking.”

But inadequate or confusing messaging is only the tip of the public health iceberg. Many aspects of our nation’s public health infrastructure were already sorely damaged, and that has been compounded by the pandemic. Light was cast on these

27 Paige M. Porrett, et al., “First Clinical-Grade Porcine Kidney Xenotransplant Using a Human Decedent Model,” *The American Journal of Transplantation*, January 20, 2022.

28 Michael T. Osterholm and Ezekiel J Emanuel, “The Omicron Surge Could Be the Worst Public Health Challenge of Our Times,” *The Washington Post*, December 30, 2021.

broader issues in a recent editorial written by Megan L. Ranney, M.D., an Emergency Physician and Academic Dean of the Brown University School of Public Health. Dr. Ranney points out that “the pandemic has laid bare the myriad inefficiencies and frank failures in our healthcare system that we had managed to paper over until a real crisis came along. Emergency departments and hospitals have worked on a thin edge for a decade. We have been the last resort for mental health and dental care...We have served as the safety net for a broken system. But with the serial surges of COVID, we simply can’t do it anymore.”<sup>29</sup>

Dr. Ranney does not necessarily believe that all is lost if we do a better job with the tools we have available to “fix and rebuild” our public health system. She cites “straightforward things, like stabilizing the training of more staff across all levels of the healthcare system—from unit assistants to certified nursing assistants to physicians—and providing emotional and financial support for those who have stayed.” She also acknowledges the need for “more complex steps, like setting up a public health emergency response system that is robustly funded, based on accurate data, and resilient” and “making sure that people can access care when and where they need it, and that our testing infrastructure, telehealth system, and home care network are intact.”<sup>30</sup>

The attention of health industry leaders, and particularly public hospital board members, must be paid to these broader issues, including the fact, increasingly acknowledged by many analysts and historians, that we will never likely be rid of the coronavirus and must instead learn to find ways to live with it.<sup>31</sup> And while we adapt to that future reality, we also need to find new ways to train, nurture, and reward our nation’s hospital workforce.

Finally, public hospital board members must also appreciate that in order to improve the U.S. healthcare system, we need to pay attention to the needs of the rest of the world. We must take heed of the warnings of world leaders like Dr. John Nkengason, who said in a recent editorial that “the world must finally learn from past mistakes. This starts by recognizing that alpha, delta, and omicron are not new threats. They are all still the coronavirus. Rather than thrusting our societies into chaos as each

29 Megan L. Ranney, “Omicron Is Making It Impossible to Work in an ER,” *The Washington Post*, January 23, 2022.

30 *Ibid.*

31 Annie Linskey, “Aim to Defeat the Coronavirus Turns to Seeking Way for the Country to Live with It,” *The Washington Post*, January 21, 2022.

new variant emerges, we need to recognize that the virus hasn't been controlled yet and that nations need better strategies to prepare, detect, and respond to future waves...SARS-CoV-2, the coronavirus that causes COVID-19, will continue to change and produce new variants. This is especially true as long as there are large groups of unvaccinated people around the world whom the virus can easily infect and use as hosts to replicate inside and mutate."<sup>32</sup>

It is well-known by now that many among the vaccine-reluctant are members of vulnerable populations served by public hospitals both in the U.S. and around the world. Those include minority groups who are particularly susceptible to misinformation and scare tactics, and/or who do not have a regular, trusted source of medical care apart from hospital emergency departments. Public hospital board members can play a significant role in helping to regain the public's trust in public health.

As Dr. Ranney said in her editorial: "Healthcare in the United States was never perfect, especially for those who live on the margins of society. It increasingly seems that after the pandemic we'll be left with something far worse: scarcity, inaccessibility, compassion fatigue."

And on a worldwide basis, as Dr. Nkengason put it: "To mitigate the impact of future variants, the world needs to establish and strengthen virus monitoring and surveillance systems that can identify emerging variants quickly so that leaders can respond. The world got lucky with omicron. It's unimaginable what would have happened if that highly contagious variant had caused disease as severe as delta has. We may not be so lucky the next time. The world cannot afford to be so unprepared ever again."

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32 John Nkengason, "There Will Be Another Variant," *The New York Times*, January 21, 2022.