Introduction

The "Underperforming" US Health Care System: Revisiting the Conventional Wisdom

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The project that produced this special issue was born several years ago in conversations between Herbert Pardes, former president and CEO of the New York-Presbyterian health care system, and a number of faculty in the Department of Health Policy and Management of Columbia University's Mailman School of Public Health. We were struck by a kind of bipolarity in the world of health policy analysis. On the one hand, we saw scholars who explored in depth the workings of the US health care system and the role of public policy in shaping it, but who (by and large) did not offer up diagnoses, explanations, and prescriptions that lent themselves to expression in the proverbial twenty-five words or less that policy makers often demand. On the other hand, we witnessed the rise and growth of a "popular" version of health policy analysis that presented policy makers with a highly accessible critical conventional wisdom.

This conventional wisdom lays at the door of American medicine and the US health care system as a whole a multitude of sins: devotion to high-tech cures instead of low-cost, but highly effective, interventions to prevent disease and promote the health of the public; blanketing the nation with specialists, not the primary care physicians it is said we "really" need; stubborn indifference to the persistence of variations in practice that defy the precepts of evidence-based medicine and encourage waste of perhaps 30 percent of society's health care dollars; charging prices and extracting profits that can only be called exorbitant; and producing inferior value for the money it spends, as demonstrated by the nation's lamentably low international standing on indicators such as infant mortality. One famous

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indictment along these lines is the Commonwealth Fund's Mirror, Mirror on the Wall report series, which since 2004 has invited the nation to behold the many dimensions of low performance that deform the US system in comparison to many of its Western peers.

Although this critique is not without force, we found it simplistic, that is, lacking in the nuanced analysis that is essential for sound deliberations on public policy. For one thing, the critique usually fails to adequately acknowledge that "the" system in question is in fact a set of intermingling and multifaceted *systems*:

- the medical system—the activities of health care providers, notably, hospitals, physicians, nurses, and other components of the clinical workforce;
- the health care system, which includes but goes beyond clinical elements to include efforts to prevent disease and promote health, especially, but not only, by means of public health interventions;
- the coverage system, which encompasses the private, public, and voluntary institutions that supply—or fail to supply—insurance for medical and health care services for the population; and
- the social system, incorporating the social determinants and social policies and services that address—or fail to address—income support, affordable housing, work opportunities and conditions, social isolation/integration, stress, and more, all of which have been found to shape health outcomes both independently and through the mediation of the medical, health care, and coverage systems.

Moreover, our own research and our interpretations of the literature(s) of health policy persuaded us that the conventional critique generally failed to do justice to the rich complexities that beset efforts to diagnose "the" sources of the system's various problems, to make explanatory sense of the forces in play, and to present policy makers with recommendations that are likely to advance the goals they profess.

Intrigued by what we took to be a foggy mirror, we decided to confront the polar spheres—the popular and professional versions of policy analysis, as it were—one with the other by taking up individual elements of the critique and investigating in each case when and why evidence tends to sustain or challenge the conventional wisdom. We settled on topics, identified researchers within and outside Columbia, wrote drafts, and with the encouragement and support of Herb Pardes and Eric Patashnik (editor of the *Journal of Health Politics, Policy and Law*) presented our works in progress at a conference at Columbia University in June 2017. Aided

by the comments of discussants and of the audience at the conference, we returned to the drawing board and produced the articles in this special issue.

Glied and Sacarny

The issue begins by examining the familiar allegation that the US health care system is replete with waste. Proposing a precise and unpolemical anchor for the discussion, Sherry Glied and Adam Sacarny use the notion of "productive (in)efficiency" to paint a nuanced picture. Some oft-cited instances of waste—obesity, for example—cannot be plausibly ascribed to systemic inefficiency. Moreover, efficiency is highly context dependent, with variable meanings and manifestations across different types of markets and industries, some of which exhibit inefficiencies comparable in scope to those in the health sector. A long list of highly touted efficiency-enhancing strategies—competition, cost sharing, managed care organizations, accountable care organizations (ACOs), payment for performance, electronic medical records, assaults on administrative spending, and care coordination, for instance—turn out to be (a) of relatively small impact, (b) more promising in some of their strategic iterations than in others, and/or (c) too new to the scene to permit much lesson drawing. The case is no less complex for practice variations, supposedly exhibit A in the critique of systemic waste. The extent and importance of variations grow cloudy when they are explored in populations beyond Medicare beneficiaries, when one considers demand-side factors as well as more widely noticed supply-side pressures, and when one seeks to identify their causes within and across regions. Glied and Sacarny conclude that inefficiencies are real (albeit less alarming than the conventional wisdom suggests) but that many derive from factors outside the health care system and that those for which the system is in some reasonable sense accountable are often conceptually and politically resistant to repair. Reformers should recognize that improved efficiencies do not lend themselves to flashy, fast-acting silver bullets and that progress is most likely to come from an incremental combining of the beneficial effects of a range of approaches—none of which, however, comes without side effects.

Gross and Laugesen

While much debate about costs in the US health care system focuses on inefficiencies and variations on the delivery side, another school of thought insists that the real culprit is the prices ("it's the prices, stupid"). Tal Gross

and Miriam J. Laugesen, noting that the United States spends much more than its cross-national peers on health care despite a volume of general medical services that seldom exceeds the level of other nations, seek to explain why US prices are so high. Although price comparisons among nations are not straightforward, sound evidence allows assessment of the contributions of several familiar explanations that are prominent in the conventional wisdom. These include greater inequality in incomes in the United States (and therefore the need to pay top dollar to attract the best and brightest into medicine), the cost of medical education (which tends to be heavily subsidized elsewhere), the insistence of US consumers on higher quality and choice among providers (you supposedly get what you pay for), the need to offset the burden of malpractice costs, and pervasive fragmentation among providers and payers. None of these factors turns out to hold much explanatory power. Another variable—high administrative costs throughout the system—is more persuasive, but it too leaves much of the puzzle unsolved. The most potent force, they argue, is rent seeking—successful lobbying by physicians, hospitals, and drug companies to keep their incomes and revenues high—and at this point prices are seen to be a problem not only of economics but also of political economy. Political power much constrains the cost-depressing effects of widely advertised solutions, such as price transparency, all-payer rate setting, managed care, and ACOs. Like Glied and Sarcany, Gross and Laugesen caution that no quick fixes are at hand. Alas, approaches to the price problem that are politically feasible seem invariably to be toothless.

Brown

Academic medical centers (AMCs) hold a special opprobrium in the conventional wisdom because they are said to embody and enable the least defensible features of the US health care system—the obsession with specialization and technology at the expense of primary care and public health, for example, and a reluctance to meet the needs of the poor and poorly (or un)insured. The citizens of other nations look to government to address these needs, but in the United States both the system and the leadership that supposedly steers it are fragmented, so some reformers look to the AMCs by default, as it were, to articulate and exemplify policies and practices that truly advance the health of the population. Viewing AMCs from an organizational perspective, Lawrence D. Brown challenges this yearning, which he sees as an instance of (to borrow terms from Alfred North Whitehead) "the fallacy of misplaced concreteness," meaning in

this case the assignment of responsibility for solving large issues of public policy to a specific institutional type that is ill-suited to tackle them. AMCs are formal organizations with an extraordinary structural complexity that attain coherence because their components unite around a core mission, centered on scientific and technical innovation, that has long drawn enthusiastic support from their social and political environment. Today, however, changing expectations within that environment spur AMCs toward market-oriented innovations that threaten the displacement of their voluntarist, not-for-profit character with a commercial ethos, pulling them into unfamiliar and uncomfortable precincts. These pressures are aggravated, meanwhile, by demands that AMCs shoulder a long list of reform priorities. The nation has no lack of policy tools with which to tilt toward primary care, public health, and broader and more uniform health care coverage. What it lacks is the political will to deploy these tools, and this the AMCs cannot reasonably be expected to supply.

Sparer and Beaussier

Conventional wisdom has it that the US health care system favors the acute-care sector over public health, notwithstanding the power of the latter to save lives "millions at a time." By exploring the evolution of public health in the United States, England, and France, Michael S. Sparer and Anne-Laure Beaussier identify inhibiting and enabling forces less different than one expects among these highly distinct settings. Disputes over the proper role of government in medical matters and about the level of government at which public health duties are best placed arise and persist in all three nations. Since the eighteenth century, outbreaks of contagious diseases such as yellow fever and cholera and worries about poor sanitation and hygiene, especially among the poor in rapidly growing cities, brought public health to the fore, only to see it lose priority once the crises were contained. Advocates of social medicine and other persuasions friendly to public health worked to reanimate interest, but with the spread of health insurance on one hand and the acceleration of technological innovation on the other—both of which elevated access to acute care on the agendas of policy makers—public health continually struggled for visibility and prominence. Beginning in the late 1980s, however, a series of insights—on the importance of public health in changing personal patterns of smoking, diet, exercise, and drug abuse; on the role of social determinants in shaping health outcomes; on the challenges of population health management for

health care providers and payers that aspire to integration; on the need for eternal vigilance against new contagions (for instance, from the contaminated blood supply that roiled French policy in the 1990s); and, not least, the gap between the potential and the capacities of public health institutions, revealed in all three countries by a stream of well-publicized reports by prestigious authors—strengthened the hands of policy entrepreneurs who, amid organizational disruptions and budgetary austerity, work toward progress in the public health sector that is more than merely symbolic. In this comparative light, the United States emerges not as a conspicuous public health laggard but, rather, as the site of some surprising virtues.

Laugesen

The conventional wisdom often attributes the high costs and weak performance of the US health care system to its obsession with highly specialized, intensely technological services and a consequent lack of commitment to primary care. This pattern supposedly contrasts unfavorably with policies in other nations that get their generalist/specialist ratios "right." Dissecting the elements of the argument, Miriam J. Laugesen challenges this ubiquitous critique. Much depends on the definition of *primary care* and thus on how practitioners are counted—matters on which authoritative sources in Europe and the United States differ. The Organisation for Economic Co-operation and Development uses a fairly narrow definition of generalist physicians, whereas the Association of American Medical Colleges counts as generalists physicians who practice family medicine, general medicine, pediatrics, and internal medicine. This computation markedly decreases the proportion of specialists and raises that of generalists in the US system. Moreover, the distribution of office visits by type of physician in the United States discloses that even in "the allegedly hyperspecialized twenty-first-century US health care system, primary care physicians remain the port of first call more than half the time." These findings throw a fresh perspective on the nation's long and frustrating debate on the urgent need to expand the ranks of primary care physicians. Given uncertainties about how primary care capacity should be defined, about whether the United States faces a shortage or a surplus of physicians overall, and about how medical education should be funded, perhaps policy should focus less on generalist/specialist ratios and quixotic quests to train more primary care physicians and more on enlarging the roles and capacities of nurses, nurse practitioners, and other allied personnel.

Muennig, Reynolds, Jiao, and Pabayo

The conventional wisdom is not only about the failings of the US health care system with respect to waste, prices, primary care, and the like but also, and very importantly, about health outcomes, and on this count Peter Muennig, Megan M. Reynolds, Boshen Jiao, and Roman Pabayo examine the disappointing international standing of the United States on infant mortality. To be sure, the nation has made substantial progress in reducing such deaths, but the pace of this reduction continues to fall below that of many of its Western peers. As usual, definitions—what is counted as an *infant death*—explain part of the discrepancy, but the search for an adequate account covers a long and winding road of considerations. Insurance status and thus exposure to the cost of care play a role, as does access to sophisticated sources of care, more common in urban than in rural areas. Other forces in play include financial hardship and racism; declining social mobility; growing psychosocial stress (which may offset more favorable trends, such as increasing maternal age, lower rates of teen pregnancies, and reduced smoking among pregnant women), which increases the risk of adverse birth outcomes; "social malaise" among women of reproductive age, manifesting in descending rates of self-reported happiness and trust in others; and, not least important, the relative weakness of US social policy protections in areas such as education, income support, and affordable housing. In short, the causes of the nation's shortfalls in the reduction of infant mortality are multiple, in need of further research, and, on the whole, more social than medical in nature.

Conclusions

Although these articles cover wide intellectual territory, several conclusions would seem to emerge from them:

- —"The" US health care system is not a unified entity but, rather, a mélange of systems—medical delivery, health care services that transcend the clinical realm, coverage, and social policy.
- —These systems overlap, interlock, and codepend, which thwarts efforts to quantify their assumedly independent respective contributions to outcomes and argues for caution in apportioning causal blame to and among them.
- —Blanket judgments about "the" performance of "the" system generally invite precisely the *yes, but* response these dicta purport to foreclose. For example, yes, performance might improve if the system had

more primary care physicians and fewer specialists but ceteris paribus does not apply here, and if one factors in coverage patterns, social determinants, public health interventions, and individual behavior, the cause/correlation picture clouds up.

—On almost every count in the conventional indictment, the case for low performance in the United States turns out to be more complex, less convincing, and less convicting than prima facie inspection—and energetic polemics—suggest.

—If the United States wants to attain health outcomes more in line with Western norms, it is unlikely that reforms in the medical delivery system (more primary care physicians, more payment for performance, more electronic health records, more ACOs, more integration, more guidelines, and so on) will do the job. A better health care system probably requires universal coverage—not merely arrangements that encourage people to buy cheap and undependable insurance or to get some sort of care even if they lack coverage, but equitable and more or less uniform coverage for all. It would also seem to demand more robust social services, broader-gauged public policies that address the social determinants of health, and implementation of acceptable public health interventions that promote healthier personal behavior.

—Those who seriously seek health care costs that approach those in Europe should rethink the nation's dogmatic faith in market forces and recognize the need for regulations that are not pop-up panaceas but, rather, system-wide rules of the health policy game.

Meanwhile, policy analysts who have cultivated the low performance critique as a strategy intended to blame and shame the nation into reform might elevate their own performance by pondering more carefully the distinction between analysis and advocacy, between expertise and entrepreneurship, and the risks that attend a protracted blurring of lines.