Commentary on Muennig, Reynolds, Jiao, and Pabayo

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In the popular media, and occasionally in academic journals, the high rate of infant mortality in the United States is compared with rates in other wealthy countries as evidence of poor US health care system performance. How can a country that spends more than any other in the world have a high rate of infant mortality? But is this a reasonable use of this measure of health system performance? Access to prenatal care may encourage expectant mothers to improve health behaviors and, by managing maternal health problems, may reduce infant mortality and improve outcomes. Similarly, appropriately staffed neonatal intensive care units for infants born with a serious health condition may help reduce rates of infant mortality. Studies have found that understaffing in neonatal intensive care units is associated with poorer health outcomes for low-weight infants (Rogowski et al. 2013).

Yet those who emphasize the economic and social determinants of health argue that infant mortality is an important indicator of social well-being but has little to do with health services (Wilkinson, Kawachi, and Kennedy 1998). The careful analysis of changes in infant mortality in the United States, which includes both international and state-level comparisons by Peter Muennig, Megan M. Reynolds, Boshen Jiao, and Roman Pabayo lends support to the latter perspective while recognizing the complex array of factors that contribute to this outcome. They also offer a creative explanation for why problems with the US health care financing system may contribute indirectly to the country's poor performance on this measure.

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Muennig, Reynolds, Jiao, and Pabayo argue that not only is material hardship a major factor contributing to infant mortality, but limited investment in the social safety net in the United States compared with other wealthy nations exacerbates "the risks among high-risk women in the United States relative to other nations." Furthermore, they argue that the high cost of medical care faced by many American families erodes disposable income, contributing to psychological stress and material hardship, which contribute to infant mortality. These findings highlight the importance of disaggregating results below the national level because there are significant differences in poverty and levels of social support within countries.

These observations are consistent with comparisons of infant mortality among and within world cities. Although New York City has experienced a remarkable decline in infant mortality in recent decades, the incidence of infant mortality is significantly higher in the poorest neighborhoods of the city. The relationship between neighborhood income and infant mortality in New York City does not exist in cities in other countries that have more generous social welfare programs and redistribute more wealth to the poor through the tax system compared with the United States (Rodwin and Neuberg 2004).

Although the review by Muennig, Reynolds, Jiao, and Pabayo generates a host of plausible hypotheses about high rates of infant mortality in the United States compared with other nations, many questions remain. Their analysis is limited by a lack of information about relevant factors. There are insufficient data available to evaluate the performance of health systems, particularly if we hope to identify the contributions of neighborhood characteristics to health (Gusmano and Rodwin 2016). The lack of data at the local level is problematic because local physical and social environments are likely to have a profound influence on health, including infant mortality. Without better information of this sort, policy makers are operating in the dark.

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