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Perspective

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FUNDAMENTALS OF U.S. HEALTH POLICY

Health Care as an Ongoing Policy Project

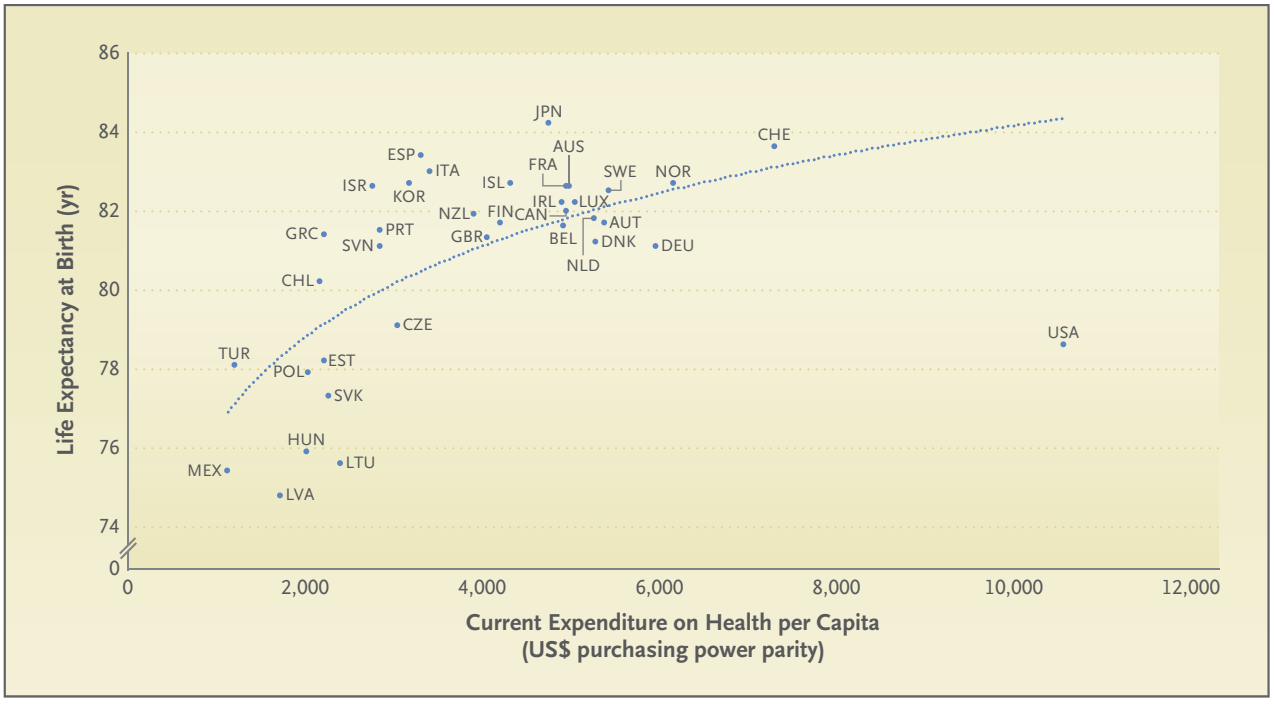
Eric C. Schneider, M.D.

An elderly woman with hypertension, diabetes, and obesity has been living independently. Over the past week, she has developed a new cough and shortness of breath on exertion. She wonders whether to call her doctor's office for advice but decides to wait and try home remedies recommended by friends. A week later she is too short of breath to get out of bed, and she calls 911.

To many Americans, U.S. health care evokes Winston Churchill's description of Cold War Russia: "a riddle, wrapped in a mystery, inside an enigma."[1] U.S. health care is a wellspring of medical scientific innovation. It offers top-flight medical training. Many of its hospitals offer the most advanced medical and surgical care for dire, acute, rare, and once-lethal conditions. Its best medical centers are the envy of other countries. And the United States spends more per person on health care than any other country.

Yet all is not well in U.S. health care. Despite these assets, the United States lags behind other high-income countries on health outcomes such as life expectancy, childhood health, and avoidable deaths. For too many Americans, the quality of care is not optimal. Access to basic care is out of reach for many. The costs of care, escalating for decades, are increasingly intolerable to those who pay the bills, whether governments, employers, or individuals. American health care is also inequitable, with gaps in insurance benefits and quality of care consigning people of color, people living in poverty, residents of rural areas, immigrants, and LGBTQ people to worse care than others. Many gaps widened even while the nation was prospering. The Covid-19 pandemic is bringing these and other weaknesses of U.S. health care into stark relief. Americans have struggled for over a century to solve this riddle and bring about a high-performing, affordable health care system. Some progress has occurred, but many Americans believe that additional reforms are needed.

Comparing the United States with other countries can shed light on both challenges and opportunities for improvement. All countries seek to optimize the population's health at a cost that people and their nations can afford. Measuring and comparing the health outcomes achieved offers a useful starting point for evaluating how delivery-system performance influences health. To produce better health outcomes, the key areas of performance include the structures that support care (the workforce and organizations that deliver care, and payment systems); the processes used to deliver safe, effective, patient-



Life Expectancy at Birth and Health Spending per Capita, 2019.

Data are from Organisation for Economic Co-operation and Development Health Statistics 2019.

centered care; and whether people have timely access to that care. Crucially, care should be delivered equitably.

The health of populations and the portion of the gross domestic product (GDP) spent on health care vary dramatically among countries (see graph). Wealth explains much of the variation, but even among high-income countries, patterns of health, health care use, and spending vary. Cultural differences matter. Countries embrace various values in determining whether health care is a right, the minimum level of care that everyone must receive, how much variation in outcomes or access to accept, and who will shoulder the costs. Different populations may have different views about the role government should play as a regulator, payer, and operator of health care facilities. They also differ on the role of taxes and other financing mechanisms that pay for care.

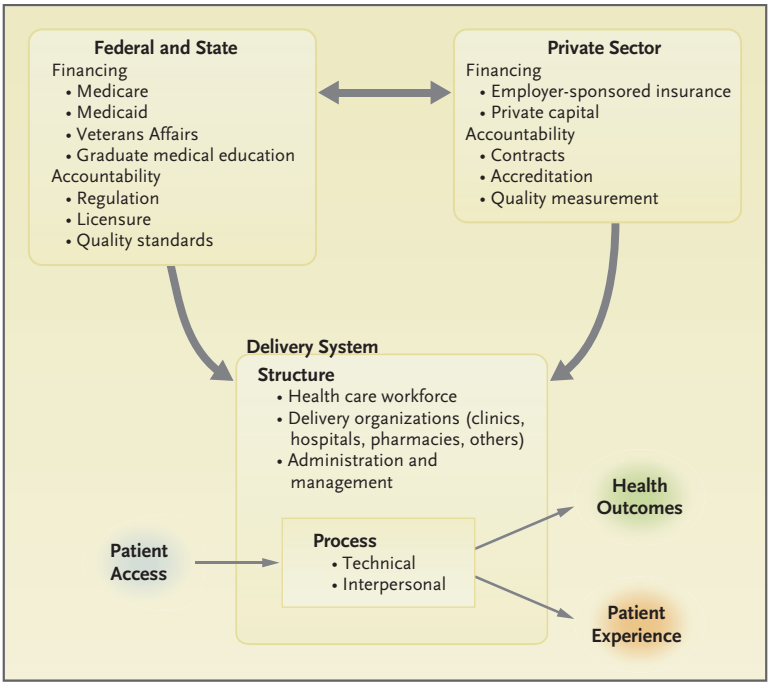
Overall, the quality of care is worse in the United States than in several other high-income countries, and Americans' health status and outcomes are worse than those of their counterparts in those countries.[2] Much of the difference is due to social factors outside the health care system. As compared with other countries, the United States spends less and more unevenly on social supports such as child care, housing support, nutrition, transportation, parental leave, unemployment, and other social safety-net programs.[3] As a result, Americans have higher rates of obesity, chronic diseases leading to preventable illnesses, complications, and deaths. U.S. life-expectancy trends have lagged behind those of other countries, and even recently fell for 3 consecutive years amid an increase in deaths due to alcohol, opioids and other drugs, and suicides. Many preventable conditions go untreated as persons such as the elderly woman described above delay seeking care. On average, U.S. maternal and infant mortality rates are higher than those in many other countries.

For a population facing such formidable health challenges, access to care is a key problem. The United States lacks the universal insurance coverage available elsewhere. Public insurance programs cover the elderly, disabled, and poor, but publicly insured patients struggle to find clinicians, particularly specialists, willing to accept them because the government pays lower rates than commercial insurance. As the current pandemic illustrates, the tie between employment and private health insurance means that millions of Americans can lose

coverage during periods of economic recession and growing unemployment. Out-of-pocket costs have been rising, too, as high copayments and deductibles — designed to make consumers more cost-conscious — have proliferated. Many Americans fear unexpected medical bills and debt.

Americans face pervasive disparities in care based on gender, race, ethnicity, income, educational attainment, language, and neighborhood.[4] Disparities have been documented on most available measures, including access to care in general and to specialty and surgical care in particular, screening rates, diagnosis, treatment, and chronic disease management. Biases are reflected in structural features of the system, including the lower payments, resources, and capital available to clinicians and hospitals serving marginalized communities. They are also revealed in biased decisions about diagnosis and treatment and in too many failures to provide patient-centered, culturally competent care.

Despite the gaps in quality, access, and equity, the United States is on track to spend more than $4 trillion on health care in 2020 — nearly one fifth of all economic activity, as assessed as a proportion of GDP. We spend nearly twice as much as other high-income countries, largely because we pay higher prices for services, medications, and devices.[5] Health care spending may create a drag on the nation's economic power and global competitiveness. And it dampens other investments the country could make to improve the quality of life, siphoning away potential investments in education, housing, transportation, and economic development that may be more powerful determinants of population health.



Simple Schematic of the U.S. Health Care System.

Spending is one metric for comparing the "cost" of health care across countries, but the costs of administrative complexity or red tape may also undermine the system. U.S. patients and clinicians spend too much time tracking insurance coverage, dealing with billing and payments, and responding to bureaucratic requirements. As accountability systems have proliferated to motivate improvement and contain cost growth, they have layered increasing complexity and labor costs onto care delivery.

All countries have at their disposal similar policy levers for improving health care performance (see diagram). Government has a crucial role, even in systems dominated by private-sector insurers, delivery organizations, and professionals. Governments license and regulate, set quality and safety standards, and either operate public delivery systems or pay private organizations directly or through insurance programs. Some amount of government subsidy is inevitable to ensure access to care for people who cannot afford it. Governments may use their purchasing leverage to negotiate prices and payments. And they have a key role in preparedness to respond to disasters like the current pandemic.

Private-sector organizations also hold many major levers of health policy, especially in the United States. Private enterprise and competitive markets capitalize and manage large parts of the system, drive innovation in diagnostics and therapeutics, and create insurance products that cover benefits and services. Functioning private markets can reduce costs and innovate in ways that broaden service availability. But

private markets may not restrain costs in health care as they do in other sectors. Patients frequently rely on professionals to decide what services are needed, and costs may not be a consideration for either patients or professionals. As the Covid-19 pandemic painfully reveals, in health care, markets can fail to allocate resources to meet health needs, preserve the quality of care, and achieve desired levels of access and equity.

In most high-income countries, governments fill the gaps where markets fail. For example, the United States provides insurance to elderly and disabled people (through Medicare) and poor people (through Medicaid) who could not afford it otherwise. But rather than operate facilities (as the government does for military veterans), the U.S. federal and state governments generally use purchasing and information-transparency strategies to try to foster competitive health care markets. Governments may also serve as a backstop, providing the dollars that keep private hospitals and professionals in operation during disasters (such as hurricanes or pandemics) or covering extreme costs for very sick patients through reinsurance to keep premiums from skyrocketing.

An audio interview with Dr. Schneider is available at NEJM.org

Americans are increasingly concerned about health care. Polls show that they are especially dissatisfied with the costs they face personally. Many Americans have begun to view high-quality health care as an opportunity available only to some people, a financial burden for many, and an unsafe and financially ruinous ordeal for others. But a health care system is not immutable. It can be changed through policies. In future articles in this series, experts will further describe the problems with quality, equity, and cost; explore solutions; and reflect on the policy levers that can help bring about reforms.

The Covid-19 pandemic reminds us that the dedicated health professionals delivering care every day are the indispensable part of any health system. Without their motivation and dedication, access to high-quality, equitable care would not be an option. But sound health policies are also indispensable. They shape the delivery system, strongly influencing whether someone like the elderly woman with chronic health problems and new and worrisome symptoms decides to suffer at home, delaying until it is too late, or seeks care when it can be most effective. And health policies set the terms under which health professionals can provide high-quality care that achieves her health goals at a price that she and society can afford.

Disclosure forms provided by the author are available at NEJM.org.

From the Commonwealth Fund, New York.

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Covid's Color Line — Infectious Disease, Inequity, and Racial Justice

Michele K. Evans, M.D.

The disproportionate effects of the Covid-19 pandemic on African Americans, Latinx Americans, and Native Americans is not unforeseen. Inequities in health, health care access, and quality of care are ingrained in the U.S. health care system. These inequities are not a sign of a broken system: in fact, in this sense, the system is operating just as it was built to operate. It promulgates poor health outcomes for Black and Brown people as an ineffable legacy of slavery. In New York City and other major metropolitan areas, Black and Latinx people have substantially higher Covid-19