United States' Health Care System In International Context

The United States’ health care system falls far behind those of comparable countries, despite the country’s monumental financial investments in this sector (Institute of Medicine [IOM] & National Research Council [NRC], 2013; Schneider, Sarnak, Squires, Shah, & Doty, 2017). Although the United States invests more money in health care than any other country, Americans have higher mortality and higher morbidity of most conditions than comparable developed countries (IOM & NRC, 2013). Furthermore, the United States has not kept pace with the advances made in other countries, increasing the gaps between the United States and their peer countries (IOM & NRC, 2013). In the evaluation of health care systems, Aday (2004) asserts that effectiveness, efficiency, and equity are broad criteria for assessing the success of health services and policy goals. Effectiveness is defined as the ability of a health care system to achieve its relevant outcomes, while efficiency in a health care system is maximized when the ratio of outputs to inputs is maximized (Aday, 2004). Meanwhile, equity is determined by the absence of unfair or avoidable differences among groups of people (World Health Organization [WHO], 2018). Depending on the context, these three aspects of a health care system may be complementary or may be in conflict (Aday, 2004). Moreover, the context within which the health care system is evaluated can influence which of these – effectiveness, efficiency, or equity – is most important. However, the United States does not perform well on any of these criteria, as shown by Schneider et al. (2017). Of the 11 countries evaluated in their report, the United States ranks 10th on administrative efficiency, 11th in equity, and 11th on health care outcomes, a measure of effectiveness (Schneider et al. 2017). A multitude of factors influence the health of a country, including not only clinical care and access to health insurance, but also social determinants of health such as education, safe housing, transportation, and social structure (IOM, 2011). According to the County Health Rankings model, clinical care accounts

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the health of a country, including not only clinical care and access to health insurance, but also social determinants of health such as education, safe housing, transportation, and social structure (IOM, 2011). According to the County Health Rankings model, clinical care accounts for only 20% of health outcomes, while social and economic factors, the physical environment, and health behaviors account for a combined 80% (Remington, Catlin, & Gennuso, 2015). Ultimately, the United States has failed to address these social determinants and a wide variety of individual health behaviors, resulting in poor outcomes despite the country's exorbitant financial investments.

The effectiveness, efficiency, and equity of a health care system provide basic measures by which to evaluate these systems (Aday, 2004). The relationships between these three aspects are highly nuanced and complex, and the relationships vary depending on context (Aday, 2004; Sassi, Le Grand, & Archard, 2001). For example, in developed countries, such as the eleven countries evaluated in The Commonwealth Fund's report Mirror, Mirror 2017, effectiveness is the most important aspect of the health care system (Aday, 2004; Schneider et al. 2017). Developed countries such as the United States have the means to invest large amounts of money in healthcare, and thus are able to sacrifice efficiency in favor of both effectiveness and equity (Aday, 2004; James, Carrin, Savedoff, & Hanvoravongchai, 2005). However, in developing countries, efficiency is much more important, as these countries must provide health care with more limited resources (Aday, 2004; James et al., 2005). Furthermore, it is possible to define many outputs of a health care system and the measure of efficiency may change dramatically depending on which outcome is deemed most relevant (Reidpath, Olafsdottir, Pokhrel, & Allotey, 2012). Although the health economics literature references the equity-efficiency tradeoff, the concept, taken from market economics, may not directly apply to the health care system (James et al., 2005; Reidpath et al., 2012). Reidpath et al. (2012) assert that because efficiency is not an outcome of the health care system and is rather the relationship between the inputs and the outcomes of the health care system, it does not make sense to evaluate its tradeoff with equity. A more meaningful comparison is the tradeoff between a health system's health gains and health equity (Reidpath et al., 2012; WHO, 2000) Regardless, based on the cross-national evidence presented by Schneider et al. (2017), there is a positive association between equity and administrative efficiency for the eleven countries compared. Effectiveness is also positively associated with both efficiency and equity, although not as strongly (Schneider et al., 2017). The United States' health care system performs poorly in all three of these measures (Schneider et al., 2017).

While the United States' health care system does not compare favorably with other developed countries on broad measures, it does exhibit some strengths, and it has made some progress following the passing of the Affordable Care Act in 2010. The United States has a highly-skilled, well-trained health care workforce, and has highly developed hospital and clinic systems (Rice et al., 2013). Furthermore, the United States has invested time and money into research and has made dramatic advances in health care technology (Rice et al., 2013). The United States' health care system also ranked well on measures examining the doctor-patient relationship (Schneider et al., 2017). Following the adoption of the Affordable Care Act (ACA) in 2010, the United States has made progress regarding access to care and health insurance availability, with the number of people gaining coverage estimated between 7.0 million and 16.4 million (Blumenthal, Abrams, & Nuzum, 2015). However, Americans still experience some of the worst health outcomes in the developed world, despite the great investments the country has made (IOM & NRC, 2013). The United States has comparably higher death rates due to injuries, transportation-related accidents, and violence than other developed countries and "compared

with other nations in the WHO's mortality database, in the United States 15-year-old girls rank 38th and 15-year-old boys rank 34th in their likelihood of reaching age 60" (Jenkins & Runyan, 2005, p. 291; IOM & NRC, 2013). Additionally, the United States had the 31st highest infant mortality rate in the Organization for Economic Cooperation and Development (OECD) from 2005 to 2009 (IOM & NRC, 2013). In addition to these comparatively high mortality rates, in 2008, the United States had the highest prevalence of diabetes and obesity among the seventeen peer countries in the OECD (IOM & NRC, 2013). Furthermore, many of these disadvantages are growing, as the United States is improving health outcomes at a slower pace than other developed countries (IOM & NRC, 2013). Beyond individual outcomes, the United States' healthcare system ranks last in health care system performance among the eleven countries examined in Mirror, Mirror 2017 (Schneider et al., 2017). In this report, it was shown that the United States ranks poorly on measures of coordination, avoidable hospital admissions, access, affordability, timeliness, administrative efficiency, health care outcomes, and equity (Schneider et al., 2017). While the United States clearly cannot compete with other developed countries on many measures of health, these disparities are not ameliorated by controlling for income, race, ethnicity, or gender (IOM & NRC, 2013). In fact, these disparities persist even among the United States' socioeconomically advantaged, non-Hispanic white population when compared to peers in England (IOM & NRC, 2013; Woolf & Purnell, 2016).

There have been many theories raised regarding the source of the United States' health outcomes disadvantage in comparison with other developed countries (IOM & NRC, 2013). Researchers have pointed to failings within the health system itself as responsible for poorer health outcomes in the United States (IOM & NRC, 2013). For example, the United States health care system does not perform well on measures of access to care, and even when patients are able to access health care, which has been greatly improved following the passing of the ACA, they tend not to receive optimal quality of care (Blumenthal et al., 2015; IOM & NRC, 2013). Additionally, the United States does not have a centralized health care system, leading to comparably lower administrative efficiency, lack of coordination, delays in care, and even medical errors (IOM & NRC, 2013; Schneider et al., 2017). The United States also has a lower provider density and a lower proportion of primary care providers when compared with OECD peer countries (IOM & NRC, 2013). In addition, both patients and physicians within the United States' health system are more likely to report being dissatisfied with the health system and to be in favor of major reforms than peers in comparable countries (IOM & NRC, 2013).

However, as Lumpkin and Quinn (2018) point out, people spend an extremely small proportion of their time in a doctor's office or hospital each year, and therefore, health outcomes must be influenced by factors outside the realm of these health care settings. As an example, in models such as the Robert Wood Johnson Foundation's County Health Rankings and Roadmaps model, clinical care is only estimated to contribute 20% toward health outcomes, overshadowed by social and economic factors (40%) and health behaviors (30%) (Remington et al., 2015). The United States has in fact demonstrated a higher than average prevalence of many individual behaviors that negatively impact health, including high caloric intake, low physical activity levels, drug misuse, use of firearms, unsafe driving practices, and high-risk sexual practices (IOM & NRC, 2013). Furthermore, social determinants and individual behaviors are largely shaped by public policy, which can influence spheres from education to the built environment (Woolf & Purnell, 2016). For example, traditional land use and development patterns in the United States have contributed to the lack of walkability of many neighborhoods in the United States and a higher reliance on automobiles for transportation (IOM & NRC, 2013). This contributes to the culture of automobile use, leading to increased transportation-related accidents, higher

environmental pollution, and decreased physical activity (IOM & NRC, 2013). Likewise, access to quality education has been shown to be one of the most influential social determinants of health, as it leads to opportunities for better employment, higher income, and upward mobility (Woolf & Purnell, 2016). However, the United States no longer has a competitive education system, compounded by the fact that not all Americans have access to the same standards of education, which can at least in part be attributed to historical segregation policies (Carr & Kutty, 2008). Additionally, the United States has a higher degree of income inequality and spends less on social programs (excluding health spending) than comparably wealthy countries (Kamal, Cox, & Kaiser Family Foundation, 2016). In 2016, of the national health expenditure of 3.3 trillion dollars, only 4.7 percent was spent on public health programs (Hartman, Martin, Espinosa, Catlin, & The National Health Expenditure Accounts Team, 2018). Moreover, although the ACA designated an additional 15 billion dollars to be spent on public health, subsequent laws and federal spending cuts have reduced that amount dramatically (Himmelstein & Woolhandler, 2016). The United States has also demonstrated a widening disparity between health outcomes by socioeconomic status, education, and income over time, indicating that these gradients are worsening (Woolf & Purnell, 2016).

Addressing these social determinants of health must be a crucial function of the health care system at multiple levels. The American College of Physicians (ACP) recommends that education regarding social determinants and their impact on individual health be included in medical education at all levels (Daniel, Bornstein, & Kane, 2018). Incorporating this issue into medical education will raise awareness for clinicians regarding their role in improving health care at both the individual and the community levels. For example, clinicians will be better able to care for patients within the context of their socioeconomic realities, understanding that social determinants influence the patient's ability to understand and follow through with treatment plans, adopt healthy behaviors, and avoid or minimize unhealthy behaviors (Woolf & Purnell, 2016). Clinicians and health professional organizations can also advocate at both the community and national level for programs and policies that will improve these social determinants and alleviate disparities between subgroups of the population (Woolf & Purnell, 2016). Although the health care system has great power to impact the nation's health in comparison with that of other countries, perhaps more important is the opportunity for the health sector to work with other sectors to create long-lasting improvements. In order to increase their current capacity for addressing the social determinants of health, the health care system must foster and create a culture of working collaboratively with multiple sectors, including legislation, businesses, education, marketing, and law enforcement, to make widespread policy changes (Daniel et al., 2018). In creating this culture, the ACP recommends moving toward a "Health in All Policies" approach, in which policymakers collaborate with multiple sectors to incorporate health considerations in their policies and practices (Daniel et al., 2018). With this cross-sectoral support, the health care system will be far more likely to make long-lasting, widespread, meaningful change in the social determinants of health and ultimately to impact the disparities observed between the United States and comparable countries.

The United States has a long way to go to bridge the health outcome gaps observed between Americans and peers in comparable countries (IOM & NRC, 2013). Although public health and the health care system traditionally are expected to address these gaps, it has become clear that the United States will need a complex solution to address this complex issue. In order to do so, the health care system in the United States must partner across sectors to more effectively and efficiently address the social determinants of health (Daniel et al., 2018). Promoting a "Health in All Policies" approach will not only benefit health care, but also sectors addressing

social determinants of health such as education, transportation, employment, food security, and housing (Daniel et al., 2018). Investing proportionally more money into public health initiatives, programs, and policies will also help to address these social determinants of health (IOM & NRC, 2013). Although the ACA has made great strides in increasing the availability of health insurance for Americans, work needs to be done in countless other measures of health system performance, including health care outcomes, administrative efficiency, and equity (Blumenthal et al., 2015; Schneider et al., 2017). These broad measures of health system performance are often used to compare health systems across nations, and although the health economics literature references an equity-efficiency tradeoff, Schneider et al. (2017) demonstrate that the United States performs poorly on all three. Furthermore, amongst the other countries evaluated in Mirror, Mirror 2017, equity and efficiency display a positive association, rather than a negative one (Schneider et al., 2017). Ultimately, if the United States is to change the course of the widening gaps in achievement demonstrated, the country must improve the effectiveness of its health system by addressing the social determinants of health.