Disrupting the Conventional Wisdom about US Healthcare and Cultivating a Healthy Skepticism of What We Think We Know

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Op-Ed, June 2018

Imagine if no one knew that per person US health expenditure is higher than it is elsewhere? Without that data, we might be oblivious to the unusually high costs of US healthcare. It's a reminder that the way we look at the healthcare system occurs with direction reference to what happens in other countries. I was reminded of the role of comparative analysis and its key role in policy debates during a memorial panel at the annual AcademyHealth conference this June for the late Uwe Reinhardt, a Princeton professor, provocateur and brilliant analyst of the foibles of US healthcare. As one panelist emphasized, he was especially talented at the "emperor has no clothes" analysis.

One such "no clothes" thesis of the sort he would have approved of was the presumption that US healthcare is higher quality. For many years, people believed our higher costs reflected higher quality, yet ultimately comparative analysis showed this idea to be flawed. The discovery of poor quality in the US was proven through domestic research, but comparative researched showed that other countries succeeded in many outcomes without spending more.

In HPM, my colleagues share an ethos Reinhardt would probably approve of. For example, currently, with Lawrence Brown, former faculty member Michael Gusmano, and NYU Professor Victor Rodwin, we are testing the assumption that fee-for-service is necessarily the culprit in US healthcare by doing a deep dive into physician payment methods in three countries that use fee for service: Germany, France, and Japan. Our project uses the key insight of others such as Jonathan Oberlander, Joseph White, and Ted Marmor, to challenge the blame attributed to fee for service. Check back for results soon!

The tendency to compare goes back decades. Thinking back to the body of work that Reinhardt and others produced in the 1980s, I recalled a staple of my graduate education in health policy, the (1984) book by Henry J. Aaron's and William B. Schwartz called "A Painful Prescription: Rationing Hospital Care," which was a landmark study comparing the US to the National Health Service in the UK. Aaron and Schwartz suggested that the US was too technologically intensive, and that there was a tendency towards overtreatment. Of course, others used this book on the NHS and other work on Canada to argue the US was better because of waiting times for treatment and the fact that citizens in these countries lacked the unfettered access to treatment that people in the US supposedly had.

Funders and researchers attuned to potential for international comparisons understand the potential of comparative analysis, because though a book like *The Painful Prescription* may not be a single catalyst, it sounds a note, and then a drumbeat of evidence can, in the aggregate, lead to large-scale policy changes. Evidence can change policy nonlinearly. People use

international evidence to envisage alternatives and they assess how shortcomings in their own systems compare to others. Voters perceive their system in reference to more desirable international benchmarks and pressure politicians to change. The ideas and "zeitgeist" in healthcare can shift over time in response to other countries' experiences. Aaron and Schwartz's book led to a rethinking of whether "more is better," an idea that has taken off and continues to shape our thinking. It happens abroad too: After the UK and Canada gained a reputation for longer waiting times and restrictive access, both systems were forced by voters to make changes in their systems.

If researchers and funders want ideas that stick, Aaron and Schwartz may give them pause---they were perhaps too successful and people forgot to re-calibrate and test. Many people still believe Canada and the UK to have substantial delays in treatment. It is as if kids still had their tonsils removed, even though we don't do that routinely anymore, or if we only reported our blood pressure based on a reading we took 10 years ago. This is the kind of idea that led former HPM chair Sherry Glied and I to publish a paper (*Health Affairs*, September 2011) where, among other things, we demonstrated a very simple fact, that the utilization of hip replacements in the US was not higher than the average, and that Americans do not go to the doctor more often. We provided a service-based and granular analysis of prices of US healthcare to challenge the assumption that utilization led to higher incomes among orthopedic surgeons.

In HPM, there is a fertile environment for debate and intellectual inquiry. My personal perception is that faculty share an ever so slightly contrarian philosophy of health policy, and we encourage students to also hone their inner skeptic—not in a counterproductive way—but to ensure they arrive at the right conclusions. My mentors and colleagues in HPM have always encouraged me to do this, which led me to write a book on Medicare pricing. I confess that I go as far as to caution students from naming something as a "public health crisis" unless it is so, because that could devalue public health problems that are genuinely crises. Good research and good policy comes from questioning what we know.

This philosophy perhaps encouraged Lawrence D. Brown and Michael S. Sparer, along with Dr. Herbert Pardes from NewYork-Presbyterian, to think about challenging the conventional wisdom in healthcare. They brought HPM faculty together for a one-day conference in June 2017 to stress-test some of the commonly held assumptions around US healthcare "exceptionalism." The conference drew together not only our own talented faculty but experts from other institutions who we asked to peer-review and comment on the papers we delivered.

This October, those papers will be published by the *Journal of Health Politics, Policy and Law.* Many of the papers will be posted online over the next few months, and authors present some counterintuitive findings, including one of my own, that generalists are not less prevalent than specialists in the US compared to other countries, and that estimates of "waste' in healthcare may be overstated (Adam Sacarney and Glied).

As faculty we play an important role in providing an independent analysis of the healthcare sector. Sometimes this means even correcting perceptions that might otherwise be used to

argue for reform. If we are to truly provide evidence-based analysis, we will often need to test the assumptions made about the US using comparative evidence, with the expectation that we can begin to tease apart why we have ended up here. Watch this space!