

## BRIEF ANALYSIS

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## How Not To Judge Our Health Care System

If you needed heart surgery, would you prefer to have the surgery done in Cuba? Barbados? Costa Rica? Or the United States?

For the last several years, some critics of the American health care system have claimed that life expectancy is a good indicator of the quality of a country's health care system. If they are right, you should be indifferent about having your surgery in Cuba or in the United States because the two countries have the same life expectancy, 75.6 years. And you would have to say that the health care system of Barbados was nearly as good as that of the United States, since average life expectancy in Barbados (75.3 years) is almost the same. In fact, if general life expectancy is the right guide, you would probably want the surgery done in Costa Rica, since life expectancy there (76 years) is higher than in the United States.

Sound silly? Of course it is. And critics of the American health care system cite several other statistics that are also poor indicators of a health care system's quality. Let's see why.

**Life Expectancy.** While a good health care system may, by intervention, extend the life of a small percentage of a population, it has very little to do with overall life spans. Life expectancy — in all but the least-developed countries — is primarily a result of genetic and social factors (e.g., lifestyle, environment, education, etc.) rather than the quality of medical care.

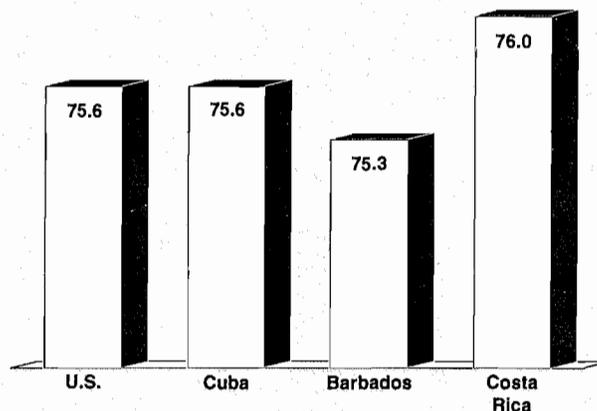
For example, Japan's average life expectancy (78.6 years) is one of the highest in the world, about three years higher than that in the U.S. If the three-year difference were the result of lower-quality health care in the United States, you would expect Japanese-Americans living in this country to experience shortened life

spans. They don't. According to the National Asian Pacific Center on Aging, in 1980 (the latest numbers available) white Americans had an average life expectancy of 76.4 years, while Japanese-Americans had an average life expectancy of 79.7 years — just about the same three-year spread that exists between the populations of the two countries. Similarly, the California Department of Health reports that people of Asian or Pacific Island ethnic origin living in the state and using its health care system have a life expectancy 5.3 years longer (81.2 versus 75.9 years) than white Californians.

Critics of the American health care system who

compare life expectancies are comparing apples and oranges. Of the industrialized countries with better life expectancies than the U.S., nearly all have overwhelmingly white populations of European descent. None have large black populations. Unfortunately, black Americans have more health problems and shorter life expectancy (70 years in 1991) than whites. The American population is a mixture of several ethnic groups — some with longer and some with shorter life spans than whites. Pointing to the average distorts the picture significantly.

**Life Expectancy  
(1992)**



Source: *Human Development Report 1994* (New York: Oxford University Press, 1994).

**Infant Mortality.** Critics claim that the second-best indicator of the quality of health care is infant mortality. However, the evidence shows that differences in infant mortality frequently reflect differences in genes, lifestyles and environments rather than in the quality of medical care. Data from the California Department of Health Services, for example, show that the average infant mortality rate was 8.6 deaths per 1,000 live births in the 1980s. But Americans of Japanese descent living in California had an infant mortality rate of 4.8 deaths per 1,000 live births through 1989 (the latest data available for these populations), while Chinese had 7.1 deaths, Filipinos 7.8 deaths, Hispanics 7.8 deaths, whites 7.7 deaths and blacks 18.0 deaths per 1,000 live births.

Since individuals in the different groups often live in the same communities and use the same hospitals and physicians, the difference clearly is a result of something more than the health care system. The health care policy problem is that some ethnic, geographic and economic groups need better health care. Desegregating the numbers helps illuminate the target populations to whom better health care must be delivered. Using national averages to stigmatize systemwide quality is clearly unjustified.

**Average Hospital Stay.** Some critics also claim that the amount of health care is greater (better) as hospital admissions and lengths of stay increase. By this standard, the United States is stingy. The average hospital stay in all developed countries is 12.9 days, compared to 6.4 days in the United States in 1992. In Japan, which spends far less per capita on health care than the United States, the average length of a hospital stay is 50 days, nearly eight times that of the United States.

However, less inpatient and more outpatient care has been a goal of U.S. health care policy for the past two decades. And most health economists regard shorter stays as a sign of hospital efficiency, not of the failure to provide needed care.

In many other countries, hospital stays are long because large numbers of patients use hospitals as nursing homes. Chronic patients, who really don't need to be in a hospital, fill about a fourth of all beds in England, Canada and New Zealand. In addition, recuperating patients are encouraged to remain hospitalized. Both groups of patients, who require little additional therapy, cost less to maintain than acute patients who need expensive treatment. Such patients, known as "bed blockers," help limit the costs of hospitals struggling under restrictive global budgets — budgets that ration care and cause long waits for hospital admission.

**Primary Care Physicians.** The U.S. is often criticized for having too many specialists and not enough primary care physicians. At the moment, medical school students choose to be specialists about 70 percent of the time, primary care doctors 30 percent. By law, the Clinton health care proposal would have changed that mix to 50 percent each, forcing another 20 percent of the young men and women entering medical school to practice primary care.

But is there a shortage of primary care physicians? Not really. When was the last time you saw a waiting line outside a primary care clinic?

Moreover, a recent survey by the American Medical Association found that if physicians who practice both specialized and primary medicine are combined with the 34 percent who practice primary care exclusively, about 47 percent of all physicians engage in some form of primary care — nearly reaching Clinton's target with *no government interference*.

There are shortages of primary care physicians in some rural and inner-city areas, but almost nowhere else. For example, a 1990 survey found that only 28 doctors serving a population of 1.7 million low-income people in New York's Harlem were qualified to provide primary care. The explanation for such shortages has little to do with the ratio of primary care physicians graduating from medical school. There simply isn't enough money in rural and inner-city areas to support such physicians. Rural areas may not have enough people to warrant having a physician close by, while Medicaid, the federal health insurance program for the poor, pays so little that very few physicians can afford to locate in inner-city areas with a preponderance of Medicaid patients.

