

Chapter Four

Outcomes

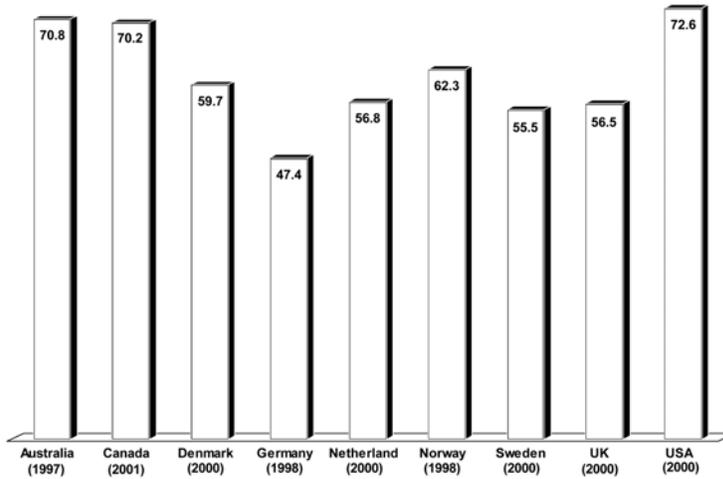
MYTH NO. 4: ALTHOUGH THE UNITED STATES SPENDS MORE PER CAPITA ON HEALTH CARE THAN COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH INSURANCE, AMERICANS DO NOT GET BETTER HEALTH CARE

This myth is often supported by reference to two facts: (1) that life expectancy is not much different among the developed countries and (2) that the U.S. infant mortality rate is one of the highest among developed countries. If the United States spends more than other countries, why don't we rate higher than the others by these indices of health outcomes? The answer is that neither statistic is a good indicator of the quality of a country's health care system. Other indicators are much more telling.

Another problem is that these comparisons involve a selective use of statistics. Although most of our readers will be familiar with America's poor ranking on infant mortality and mediocre ranking on life expectancy (because these statistics are repeated so often by the critics), we suspect that few will be familiar with figures 4.1 and 4.2. Yet, as these figures show

- The percent of American seniors reporting they are in good health (72.6 percent) is the highest of any country in the Organization for Economic Cooperation and Development (OECD); among the also-rans, the range is from 70.8 percent in Austria to less than half (47.4 percent) in Germany.
- Among those age forty-five to sixty-four who report they are in good health, Americans top out at 85.4 percent; the others range from 84.9 percent in Canada to 58.2 percent in Germany.

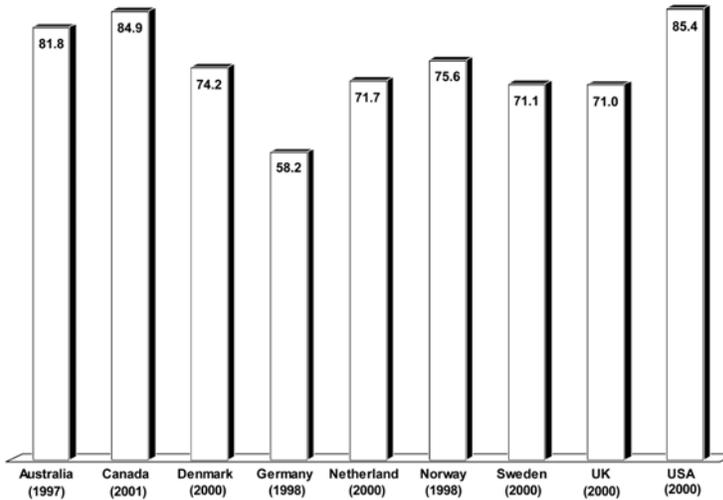
FIGURE 4-1
Percent of Americans Age 65+
Reporting Health as “Good”



Source: *OECD Health Data 2002*.

Note: Most recent data available for each country.

FIGURE 4-2
Percent of Americans Ages 45-64
Reporting Health as “Good”



Source: *OECD Health Data 2002*.

Note: Most recent data available for each country.

Like infant mortality and life expectancy statistics, self-reported evaluations of health status may be of interest for some purposes. But these numbers are also not very good indicators of the quality of health care systems.

LIFE EXPECTANCY AND HEALTH CARE

Average life expectancy tells us almost nothing about the efficacy of health care systems because, throughout the developed world, there is very little correlation between health care spending and 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 the average life span of the whole population. Instead, the number of years a person will live is primarily a result of genetic and social factors, including lifestyle, environment and education.¹ The American population is a mixture of ethnic groups with strikingly different expected life spans. Figures 4.3 and 4.4 show the following:

- In 1999, male life expectancy at birth ranged from 80.9 years for an Asian American, 77.2 for a Hispanic, 74.7 years for a white non-Hispanic, and 72.9 years for an American Indian down to 68.4 years for an African American.²
- That same year, female life expectancy ranged from 86.5 years for an Asian, 83.7 for an Hispanic, 82 years for an Indian, and 80.1 years for a white non-Hispanic down to 75.1 years for a black.³

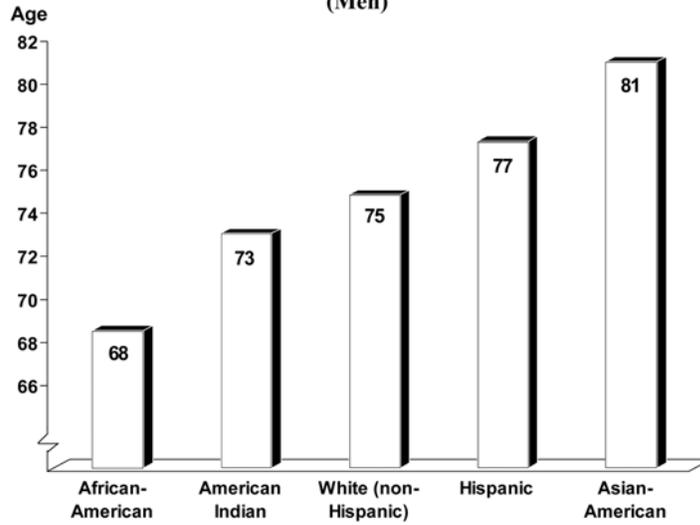
The 74.1-year life expectancy rate for the United States as a whole is a composite of these different rates. The differences between the expected life spans of groups in the United States, however, cannot be explained by differences in access to health care. Take the case of Japanese Americans. At 78.6 years, Japan has the longest life expectancy of any industrialized country, about three years longer than the United States. If the health care system were the cause of shorter life spans in the United States, one would not expect Japanese Americans to live as long as their counterparts in Japan. But they do.⁴

America is nation of immigrants, and ethnic differences in longevity tend to persist. Thus, white Americans have life expectancy rates similar to the rates for Western Europe.⁵

INFANT MORTALITY AND HEALTH CARE

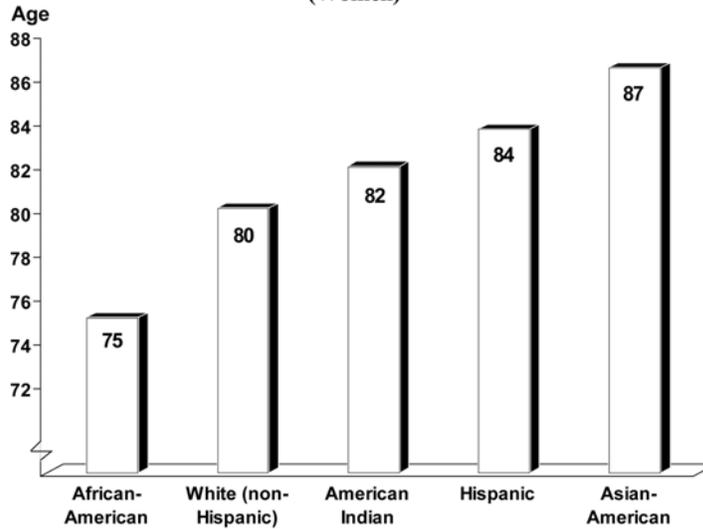
The infant mortality rate in the United States is higher than the average among developed countries at 7.2 deaths per 1,000 live births in 1998, compared to a

FIGURE 4-3
United States Life Expectancy
(Men)



Source: National Projections Program, Population Division, U.S. Census Bureau, January 13, 2000.

FIGURE 4-4
United States Life Expectancy
(Women)



Source: *OECD Health Data 2001*.

developed country average of about 5.0.⁶ Why does the United States have a much higher infant mortality rate than countries with comparable living standards? Like the life expectancy rate, the U.S. infant mortality rate is a composite average.⁷ Overall, the chances that an infant will die at birth vary widely according to such factors as race, geography, income and education:

- *Race:* According to the National Center for Health Statistics, in 1997, the mortality rate (per 1,000 live births) for infants born to black mothers was 13.7 compared to 8.7 for American Indian mothers, 7.9 for Puerto Rican mothers, 6.0 for non-Hispanic white mothers and 5.0 for Asian mothers.⁸
- *Geography:* Among the sixty largest U.S. cities, infant mortality ranged from a high of 15.4 (Memphis) to a low of 4.5 (Seattle); among U.S. states, rates varied from a high of 10.2 (Alabama) to a low of 4.4 (New Hampshire).⁹
- *Income and education:* Infants born to low-income mothers who did not finish high school were about 50 percent more likely to die than infants whose mothers finished college.¹⁰

An important cause of infant mortality is low birth weight (e.g., less than 2,500 grams) deliveries, which increase the probability of infant death by as much as twenty times.¹¹ Several factors are known to increase the likelihood of low-birth-weight babies, but the most significant is race. African American women deliver very small babies at twice the rate of white American women. This is true even when controlling for the mother's age, income and education.¹² It is even true holding constant the number of prenatal medical visits.¹³ Why some ethnic groups have disproportionate numbers of low-birth-weight babies is not fully understood. However, studies of twins suggest 40 percent of the variation is due to genetic factors.¹⁴

The infant mortality rates for some segments of the U.S. population are similar to and in many cases lower than in European countries. For example, Norway and the state of New Hampshire have small, culturally and racially homogenous populations with similar demographics. Their infant mortality rates are both quite low, at 4.1 and 4.4, respectively.¹⁵

Another factor relevant to comparisons of infant mortality in the United States and Europe is that not all countries measure infant mortality the same way. For example, in 1998, Switzerland's infant mortality of 4.8 per 1,000 births was only two-thirds of the U.S. rate (7.2 per 1,000).¹⁶ However, Switzerland does not treat the death of an infant born less than thirty centimeters in length as a live birth. This threshold effectively excludes many very low-birth-weight babies, such as those weighing less than one kilogram (2.2 pounds), most of whom measure less than thirty centimeters. Yet, close to one-third of all infant deaths recorded in the United States are

among infants weighing 2.2 pounds or less. If these infants were reclassified as “stillborn” rather than “live births,” the respective rates of the two countries would be similar.¹⁷ Taking into account such data-reporting differences, the rates of low-birth-weight babies born in America are about the same as other developed countries in the OECD. Overall,

- Although the U.S. composite rate for low birth weight is 6.6 percent of live births, the rate for non-Hispanic whites is 5.6 percent.¹⁸
- In Canada, approximately 5.5 percent of live births are low birth weight.¹⁹
- In Britain, the rate is 7.6 percent, up from 6.9 percent only a few years ago.²⁰
- The rate of low-birth-weight babies in Denmark is 5.3 percent.²¹

Note again that the factors that seem most important in explaining infant mortality rate—race, geography, income, education or low-birth-weight measurement procedures—have nothing to do with the quality of (or access to) health care.

VARIATIONS IN INFANT MORTALITY WITHIN OTHER COUNTRIES

Wide variations in infant mortality also occur in other developed countries. Consider Canada, which is often praised for its low overall infant mortality rate of 6.1 deaths per 1,000 live births.²²

- At 7.5 deaths per 1,000, the infant mortality rate among the lowest one-fifth in the income distribution is two-thirds higher than rates among the wealthiest one-fifth (4.5 per 1,000).²³
- Among Canadian provinces, infant mortality rates vary from a high of 9.1 in Saskatchewan to a low of 4.6 on Prince Edward Island.²⁴

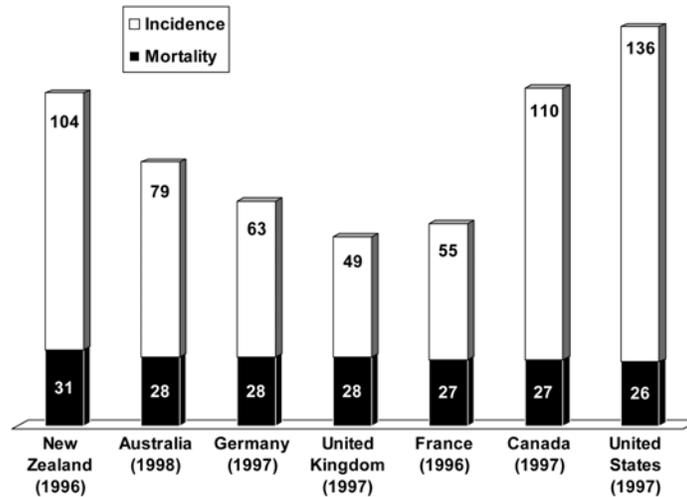
Not surprisingly, these variations reflect socioeconomic differences, with wealthier provinces enjoying lower rates.

Britain also has significant differences between different income groups and regions:

- Overall, infant mortality rates in Britain are considerably higher in the north and in urban areas than in the south and in rural areas, even though all participate in the NHS.
- Infant mortality in Leeds, an industrial city in Northern England, is more than twice as high as in rural Dorsetshire; and children born in Manchester,

FIGURE 4-5

Prostate Cancer Incidence and Mortality per 100,000 Males per Year



Source: Gerard F. Anderson and Peter S. Hussey, "Multinational Comparisons of Health Systems Data," Commonwealth Fund, October 2000.

Britain's third-largest city, are eight times as likely to die before reaching age four as children born in rural Gloucestershire.²⁵

- Across Britain, the rate among the second lowest-income quintile ("manual classes") was 6.2 in 1999, compared to 4.3 among the highest-income quintile ("professional classes").²⁶
- In the past three years alone, the rate for the lowest-income group ("unskilled manual class") has increased to double the rate of the highest-income group, a widening of nearly 10 percent.²⁷

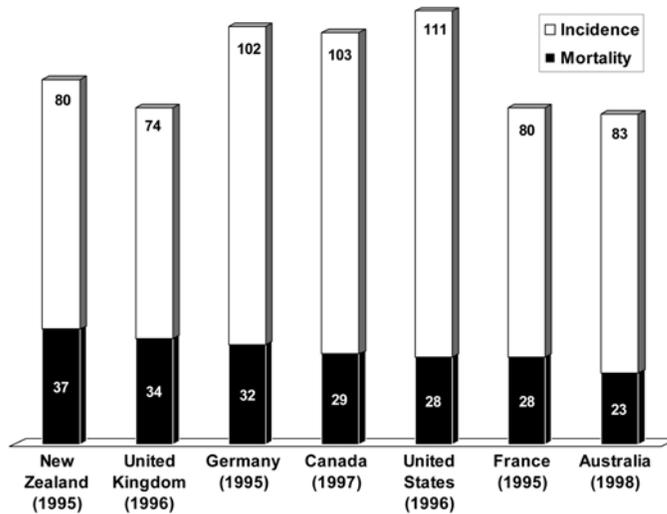
No one has seriously claimed that these differences between income groups and regions are the result of the Canadian or British health care systems. Yet, many still attempt to correlate the infant mortality rate in the United States with our health care system.

WHERE HEALTH CARE MAKES A DIFFERENCE

Although a population's general mortality is affected by many factors over which doctors and hospitals have little control, for those diseases and injuries

FIGURE 4-6

Breast Cancer Incidence and Mortality per 100,000 Females per Year



Source: Gerard F. Anderson and Peter S. Hussey, "Multinational Comparisons of Health Systems Data, 2000," Commonwealth Fund, October 2000.

modern medicine can effectively treat, the country in which a patient lives makes a big difference. For premature babies, for children born with spinal bifida or for people who have cancer, heart disease, chronic renal failure or almost any other serious illness, the chances of survival are best in the United States, where modern medical technology is most available and accessible.

Take prostate cancer, for example. In the United States, the male mortality rate for prostate cancer is slightly lower than in most other OECD countries, even though the incidence is apparently much greater (see figure 4.5). Similarly, although the incidence of breast cancer is relatively high in the United States (arguably because of lifestyle and diet), the proportion of women who die from breast cancer is among the lowest of any industrial country (see figure 4.6).

NOTES

1. "How Not To Judge Our Health Care System," National Center for Policy Analysis, Brief Analysis No. 141, November 15, 1994.

2. National Projections Program, Population Division, U.S. Census Bureau, January 13, 2000. By contrast, the 1998 figures for men in other countries are 74.8 for

Britain, 75.2 for New Zealand, 76.1 for Canada, and 76.9 for Sweden. For more information, see *OECD Health Data 2001*.

3. The 1998 figures for women in other countries are 79.7 for Britain, 80.4 for New Zealand, 81.5 for Canada, and 81.9 for Sweden. For more information, see *OECD Health Data 2001*.

4. "How Not To Judge Our Health Care System."

5. For a discussion on how life expectancy of Americans compares to that of Europeans, see Nicholas Eberstadt, *The Tyranny of Numbers: Mismeasurement & Misrule* (Washington, D.C.: American Enterprise Institute Press, 1995).

6. "Kids Count: 2001 Data Book Online," Annie E. Casey Foundation, May 17, 2002. Available at www.aecf.org; "Health, United States, 2000," National Center for Health Statistics, 2000; and *OECD Health Data 2002*.

7. The overall infant mortality rate has been falling in recent years. For example, according to OECD health data from 1998, the United States infant mortality rate fell to 7.2 per 1,000 births from 9.2 eight years earlier. The rate for the United Kingdom was 5.7 versus 7.9 eight years earlier. During the same time period, the rate in Canada dropped to 5.3 from 6.8; Australia fell to 5.0 from 8.2; and New Zealand fell to 6.8 from 8.4. See *OECD Health Data 2001*.

8. "Infant Mortality Statistics from the 1997 Period: Linked Birth/Infant Death Data Set," *National Vital Statistics Reports* 47, no. 23 (July 30, 1999).

9. *Racial and Ethnic Disparities in Infant Mortality Rates: 60 Largest U.S. Cities, 1995–1998*, Centers for Disease Control and Prevention, April 19, 2002; and *Infant Mortality: State Rankings*, National Center for Health Statistics, 2000, table 125.

10. *Racial and Ethnic Disparities in Infant Mortality Rates: 60 Largest U.S. Cities*. Also see "U.S. Childhood Mortality, 1950 through 1993: Trends and Socioeconomic Differentials," *American Journal of Public Health* 86, no. 4 (April 1996): 505–12; George A. Kaplan, "Inequality in Income and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal* 312 (April 20, 1996): 999–1003; and Bruce P. Kennedy, "Income Distribution and Mortality: Cross-Sectional Ecological Study of the Robin Hood Index in the United States," *British Medical Journal* 312 (April 20, 1996): 1004–7.

11. Eberstadt, *The Tyranny of Numbers*. Also see "Infant Mortality, Low Birthweight and Racial Disparity in Perinatal Outcomes," National Healthy Start Association, 2001; "Healthier Mothers and Babies 1900–1999," *Journal of the American Medical Association* 282, no. 19 (November 17, 1999); and "Closing the Gap: Addressing the Disparity of Infant Mortality among African-American and White Infants," Maryland Commission on Infant Mortality Prevention, 1998.

12. Eberstadt, *The Tyranny of Numbers*.

13. Eberstadt, *The Tyranny of Numbers*.

14. Eberstadt, *The Tyranny of Numbers*. On twin studies, see Olga Basso et al., "Change in Social Status and Risk of Low Birth Weight in Denmark: Population-Based Cohort Study," *British Medical Journal* (December 6, 1997): 1498–1502.

15. "Infant Mortality Rates and International Rankings," Centers for Disease Control and Prevention, 2001; and Eberstadt, *The Tyranny of Numbers*.

16. *OECD Health Data 2001*.

17. Eberstadt, *The Tyranny of Numbers*.
18. Eberstadt, *The Tyranny of Numbers*. The comparable rate of low birth weights for African Americans is 12.2.
19. *The Health of Canada's Children: A CICH Profile*, 2nd ed., Canadian Institute of Child Health, 1995.
20. Sheffield Health Authority reports 7.1 percent for England and Wales; North West Lancashire Health Authority reports 6.9 percent. By 2000 the latter figure had risen to 7.6 percent. See *Births, Perinatal and Infant Mortality Statistics 2000*, Health Regional Office and Health Authority of Usual Residence, UK Office of National Statistics, 2000.
21. *Medicinsk fødselstatistik 199: Sundhedsstatistikken* (Copenhagen: Sundhedsstyrelsen, 1995), cited in Olga Basso et al., "Change in Social Status."
22. *Births and Deaths, 1995*, Statistics Canada, Catalogue 84-210-XPB.
23. *Births and Deaths, 1995*, Statistics Canada, Catalogue 84-210-XPB. Also see R. Wilkins, "Mortality by Neighborhood Income in Urban Canada, 1986–1991," presentation to the Canadian Society for Epidemiology and Biostatistics, St. John's, Newfoundland, August 1995.
24. *Births and Deaths, 1995*, Statistics Canada, Catalogue 84-210-XPB.
25. Daniel Dorling, "Death in Britain: How Local Mortality Rates Have Changed," Policy Brief Report, Joseph Roundtree Foundation, 1997.
26. "Health Inequalities—National Targets on Infant Mortality and Life Expectancy," *Health Statistics Quarterly*, no. 12, November 2001.
27. "Health Inequalities—National Targets."