

Chapter Six

Quality

MYTH NO. 6: COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH CARE SYSTEMS HAVE A HIGHER QUALITY OF HEALTH CARE THAN THE UNITED STATES

Proponents of a single-payer system for the United States maintain it would “provide access to high-quality care for everyone at an affordable price.”¹ To support this idea, some point to a report comparing health systems in countries worldwide, published by the World Health Organization (WHO). However, the WHO report does not support the claims that single-payer health insurance leads to high-quality care.

INTERNATIONAL COMPARISON: THE WHO REPORT

In 2000 the WHO issued a report comparing health care systems in 191 countries.² In the overall WHO ranking, the French health care system ranked first. The U.S. system ranked thirty-seventh, just above Slovenia (38) and below Costa Rica (36).

Rest assured. Americans are not boarding planes bound for Costa Rica—or even for France—in search of better health care. Still, officials in other countries have used the report to argue that their health systems are not as bad as their citizens might suspect. And some politicians in the United States have used the report to support their claim that American health care needs even more government intervention and control.

So what's wrong with the WHO report? What's wrong is that it mainly reflects perceptions of fairness and equity rather than success at saving lives and curing diseases.

The WHO report ranks nations with respect to "overall health system performance" based on five factors, using data from the OECD and WHO surveys of the opinions of experts and officials in those countries. The five factors (and their weighting in the overall scores) were the level of health (25 percent); the equal distribution of health indicators by income and/or ethnic group (25 percent); the responsiveness of the system to patient needs—including the level of responsiveness (12.5 percent) and the distribution of responsiveness by income and/or ethnic group (12.5 percent); and the fairness of the country's financing (25 percent), which measures how much more, as a portion of income, higher-income groups pay for their health care than lower-income groups.

These measures produced some odd, almost random rankings. For example:

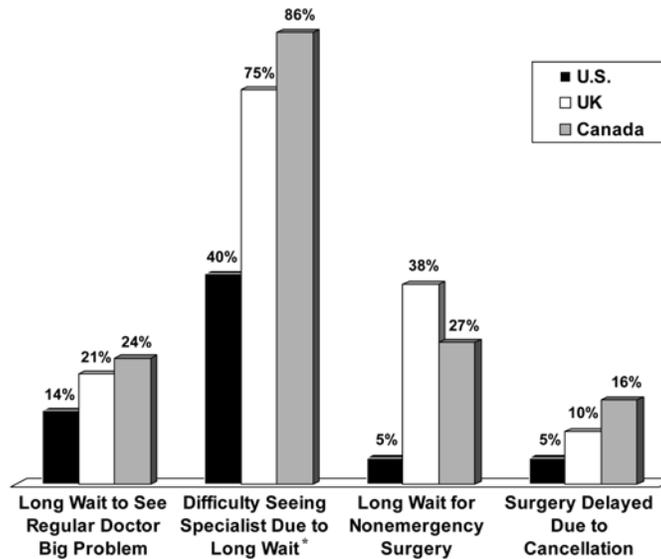
- Japan ranked first on the attainment of health, measured in Disability Adjusted Life Expectancy (DALE), but Chile ranked first in the equal distribution of DALE among subgroups.
- The United States ranked first in the responsiveness of its system, but the United Arab Emirates (UAE) ranked first in the distribution of responsiveness.
- Colombia ranked first in the fairness of its health system financing.

As we discussed previously, the overall health of a country's population is strongly influenced by its demographic makeup. Thus, it makes sense that Japan, with low infant mortality and greater life spans, ranks first in terms of overall healthiness. But beyond some basic public health measures, there is not much correlation internationally between health care inputs and the overall health of a population.

Of the five measures used to calculate the overall WHO ranking, only health system responsiveness takes patients into account. And even this ranking was not based on objective data. It was based instead on patient surveys and surveys of officials and experts in each country with regard to "(a) respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health); and (b) client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider)."

On that measure, the United States ranked first. But so what? Respect and amenities are nice. But what about life saving treatment? In most people's minds that matters much more.

FIGURE 6-1
How Sicker Patients
Evaluate Their Health Care



* Note: Sample was of those who reported difficulty seeing specialist.

Source: Robert J. Blendon, et al., "Inequities in Health Care: A Five-Country Survey," *Health Affairs*, Vol. 21, No. 3, May/June 2002, pp. 182-191; Robert J. Blendon et al., "Common Concerns Amid Diverse Systems: Health Care Experiences In Five Countries," *Health Affairs*, Vol. 22, No. 3, May/June 2003, pp. 106-121.

INTERNATIONAL COMPARISON: THE COMMONWEALTH FUND SURVEYS

While the WHO rankings are mainly based on what people think is fair, a series of Commonwealth Fund surveys asked patients about their actual health care. In particular, the surveys asked patients and "sicker" adults, most of whom described their health as "fair" or "poor," in several countries to rate the performance of their nation's health care system.³ Figure 6.1 shows the following:

- Only 14 percent in the United States cited long waits to see their regular doctor as a "big problem," compared to 21 percent in the United Kingdom and 24 percent in Canada.⁴

- Among those experiencing difficulties seeing a specialist, 40 percent in the United States reported difficulty due to a long waiting list, compared to 75 percent in the United Kingdom and 86 percent in Canada.⁵
- Only 5 percent in the United States reported long waits for nonemergency surgery, compared to 27 percent in Canada and 38 percent in the UK.⁶
- Only 5 percent in the United States reported a surgery delayed due to a cancellation, compared to 10 percent in the United Kingdom and 16 percent in Canada.⁷

QUALITY PROBLEMS IN CANADA

Canada's federal health care payments to the provinces were slashed after the 1995–1996 budget year. Many hospitals were closed or consolidated.⁸ Waiting periods for patients facing life-threatening conditions grew as a result and the effects have been severe. Whereas the Canadian Society of Surgical Oncology recommends that cancer treatment, including surgery, begin within two weeks after preoperative tests, one study found that the median wait was much longer. Depending on the type of cancer, the median waiting time for surgery varied from almost a month (29.0 days) for colorectal cancer to more than two months (64.0 days) for urologic cancers.⁹

The frustration felt by physicians who witnessed first hand the deteriorating standards of care in Canada's hospitals is apparent in a survey conducted by the Canadian Medical Association. Of physicians surveyed, only 27 percent rated their access to advanced diagnostic services as excellent, very good or good. Fewer than two-thirds rated their access to acute care when urgently needed as excellent, very good or good.¹⁰

The Canadian press is replete with the names of the victims of rationing or inadequate care. Among the cases reported,

- It took four hours for a Toronto critical care specialty referral service to find an available hospital bed for Jeyaraanie Kaneshakumar, a pregnant woman who collapsed in her suburban Scarborough home from a brain hemorrhage. She died.¹¹
- A Toronto man who fell ill while vacationing in Rhode Island was forced to stay in an American hospital for six weeks because no bed could be found for him in Ontario. A free bed was located only after the media exposed the man's plight.¹²
- Dan Smith of Brampton, Ontario, was denied a double lung transplant—his only hope for survival—when his surgery was cancelled due to a bed shortage in intensive care units (ICUs). A pair of donated lungs was wasted, although thirty other Ontarians were also waiting for lung transplants.¹³

- Kyle Martyn, a five-year old boy taken to the emergency room with toxic shock waited three hours to see a doctor. The ER was backlogged because three-fourths of its beds were occupied with patients awaiting transfer to acute care beds. The acute care beds were full of “bed blockers” who had nowhere to go due to shortage of long-term care beds. Kyle died from complications.¹⁴

QUALITY PROBLEMS IN BRITAIN

In an extensive study of Britain’s NHS in the mid-1980s, Brookings Institution economists estimated the number of British patients denied treatment each year, based on U.S. levels of treatment. Most of the patients suffered from life-threatening diseases and the denial of treatment meant certain death. According to the study,¹⁵

- About 9,000 British kidney patients failed to receive renal dialysis or a kidney transplant—and presumably died as a result.
- As many as 15,000 cancer patients and 17,000 heart patients failed to receive the best treatment.
- As many as 1,000 British children failed to receive lifesaving total parenteral nutrition (TPN) therapy and about 7,000 elderly patients were denied pain-relieving hip replacements.

Although the study has not been updated, casual observation suggests that the difference between United States and British levels of care have widened rather than narrowed over the past twenty years. Take kidney dialysis, for example.¹⁶ The number of dialysis patients per 100,000 Britons is only about one-third the rate of the United States’, although the prevalence of kidney disease is not much different.¹⁷ One in eight British nephrologists say that due to limited resources they have refused treatment to patients they thought were suitable for such care.¹⁸ The comparable figure among United States nephrologists is 2 percent.

NHS officials are repeatedly embarrassed by the popular press. Britons are now more likely to be killed by an infection caught in hospital than by a car accident, claimed a BBC broadcast based on a leaked government report.¹⁹ Like the Canadian media, the British media teems with reports of patients harmed by inadequate care:

- Nine-year-old Tony Clowes, in a hospital to have the tip of his right index finger reattached after a bicycle chain accident, died under anesthesia from lack of oxygen when a breathing tube became blocked. The \$1.50 tube, designed for one use only, had been used for six weeks to reduce costs.²⁰

- George Mitchell Sr., 73, who was undergoing treatment for bladder cancer at Scotland's biggest cancer treatment center, was sent off in a taxi to a hotel with no access to medical care before the treatment was finished because the hospital was short of beds. Hospital officials said it was a mistake.²¹
- Britain's Audit Commission said hospital pharmacies lack the computer systems needed to keep pace with modern medicine. Consequently, in England and Wales, five times more patients died in 2000 from receiving the wrong medicine than a decade earlier.²²

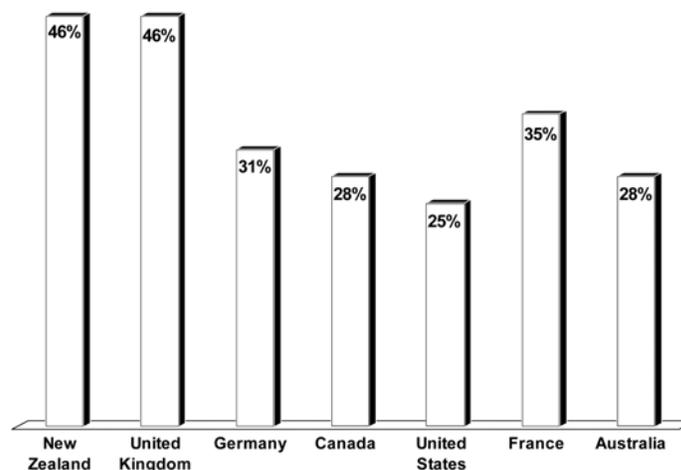
COMPARING MORTALITY RATES

As we discussed previously, a country's overall mortality rate isn't much affected by its health system. The mortality rate for certain conditions is very much affected by the quality of care, however. In countries where governments control health care resources, patients do not always receive the treatment they need or they may be denied access to the most effective treatment.

Take cancer mortality rates, for example. As figure 6.2 illustrates, in New Zealand and the United Kingdom nearly half of all women diagnosed with

FIGURE 6-2

Breast Cancer Mortality Ratio (Percent of those with the disease who die from it)



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

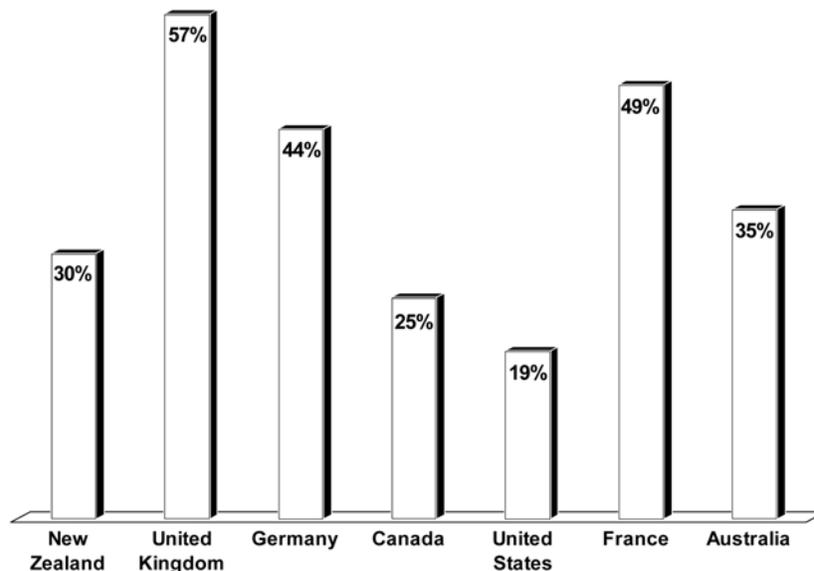
breast cancer die of the disease. In Germany and France, almost one in three die. By contrast, in the United States only one in four women diagnosed with breast cancer dies.

In the United States, slightly less than one in five men diagnosed with prostate cancer dies of the disease. In the United Kingdom, 57 percent die. France and Germany fare slightly better at 49 percent and 44 percent, respectively. At 30 percent and 25 percent, respectively, death rates from prostate cancer in New Zealand and Canada are still well above those of the United States (see figure 6.3).

Overall, the annual rate of cancer deaths is 70 percent higher in the United Kingdom than in the United States—275 deaths per 100,000 and 194 deaths per 100,000, respectively.²³ Indeed, a WHO study calculated that 25,000 people die unnecessarily in Britain each year because they are denied the highest quality of cancer care.²⁴

FIGURE 6-3

Prostate Cancer Mortality Ratio (Percent of those with the disease who die from it)



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

QUALITY PROBLEMS IN THE UNITED STATES

There are also quality problems in the United States. Several studies have identified a rate of hospital injury—due to negligence or treatment errors—of approximately 0.92 percent of admissions. Nationally, that translates into about 300,000 patients injured each year.²⁵ In 1999 the Institute of Medicine reported that between 44,000 and 98,000 patients die each year of medical errors.²⁶ Some of these incidents are widely reported. Linda McDougal, 46, was diagnosed with an aggressive form of breast cancer and doctors performed a double radical mastectomy at a St. Paul, Minnesota, hospital. Days after the surgery, her doctor revealed that her test results had been switched with another woman's, and she had no cancer.²⁷ A Rhode Island surgeon operated on the wrong side of a patient's head after a CT scan was placed backward on an X-ray viewing box. The surgical site had not been marked with a pen as hospital policy required.²⁸ However unfortunate such surgical errors are, they appear to be unusual.²⁹

The United States shares some quality problems with the systems of other developed countries because of a common defect noted in the Introduction: all developed countries have suppressed normal market forces. As a result, in health care we do not observe the quality control we have come to expect in profit-making enterprises. Indeed, all over the developed world hospitals lack the quality controls observable in corner supermarkets.³⁰ In this respect, differences between the United States and other countries are differences of degree. We note parenthetically, however, that the United States is more aggressively pushing its hospital sector to adopt business techniques for managing quality.

In other respects, differences between the U.S. health care system and the systems of other countries are differences of kind. Although mistakes are made in U.S. hospitals, patients are not routinely denied access to lifesaving drugs and lifesaving technology, as happens elsewhere around the world.

NOTES

1. Don R. McCanne, "Would Single-Payer Health Insurance Be Good for America?" Physicians for a National Health Program, March 27, 2000.
2. *The World Health Report 2000—Health Systems: Improving Performance* (World Health Organization, 2000).
3. Sample population is "sicker" and is likely to rate health as "fair" or "poor." New Zealand had the least unhealthy sample, 38 percent of sample rating their health "fair" or "poor." The United Kingdom had the most unhealthy sample with 62 percent rating their health "fair" or "poor."

4. Robert J. Blendon, Cathy Schoen, Catherine DesRoches, Robin Osborn, and Kinga Zapert, "Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries," *Health Affairs* 22, no. 3 (May/June 2003): 106–21.
5. Blendon et al., "Common Concerns Amid Diverse Systems."
6. Robert J. Blendon, Cathy Schoen, Catherine M. DesRoches, Robin Osborn, Kimberly L. Scoles, and Kinga Zapert, "Inequities in Health Care: A Five-Country Survey," *Health Affairs* 21, no. 3 (May/June 2002): 182–91.
7. Blendon et al., "Common Concerns Amid Diverse Systems," 106–21.
8. "Ottawa Eyes Cure for Health Funding," *Toronto Star*, November 4, 1997.
9. Marko Simunovic et al., "A Snapshot of Waiting Times for Cancer Surgery Provided by Surgeons Affiliated with Regional Cancer Centres in Ontario," *Canadian Medical Association Journal* 165, no. 4 (August 21, 2001): 421–25.
10. "Physician Resource Questionnaire," Canadian Medical Association, January 1998; and Canadian Medical Association, "Canadians' Access to Quality Health Care: A System in Crisis," submitted to the House of Commons Standing Committee on Finance, August 31, 1998.
11. Kellie Hudson, "Patient's Death 'Anomaly': Despite Futile Bed Search; Agency Says System Works but Doctors Disagree," *Toronto Star*, July 3, 1998.
12. Siri Agrell, "Toronto Bed Found for Man Who Fell Ill in U.S.," *National Post*, August 8, 2003.
13. Vince Talotta, "The Sickness in Our Health System," *Toronto Star*, February 6, 1999.
14. "The Boy Who Ran Out of Time," *Toronto Star*, December 12, 1999.
15. Author's calculations based on Henry J. Aaron and William B. Schwartz, *The Painful Prescription: Rationing Hospital Care* (Washington, D.C.: Brookings Institution, 1984). Reported in John C. Goodman and Gerald L. Musgrave, "Twenty Myths About National Health Insurance," NCPA Policy Report No. 128, National Center for Policy Analysis, December 1991.
16. Although its population is about one-sixth that of the United States, the United Kingdom spends less than 6 percent as much on treatment of renal failure, or less than \$1 billion per year compared to more than \$17 billion in the United States. Figures reported in British pounds were converted to U.S. dollars. See Sheffield Kidney Research Foundation, Background to SKRF, available at www.skrf.org.uk/background.html. Accessed December 4, 2003.
17. Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): Exhibit 6. See also E. C. Mulerrin, "Rationing Renal Replacement Therapy to Older Patients: Agreed Guidelines Are Needed," *QJ Med* 93, no. 4 (April 2000): 253–55.
18. J. K. Mackenzie et al., "Dialysis Decision Making in Canada, the United Kingdom, and the United States," *American Journal of Kidney Diseases* 31, no. 1 (1998): 12–18. Britain, at 12 percent, was only slightly worse than Canada, where 10 percent of nephrologists report refusing treatment due to limited resources.
19. "Watchdog Healthcheck," *BBC Online News*, January 15, 2001. Research by the Public Health Laboratory Service and the London School of Hygiene and Tropical

Medicine set the cost of hospital-acquired infections at £1 billion. The National Audit Office estimates that as many as 5,000 people die each year of the infections. See “Hospital Infections Cost £1 Billion a Year,” *BBC News*, January 18, 2000; and “NHS Bugs Kill 5,000 a Year,” *BBC News*, February 17, 2000.

20. Olga Craig, “How Could Someone Look Down at My Little Boy and End His Life, in a Hospital, Where He Should Be Safe?” *Sunday Telegraph* (London), August 19, 2001.

21. Aine Harrington, “Beatson Put Dying Man in a Hotel; Son Tells of Father Being Moved ‘from Pillar to Post,’” *Glasgow Herald*, November 16, 2001.

22. Lorna Duckworth, “Obsolete Systems Blamed for Rise in NHS Drug Deaths,” *The Independent*, December 18, 2001.

23. This may be partially due to the fact that the NHS spends much less on treatment—\$1.35 per capita compared to \$24.35 per capita in the United States. Nick Bosanquet, “A Successful NHS: From Aspiration to Delivery,” Adam Smith Institute, 1999, 10.

24. Karol Sikora, “Cancer Survival in Britain,” *British Medical Journal* (August 21, 1999): 461–62.

25. Elise C. Becher and Mark Chassin, “Improving the Quality of Health Care: Who Will Lead?” *Health Affairs* 20, no. 5 (September/October 2001): 164–79.

26. Institute of Medicine, *To Err Is Human: Building a Safer Health Care System* (Washington, D.C.: National Academy Press, 1999).

27. “Mastectomy Mistake Fuels Debate,” *CBSNews.com*, January 21, 2003.

28. “Protect Yourself from Wrong Site Surgery,” Employer Health Care Alliance Cooperative, available at www.alliancehealthcoop.com. Accessed December 12, 2003.

29. The sentinel event database of the Joint Commission on Accreditation of Healthcare Organizations lists a total of 232 wrong site surgeries from 1995 to October 28, 2003. “Sentinel Event Statistics: As of October 28, 2003,” Joint Commission on Accreditation of Healthcare Organizations, available at www.jcaho.org. Accessed December 12, 2003.

30. About 125 of the more than 5,000 hospitals in the United States used supermarket-style bar code systems to identify drugs and vials of blood in 2003. A 2004 Federal Food and Drug Administration order was expected to require bar codes on medications sold to hospitals. See Lauren Neergaard, “New Rules Expected to Reduce Deaths from Medication Errors,” *Associated Press/Dallas Morning News*, December 17, 2003.