

Chapter Eight

Efficiency

MYTH NO. 8: COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH INSURANCE HOLD DOWN COSTS BY OPERATING MORE EFFICIENT HEALTH CARE SYSTEMS

Advocates of single-payer health insurance often point to the low level of health care spending in countries with national health insurance as evidence of efficient management. But cheap is not the same as efficient. By and large, countries that have slowed the growth of health care spending have done so by *denying services*, not by using resources more efficiently. In Britain, it is not unusual to find a modern laboratory and an antiquated radiology department in the same hospital. Nor is it unusual to find one hospital with a bed shortage near another with a bed surplus. Excellence is random and is often the result of the energy and enthusiasm of a few isolated individuals rather than decisions by hospital management.

How much does it cost a hospital to perform an appendectomy? Outside the United States, it is doubtful that any public hospital could provide the answer. Nor do government-run hospitals typically keep records that would allow anyone else to find out.¹ In organizational skills and managerial efficiency, the public hospitals of other countries lag far behind hospitals in the United States. Nor is it easy for other countries to change course. One reason is that health care is political. Health economist Alain Enthoven has observed that because health care in Britain is so politicized, “it is more difficult to close an unneeded [British] hospital than an unneeded American military base.”²

INEFFICIENCY IN BRITAIN

Britain has about 20 percent fewer inpatient hospital beds per capita than the United States and about 44 percent fewer than the OECD median of 4.3 per 1,000 population.³ Partly due to this smaller capacity, it has experienced a persistent shortage of hospital beds. In recent years, the shortage has become critical. Britain also suffers from staffing shortages and is therefore unable to utilize all available beds. Furthermore, beds are often utilized inappropriately. For example, in 2000, 90 percent of hospital geriatric beds were occupied, whereas only 60 percent of maternity beds were occupied. Had the 40 percent of vacant maternity beds been converted to geriatric use, queues for hospital admission would have been much shorter.⁴

On the other hand, long-term care patients who should be in nursing homes, geriatric wards or at home are often found occupying acute care beds in Britain, a practice known as “bed blocking.” As a result, many patients must wait for admission and treatment because patients treated earlier are waiting for discharge to an appropriate facility and thus “blocking” access to a bed. Officials estimate that about 3.3 percent of beds are blocked at any given time.⁵ And many public health officials think the actual number may be far higher. Liam Fox, the Conservative party’s shadow health secretary in the British parliament, has estimated that the true number of blocked beds is closer to 15 percent.⁶

Nicola Sturgeon, a member of the Scottish parliament, reported that 10 percent of acute care beds in Scotland are “occupied by geriatric patients needing residential care.”⁷ A survey of a hospital in Coventry found that three-fourths of patients occupying beds no longer needed acute care, but had nowhere suitable to go.⁸ The problem is so severe that in an attempt to free up more hospital beds for acute care patients, the Department of Health launched a pilot project that sends patients to recover at bed-and-breakfast inns in the countryside.⁹

The statistics on bed utilization indicate bed management in Britain is highly inefficient. More than one million people are waiting for medical treatment in British hospitals at any one time and an estimated 500,000 surgeries were cancelled in the past five years due to the shortage of NHS hospital beds.¹⁰ Yet close to 30,000 beds (16 percent of the total) are empty on any given day.¹¹ Add to that the number of beds filled with patients who do not belong in a hospital at all and this implies that one out of every three NHS hospital beds are unavailable for acute care patients!

Britain also experiences wide differences in the cost of services within the NHS. Although in general real hospital costs for various procedures are difficult or impossible to determine, one study estimated that costs vary by as

much as 58 percent between Britain's most- and least-expensive hospitals. For example¹²:

- The cost of a hip replacement varied from \$2,616 to \$9,264, a difference of 254 percent.
- The cost of a vasectomy ranged from \$211 to over \$1,427, a difference of 550 percent.

The cheapest hospital trust in England costs 30 percent below the national average, while the most expensive had costs 60 percent above the average.¹³

INEFFICIENCY IN CANADA

In Canada a large percentage of acute care hospital beds also are used for patients who do not need acute care. The Manitoba Center for Health Policy found that across the provinces from 7 percent to 51 percent of Canadian adult admissions and from 27 percent to 59 percent of the days patients spent in hospitals were for conditions that did not require acute care, although most did need some form of supervised care.¹⁴ Among the findings,

- In Manitoba, 23 percent of the bed days spent by short-stay patients in acute care hospitals were unnecessary.¹⁵
- In Winnipeg, Manitoba, 40 percent of the acute care beds were used by only a few patients, each staying more than thirty days.¹⁶

Although the less efficient use of acute care beds generally is attributed to a lack of other facilities, especially for patients needing long-term care, global budgets create incentives to keep chronic patients in acute hospital beds. Hospital managers find it less expensive when a bed is occupied by a long-term patient who needs mostly "hotel" services than when the bed is occupied by a patient who needs more costly treatment.¹⁷ The practice may also make life more convenient for doctors, despite the social cost. Some physicians find it easier and faster to arrange a diagnostic test like a CT scan or stress test for an inpatient and easier to locate the results because they are on the patient's chart.¹⁸

EFFICIENCY MEASURE: HOSPITAL LENGTH OF STAY

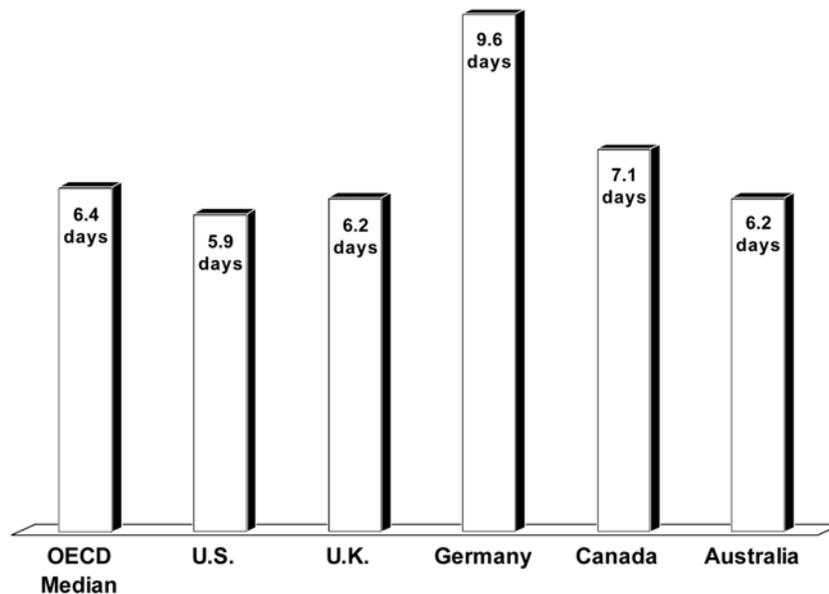
One widely used measure of hospital efficiency is average length of stay (LOS).¹⁹ Hospital-related services are the largest component of health care

costs in most countries.²⁰ Thus, the inappropriate use of hospital facilities has a significant impact on the efficiency of the health care system. It is an inefficient use of resources to fill an acute care hospital bed with a patient awaiting nonemergency care, or a geriatric patient awaiting transfer to a nonacute facility, or simply because the hospital has not gotten around to discharging that patient. This is especially true when there are lengthy waiting lists for hospital admission. Generally, the more efficient the hospital, the more quickly it will admit and discharge patients.²¹

By this standard, U.S. hospitals are ahead of their international counterparts (see figure 8.1).²² The average length of hospital stay in the United States is 5.9 days compared to 6.2 days in Australia, 9.0 in the Netherlands and 9.6 Germany. Whereas patients from other countries routinely convalesce in a hospital, American patients are more likely to recover at home.

FIGURE 8-1

Average Length of Hospital Stay



Source: Gerard F. Anderson, Uwe E. Reinhart, Peter S. Hussey and Uarduhi Petrosyan, "It's the Prices, Stupid: Why the United States is So Different from Other Countries," *Health Affairs*, Vol. 22, No. 3, May/June 2003, Exhibit 5, p. 97.

COST COMPARISON: BRITAIN'S NHS VERSUS U.S. HMOS

A comparison of the NHS and Kaiser Permanente, a large U.S. HMO, concluded that the per capita costs of the two systems were similar. However, the analysis found that Kaiser provided its members with more comprehensive and convenient primary care services and much more rapid access to specialists and hospital admissions. After adjustments for differences between countries, the NHS cost was calculated at \$1,764 per capita compared to a Kaiser cost of \$1,951.²³ However, Figure 8.2 shows the following:

- Kaiser had two and one-half times as many pediatricians, twice as many obstetricians-gynecologists and three times as many cardiologists per enrollee as the NHS.
- After referral, waiting times to see a specialist were more than six times as long in the NHS.
- For nonemergency hospital admission, 90 percent of Kaiser patients waited less than three months; one-third of NHS patients waited more than five months.

One of the most striking differences between the two health systems was the length of stay. Kaiser had 270 acute care bed days per 1,000 population, whereas NHS patients stayed in the hospital more than three times as long—an average of 1,000 acute care bed days per 1,000 population.²⁴ In summary, the study found²⁵

The widely held beliefs that the NHS is efficient and that poor performance in certain areas is largely explained by underinvestment are not supported by this analysis. Kaiser achieved better performance at roughly the same cost as the NHS because of integration throughout the system, efficient management of hospital use, the benefits of competition and greater investment in information technology.

PRIVATE SOLUTIONS FOR THE PROBLEMS OF NATIONAL HEALTH INSURANCE

Several European countries with single-payer health care systems have discovered the value of competition, albeit sometimes reluctantly. European Union regulations that force reductions in taxes have driven some countries to experiment with “internal markets” that introduce private health care providers into the publicly financed system. One example is in Stockholm, the capital of Europe’s most heavily socialized welfare state. After first allowing competition by

contractors for nonmedical services, the city's Health Services Council began privatizing all primary care in 1998 and sold St. Göran's, one of Sweden's largest hospitals, to a private company in 1999. Most of the funding still comes from the government, which is getting far more for its money than before. A study of the privatization program found²⁶

- The cost per consultation in private practices compared to public hospital outpatient clinics ranges from 13 percent lower in general surgery, internal medicine and dermatology to 17 percent lower among ear, nose and throat specialists and 28 percent lower in ophthalmology.
- At St. Göran's, costs for lab and X-ray services fell by 50 percent and overall costs by 30 percent.
- Private nursing home costs were 30 percent lower.
- On average, St. Göran's now treats 100,000 more patients each year than it did as a public hospital, while using fewer resources.

As a result of the experiment, the Health Services Council plans to turn over operations of the seven remaining public acute care hospitals in Stockholm to private investors.

NOTES

1. For Britain, see the discussion in Alain C. Enthoven, "Internal Market Reform of the British Health Service," *Health Affairs* 10, no. 3 (Fall 1991): 60–70. A Canadian observer reports that "Ontario hospitals lag at least a decade behind their U.S. counterparts in expenditure tracking and management information systems." See C. David Naylor, "A Different View of Queues in Ontario," *Health Affairs* 10, no. 3 (Fall 1991): 112.

2. Enthoven, "Internal Market Reform," 62.

3. Gerard Anderson and Peter Sotir Hussey, "Comparing Health System Performance in OECD Countries," *Health Affairs* 20, no. 3 (May/June 2001): 219–32.

4. "Publication of Latest Statistics on Bed Availability and Occupancy for England, 2000–2001."

5. For example, a BBC report claimed that on any given day, around 6,000 (out of a total 186,000 hospital beds) are occupied by "bed blockers." Two-thirds of these are elderly patients in need of less-expensive community facilities. See Karen Allen, "Analysis: How to Beat NHS Gridlock" *BBC News*, October 10, 2001 and "Bed-Blocking a Massive Problem," *BBC News*, April 17, 2002.

6. See Jenny Booth, "Scandal of Stranded Hospital Pensioners: Labour Accused over the Shortage of Money and Nursing Home Places That Leaves Patients Blocking NHS Beds, Reports Jenny Booth," *Sunday Telegraph* (London), August 12, 2001.

7. *Scottish Parliament Official Report* 9, no. 2 (November 16, 2000).

8. Karen Hambridge, "Shocking Truth behind Lack of Hospital Beds: Wards Full of Patients Who Shouldn't Be There," *Coventry Evening Telegraph*, June 30, 2001.

9. See Valerie Elliott, "'Bed Blockers' Farmed Out for B&B Recovery," *The Times* (London), February 9, 2002.

10. Elliott, "'Bed Blockers' Farmed Out."

11. The U.S. occupancy rate of approximately 65 percent is far below Britain's rate of 84 percent. For information on Britain's bed occupancy rate, see "Publication of Latest Statistics on Bed Availability and Occupancy for England, 2000–2001," UK Department of Health Press Release, September 19, 2001.

12. Linda Beecham, "Cost of NHS Operations Varies Widely," *British Medical Journal* (November 14, 1998): 1393.

13. Beecham, "Cost of NHS Operations."

14. Carolyn DeCoster, Sandra Peterson and Paul Kasian, "Alternatives to Acute Care," Manitoba Centre for Health Policy and Evaluation, July 1996.

15. Sharon Bruce et al., "Acuity of Patients Hospitalized for Medical Conditions at Winnipeg Acute Care Hospitals," Manitoba Centre for Health Policy and Evaluation, June 2001.

16. Carolyn DeCoster and Anita Kozyrskyj, "Long-Stay Patients in Winnipeg Acute Care Hospitals," Manitoba Centre for Health Policy and Evaluation, September 2000.

17. Raisa Deber, a professor of health policy at the University of Toronto, described the incentive: "Since hospitals have budgets to follow, they may have to ration the use of expensive procedures even though this might result in waiting lists." Raisa Deber, "Canada's Healthcare System," presentation to the Maine Development Foundation, 2000.

18. DeCoster, Peterson and Kasian, "Alternatives to Acute Care."

19. See, for example, "The New NHS, Modern and Dependable: A National Framework for Assessing Performance," UK Department of Health, 1998, Attachment A.iv and Attachment B.xviii, available at www.doh.gov.uk/newnhs/consdoc/info.htm; Harald Buhaug, "Length of Stay in General Hospitals," available at www.valm.lv/orahs99/Abstr24.html; and Marni D. Brownell and Noralou P. Roos, "Variation in Length of Stay as a Measure of Efficiency in Manitoba Hospitals," *Canadian Medical Association Journal* 152, no. 5 (March 1, 1995): 675–82.

20. In the United States, hospitalization accounts for 42.2 percent of health costs.

21. The actuarial firm Milliman & Robertson has devised the "Length of Stay Efficiency Index," which compares average length of stay by diagnosis-related group (DRG) code and other factors; see www.hospitalefficiencybenchmarks.com. For a discussion of length of stay, see Helen Lippman, "The Bottom Line on Length of Stay," *Business and Health* (April 2001).

22. 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).

23. Richard G. A. Feachem, Neelam K. Sekhri and Karen L. White, "Getting More for Their Dollar: A Comparison of the NHS with California's Kaiser Permanente," *British Medical Journal* (January 19, 2002): 135–43.

24. Feachem et al., "Getting More for Their Dollar," 143. The authors noted, "There is ample evidence that reduced length of hospital stay does no harm and, in view of the risk of staying in hospital, may be beneficial."

25. Feachem et al., "Getting More for Their Dollar," 143.

26. A. Wess Mitchell, "Sweden Edges toward Free-Market Medicine," National Center for Policy Analysis, Brief Analysis No. 369, August 31, 2001.