PERSPECTIVE

There Is No Perfect Health System

All countries need to improve the way they measure and track the quality of patient care.

by Elizabeth A. McGlynn

ABSTRACT: Extensive research into quality of care in different countries yields no conclusive findings that one system is better or worse than others. Quality does not necessarily vary with financing mechanisms; even countries with single-payer systems have variations in quality. Quality is not directly related to the amount spent on health care, since the highest-spending country (the United States) does not have measurably better outcomes. Investments in the quality measurement and reporting systems in all countries would substantially increase the opportunities to learn from cross-national comparisons.

LAST YEAR MY COLLEAGUES and I reported that U.S. adults receive about half of needed medical care for the leading causes of death and disability.[1] We were asked whether other countries do better than the United States. The paper by Peter Hussey and colleagues suggests that the answer is "no."[2] No country was the top or bottom performer in the twenty-one areas for which comparative data were available. Although this latest study is not comprehensive, we can safely conclude that there is no exemplary health system. So, can these results help policymakers improve quality?

It's Not The Financing

The quality problem is not caused by the way health care is financed. All of the countries included in the study, except the United States, have some form of national health insurance. Access does not ensure quality. This conclusion is consistent with previous findings. There is no evidence that clinical quality in the United States is consistently better or worse in fee-for-service than in health maintenance organizations (HMOs).[3] The appropriateness of many surgical procedures is similar in the United States, Canada, and the United Kingdom, although the rates at which the procedures are used are quite different.[4]

Although focused mechanisms that align financial incentives with improved quality performance may contribute to better quality, policymakers should stipulate that universal coverage will not solve the quality problem.

It's How You Spend, Not How Much You Spend

Hussey and colleagues demonstrate that the amount spent on health care is not related to quality. Health care as a proportion of gross domestic product (GDP) varies from 7.6 percent in the United Kingdom to 13.9 percent in the United States.[5] The United Kingdom and New Zealand (8.2 percent of GDP spent on health care) had the lowest rates of performance on the greatest number of indicators (eight of nineteen areas). However, the United Kingdom and Australia had the best performance in six areas. The United States, with the highest rate of GDP spending, had the worst performance in two areas and the best perfor-

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mance in four areas.

Mechanisms for reducing expenditures frequently have blunt effects on quality. For example, studies of efforts in New Hampshire to reduce prescription drug costs found that these efforts reduced the use of both necessary and unnecessary medications.[6] Similarly, eliminating payment for ineffective medications in New Jersey was associated with an overall increase in the number of prescriptions and resulted in both desirable and undesirable clinical substitutions.[7] Cost sharing reduced overall spending on antibiotics, but appropriate and inappropriate uses were reduced at the same rate.[8]

Improved quality may reduce costs. Better management of chronic conditions in outpatient settings can prevent hospitalizations.[9] Influenza and pneumonia vaccines reduce hospitalizations and deaths.[10] Improved management of depression has been associated with improved health and increased rates of employment.[11] However, not all improvements in quality will reduce costs. We do not know the net effects on health care spending of comprehensive strategies to improve quality. Nonetheless, if we want to improve quality and reduce costs, we should focus on quality improvement rather than cost reductions.

What Gets Measured Gets Done

None of the countries studied routinely and comprehensively measures quality. Hussey and colleagues started with about 1,000 quality measures collected in one or more countries and ended up with just sixteen measures that could be applied in all five. The measures themselves are, by the authors' own admission, an opportunistic set that does not give a comprehensive picture of quality in any of these countries. To understand better how each country's health system works, we all need to invest in measurement.

Hussey and colleagues suggest that by comparing the results of these measures, countries might learn from one another. A closer look at the results, however, delivers a smoking gun without motive, means, or an opportunity to do better.

Two examples illustrate this point. The United States performed best among the five countries in breast cancer survival (85.5 percent of American women who are diagnosed with breast cancer survive at least five years, compared with 75 percent of British women). However, the United States did not have the highest rate of breast cancer screening (69.9 percent compared with 73.7 percent in Australia), and the United Kingdom did not have the lowest rate (66.8 percent, compared with 63 percent in New Zealand). Detecting breast cancer at an early stage, through screening, increases the likelihood of survival. But for the benefits of screening to be realized, a woman must get timely and effective care beyond the mammogram—she must have a thorough work-up, a definitive diagnosis, an appropriate course of treatment, and ongoing monitoring. A failure of any of these steps will decrease the odds of survival. But none of these countries routinely measures each step, so we don't know what happened between screening and survival.

An interesting counterexample was a study comparing the care and outcomes for people who had a heart attack in Minneapolis/St. Paul, Minnesota, and Goteborg, Sweden.[12] There were significant differences between the two cities in the use of proven approaches to diagnosis and treatment but no differences in mortality rates thirty days after admission or three years later. Both cities could identify explicit opportunities to improve care processes and in turn health outcomes.

For quality of care to improve, health professionals and consumers need to know what should be done differently and how much of a difference is necessary to get a better result. This means that we need much more comprehensive measures of quality than are available routinely in any of these countries.

It's The Way Medicine Is Practiced

If the way health care delivery is financed does not explain differences in quality and if more is not necessarily better, where does this leave us? Despite differences in the context in which medical care is practiced and the expec-

tations of the populations in each of these countries, there are vast similarities at the micro level in how health care is delivered. None of the five countries has electronic clinical information systems capable of tracking patients across multiple providers and settings of care. Relatively little proactive management of preventive care and chronic disease occurs. Health care is divided up in different ways between primary care and specialty care, but communication across the divide is limited. The ability for human beings in any of these systems to match the array of what is possible against the needs of a particular patient is limited and rarely supported by modern decision-support tools. Fundamental changes in the way medical care is organized, managed, and delivered will be necessary if we are all to take advantage of what science has to offer. Efforts are under way in the United Kingdom, Canada, New Zealand, and Australia to change health care organizations, adopt electronic medical records, and increase health system accountability. Let's hope the United States is not left behind.

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NOTES

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