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POLICY BRIEF

Assessing the quality of health care in the United States – how the U.S. compares with countries around the world

By Dr. Roger Stark, Senior Fellow in Health Care Policy,
Center for Health Care

November 2021

Key Findings

1. The United States spends more money on health care than any other country. Advocates of a single-payer health care system argue that the U.S. has worse outcomes than other industrialized countries, in spite of the high cost.
2. The two organizations that are most often cited on international health care rankings are the World Health Organization and the Commonwealth Fund. Both groups penalize the U.S. because the country does not have government-mandated universal health insurance.
3. Simply having health insurance does not guarantee timely access to medical care.
4. Research shows that the U.S. ranks either first or in the top five countries when dealing with the two most common health issues – cardiovascular disease and cancer.
5. Personal responsibility is critically important to maintaining good health but is virtually always overlooked when discussing health care delivery systems.
6. A country's health care system cannot and should not be responsible for individual lifestyle choices, which in many cases contribute to illness. The effectiveness of health care delivery should be based on clinical outcomes.

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Introduction

The United States spends more money on health care than any other country. In 2019, the year before the COVID-19 pandemic, the U.S. spent $3.8 trillion, or 17.7 percent of the economy's gross domestic product (GDP), on medical care.[1] The question is whether this amount of spending provides better clinical outcomes for patients.

Advocates of a socialist, single-payer health care system argue that the U.S. has worse health outcomes than other industrialized countries, all of which have some form of government-run medical care. At the same time, there is an increasing trend in the U.S. for payers, employers and government programs, to only reimburse providers for "quality" medicine.

This Policy Brief reviews data that compares clinical health outcomes in the U.S. with those of other countries. It examines how the criteria of "pay-for-quality" (PFQ) are generated and whether so-called PFQ policies provide any real benefit to patients. This study explores how data on "unnecessary" hospital deaths is collected. It also correlates the lifestyle choices of individuals with health outcomes.

Background – The evolution of the United States health care system

The United States has a unique health care delivery system. Unlike other industrialized countries which all have some form of top-down, government-run system, the structure of medical care in the U.S. has evolved organically over the past 80 years.

Until World War II, patients paid doctors and hospitals on a fee-for-service (FFS) basis, just as they would pay other professionals, such as lawyers, architects and auto mechanics for their services. Few people had health insurance. During the war, the government imposed strict wage and price controls on the economy, but officials did allow employers to pay for employee health insurance as a way of supplementing capped wages.

This policy was the beginning of a health care system in the United States in which a non-involved third party, the employer, paid for medical services provided to employees and their families. The government further entrenched this third-party,

1 "National health care spending in 2019: Steady growth for the fourth consecutive year," by A.B. Martin, et.al., National Library of Medicine, January, 2021, at https://pubmed.ncbi.nlm.nih.gov/33326300/.

employer-paid model by allowing employers to deduct the cost of employee health benefit expenses from their corporate taxes. The government did not extend this generous tax benefit, however, to individuals and families, making privately-owned health insurance much more expensive.

Doctors and other health providers were still paid on a fee-for-service basis, either by employers directly or by employers through insurance companies.

In 1965, the government became directly involved as a third-party payer in the U.S. health care system when Congress passed the Medicare and Medicaid entitlement programs. Medicare is socialized health care for seniors, paid for by payroll taxes on workers, the federal general fund, and individual premiums. Medicaid, at least in theory, is a safety-net insurance plan for low-income people, some long-term care, and the disabled. It is paid for by both state and federal taxpayers who, of course, are the same people. Doctors and hospitals were traditionally paid on a fee-for-service basis in both entitlements, although the current trend is toward pre-paid, health-maintenance models.

Government officials further involved themselves in health care relationships when Congress narrowly passed the Affordable Care Act, or Obamacare, in 2010. The ACA expanded Medicaid and now gives taxpayer subsidies to middle-income people to help them buy health insurance through state and federal insurance exchanges.[2]

The vast majority of health care in the U.S. is now paid for by a third party, either employers or government officials. As a consequence, demand and spending on health care have exploded, which is consistent with the economic principle that utilization of a product or service will increase dramatically if consumers believe someone else is paying for it.

Advocates of a single-payer system in the U.S. believe this existing hybrid system is detrimental to patient care. They argue that the government can not only control costs but should try to control and improve individual medical outcomes as well.

Health care measurements

The two organizations that are most often cited in assessing international health care rankings are the World Health Organization[3] and the Commonwealth Fund[4].

The WHO lists five separate categories that it applies to each country's health care delivery system. It also weights each category for ranking purposes:

- Overall population health – 25 percent
- Health inequality – 25 percent
- Level of responsiveness – 12.5 percent

2 "Changes in patient and doctor relationships in United States health care," by R. Stark, MD, Policy Note, Washington Policy Center, November, 2015, at https://www.washingtonpolicy.org/library/doclib/Stark-Changes-in-patient-and-doctor-relationships-in-United-States-health-care.pdf

3 "Measuring overall health system performance for 191 countries," by A. Tandon, et.al., World Health Organization, Paper 30, at https://www.who.int/healthinfo/paper30.pdf

4 "Mirror, mirror 2021: Reflecting poorly," by E.C. Schneider, et. al., The Commonwealth Fund, August 4, 2021, at https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly.

- Distribution of responsiveness – 12.5 percent
- Fairness in financing – 25 percent

The Commonwealth Fund also uses five categories that are somewhat different than those used by the WHO. The CF does not use percentages in its rankings:

- Access to care – this includes affordability and timeliness (but not wait times)
- Care process – this includes preventative and coordinated care
- Administrative efficiency – basically refers to the amount of paperwork that providers must complete
- Equity – especially as it applies to patient income
- Health care outcomes – specifically age mortality, chronic conditions in the non-elderly, preventable deaths, 30-day in-hospital mortality for heart attacks and strokes, incidence of maternal deaths, and suicides (it does not include five-year cancer survival rates)

United State's rankings

The World Health Organization's paper looked at all 191 countries in the world and is arguably the most often quoted by media organizations. Officials there ranked the U.S. 37th, behind Greece, Columbia, and Morocco. They ranked communist Cuba 39th, to put their study method in perspective.

The researchers at the Commonwealth Fund studied 11 industrialized countries. They ranked the United States last, with smaller countries, Australia, Norway, and Switzerland, ranking one through three respectively. Commonwealth researchers did not take into account the size or diversity of a country.

The critical issue in both studies is the emphasis on the supposed "equity" in a country's health care delivery system. The WHO study put percentages on its criteria. At least 62.5 percent of its ranking is based on a country having a single-payer, or at least a government-run, health care delivery system in which every citizen has health insurance, although not necessarily access to good care. The U.S. does not have a single-payer system, at least at present, and was therefore punished in the rankings before the study was even published.

The Commonwealth Fund paper did not place percentages on its criteria. Yet, it is very clear that emphasis was again put on "equity" in the system and countries were ranked accordingly. Of course, simply having health insurance does not guarantee timely access to care. When a patient is ill, the most important feature of health care is timely access to diagnostic and treatment procedures, not a paper entitlement.

Pay-for-Performance (P4P)

Unlike other economic activities, as we noted above, health care in the U.S. is largely paid for by a third party – either the government or employers. The Centers for Medicare and Medicaid Services control the government health care spending for

both those entitlements, plus spending for those people enrolled in the Obamacare exchanges. The Affordable Care Act, also known as Obamacare, codified Pay-for-Performance (P4P) for most government health care spending.[5] Private health insurers are following the government's lead on P4P in increasing numbers.

P4P sets outcome parameters that providers must achieve if they are to be reimbursed the maximum payments. If hospitals and doctors fall short of these bureaucratic goals, they are punished by being paid less.

Researchers at the Rand Corporation reviewed 69 studies of P4P extending from 2007 to 2016.[6] They found that P4P could improve the process of care but had very little influence over actual clinical outcomes for patients. Where P4P had its greatest effect was in lower-income, relatively ill patients.

A growing argument that accompanies P4P is for the U.S. health care industry to use the aviation industry as a model. Commercial flying in the U.S. is unquestionably safe. Much of this safety is due to the pilot's use of checklists and their use of rote procedures. However, the human body is not a machine. While set procedures work in an aircraft, human bodies do not always respond to treatments in a uniform fashion. Medical complications are an unfortunate aspect of treating sick patients.

"Unnecessary" hospital deaths

Multiple organizations have estimated the number of unnecessary hospital deaths each year in the U.S. The most often-quoted source is The Leapfrog Group which recently (2019) used data gathered by researchers at the Armstrong Institute, part of Johns Hopkins School of Medicine.[7] The authors estimate that during the year of the study, 150,000 patients died unnecessarily in U.S. hospitals.

The researchers used 15 separate medical events and attached a mortality rate to each of those events. Post-operative respiratory failure and central intravenous line infections were two of the leading reported causes of in-hospital deaths. The authors do admit that "multiple measures" may play a role in these patient deaths. In other words, the researchers can not and did not identify co-morbid conditions. A death from post-operative respiratory failure may have happened because the patient also suffered from cardiac failure. An IV infection may have occurred in a patient who was terminally ill because of other conditions.

Every provider should, and hopefully does, strive to improve patient care. Even with the best of intentions, reporting "unnecessary" deaths in an isolated fashion as The Leapfrog Group does, is a disservice to medical providers. In addition to being inaccurate, it undermines patient confidence in the U.S. health care system.

5 "What is Pay for Performance in health care?," by NEJM Catalyst, NEJM Group, March 1, 2018, at https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245.

6 "The effects of Pay for Performance programs on health, health care use, and processes of care," by A. Mendelson, et. al., The Rand Corporation, March 14, 2017, at https://www.rand.org/pubs/external_publications/EP67025.html

7 "Lives lost, lives saved: An updated comparative analysis of avoidable deaths at hospitals graded by The Leapfrog Group," by M. Austin and J. Derks, The Armstrong Institute, March, 2019, at https://www.hospitalsafetygrade.org/media/file/Lives-Saved-White-Paper-FINAL.pdf

Specific disease outcomes in the United States compared to other countries

The most important aspect of a country's health care delivery system is its responsiveness and success in treating specific diseases. When a person becomes ill, the critical issue is the medical system's ability to reduce the morbidity and mortality of that patient.

Cardiovascular (CV) disease, such as heart attack and stroke, remains the leading cause of death globally and in the United States. Industrialized countries, in general, have a lower mortality rate from CV diseases compared to less developed countries.

Research shows that the 30-day mortality rate after admission to the hospital for a heart attack patient is 4.9 percent in the U.S. compared to a 5.8 percent average for five other industrialized countries.[8] The stroke numbers are similar with a 4.1 percent mortality rate in the U.S. compared to an average of 6.4 percent in five similar countries.

The combination of all cancers is the second leading cause of death for virtually all countries. The Concord-3 study is one of the largest international cancer reports.[9] Researchers examined records of 37 million patients and looked at five-year survival rates for 18 different types of cancer in both adults and children. Again, the U.S. ranked either first or in the top five countries in the most common types of cancer – breast, prostate, and lung.

Health problems in the United States

The U.S. does fall behind other industrialized countries in certain health areas. Data from the Center for Disease Control and Prevention show that 74 percent of Americans are overweight and 43 percent are obese.[10] Weight problems are associated with heart attacks, stroke, type II diabetes, and certain types of cancer.

Research shows that the U.S. lags behind other countries in some generalized health problems such as premature death, longevity, and maternal mortality.[11]

The U.S. also has a high incidence of major physical trauma, such as gun violence and car crashes, as well as a significant rate of suicide. These trauma issues definitely contribute to poor longevity numbers in the U.S. However, they are a consequence of serious social problems and should in no way be a reflection of the health care delivery system.

8 "How does the quality of the U.S. health care system compare to other countries?," by N. Kurani and E. Wager, Peterson-KFF Health System Tracker, September 30, 2021, at https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/#item-start.

9 "CONCORD global surveillance of cancer survival," by the Cancer Survival Group, London School of Hygiene and Tropical Medicine, 2018, at https://csg.lshtm.ac.uk/research/themes/concord-programme/.

10 "Obesity and overweight," Center for Disease Control and Prevention, accessed October 8, 2021, at https://www.cdc.gov/nchs/fastats/obesity-overweight.htm

11 See note #8.

Policy analysis

The purpose and goals of a country's health care delivery system are fundamental issues for any society. Some would argue that the system should include public health and preventive care. Others would say that health care services should focus on treatments once a person becomes sick.

Patients and their families simply want the best medical care available for their specific problems. They hope for the best outcomes regardless of any other aspects of the health delivery system. They want access to the most reliable diagnostic tools and the best treatments.

Disease prevention is definitely important, but personal responsibility plays an enormous role in prevention. Seeking medical input when a person feels well, taking their medications as prescribed, and making good lifestyle decisions such as not smoking and maintaining an ideal weight are all critical to preventing illness. Governments cannot, and should not, force their citizens to follow these lifestyle actions. No government health care system, including a single-payer socialized program, can dictate personal responsibility. Apart from the injustice of using force, no government can, or should, micro-manage the daily lives of its citizens.

Pay for performance is becoming more popular with the payers of health care in the U.S. Yet research shows that its impact on health outcomes is negligible. The easiest way for providers to achieve "quality" outcomes is to simply avoid caring for very sick patients. This can be accomplished in certain insurance situations such as the gatekeeper concept with health maintenance organizations. Socialist systems have achieved this by rationing care and denying treatments to very sick or elderly people.

Likewise, "unnecessary" hospital deaths must be taken into context. It is very common for very sick patients to have multiple health problems. Even though a patient has a complication, the cause of death in many cases may be a separate medical problem.

The U.S. has a higher incidence of deaths from gun violence and automobile crashes than many other countries. These are serious societal problems, but they are not medical issues and should not reflect on the quality of our health care delivery system. Suicide is clearly a mental health problem, but its cause is complex and multifactorial.

One of the largest testaments to the high quality of health care in the U.S. is the fact that thousands of foreign patients travel to America every year for their care. These people have choices and yet elect to utilize our health care system, rather than seek care in their own country.

While it is true that the U.S. spends more on health care than other countries, the reason for this spending must be separated from the discussion of clinical outcomes. Over 90 percent of Americans are either in a government-run health insurance program or have employer-paid health insurance. From a fundamental economic standpoint, it is this third-party payer system shielded from healthy market competition, that drives up health care spending in the U.S. The spending arguments, however, must be separated from the clinical outcome discussion. The quality of

U.S. health care is excellent, but how health services are financed needs significant improvement.

Conclusion

Some would argue that the U.S. health care system has problems, but research shows that treating specific diseases is not one of them. Outcomes in the U.S. for the treatments of the leading causes of death rank the country either at the top or very near the top in benefits to patients when compared to other industrialized countries.

A country's health care system cannot and should not be responsible for individual lifestyle choices, which in many cases directly contribute to a person's illness. A fair measurement of the effectiveness of health care delivery should be based on clinical outcomes, not ideological bias.

Patients and their providers should be free to make the best medical decisions within a transparent and competitive market. Although at risk from those who want more government intervention, the United States health care system currently ranks as one of the best in the world because it allows these more personalized decisions to be made.

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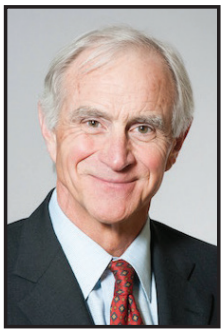
If you have any comments or questions about this study, please contact us at:

Washington Policy Center
PO Box 3643
Seattle, WA 98124-3643

Online: www.washingtonpolicy.org
E-mail: wpc@washingtonpolicy.org
Phone: (206) 937-9691



Dr. Roger Stark is a Senior Fellow at Washington Policy Center and served as its Center for Health Care Policy Analyst from 2008 to 2020. A retired physician, he Dr. Stark has authored three books including the just-published Healthcare Policy Simplified: Understanding a Complex Issue, and The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It. He has also authored numerous in-depth studies on health care policy for WPC, including The Impact of the Affordable Care Act in Washington State, A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States, What Works and What Doesn't: A Review of Health Care Reform in the States, and Health Care Reform that Works: An Update on Health Savings Accounts. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open-heart surgery program at Overlake Hospital. He has served on the hospital's governing board. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. He currently serves on the Board of the Washington Liability Reform Coalition. He and his wife have children and grandchildren in the area.