Quality in consumer-driven health systems

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Abstract

In the global quest for improved ‘quality’ in health care, the purely clinical quality of health care should not be confused with the quality of the health care experience. Although the former is central to the latter, it is the latter that determines the overall quality of a health system. Americans have long had trouble with this crucial distinction. A survey of several distinct dimensions of the quality of the entire health care experience, for example, can help to explain why the technically sophisticated, expensive and often very luxurious American health system tends to earn relatively low scores in cross-national surveys in which respondents are asked to rate the overall quality of their health system. Many useful insights can undoubtedly be had from the system’s myriad experiments with continuous improvements in the clinical quality of health care (just as Americans, however, could learn from similar experiments abroad). On the other hand, the bewildering and ethically dubious financial and managerial systems that Americans have put in place to foster continuous quality improvement in their health care may be self-defeating in the end. Policy analysts and policy makers in other countries may learn from the American experience to spare their citizens the agony.

Keywords: clinical quality, consumer choice models, health system quality

In recent years, the governing credo in American health care has been that only a ‘market driven’ health system can produce a high quality health system. Although not universally shared, even within the USA, the credo has traveled and has excited policy makers in many countries around the globe.

Unfortunately, the term ‘market driven’ is no more descriptive than is the word ‘animal’, which covers many diverse creatures. Every health system has a supply side and a demand side and, therefore, constitutes a ‘market’ of sorts. Every health system also has sundry prices, be they monetary prices for health services or the time prices imposed by queues, that equilibrate the two sides of the market. Every health system therefore is ‘market driven’ in some sense. Indeed, every health system also can be said to be ‘consumer driven’ in some sense, because even under first-dollar insurance coverage (such as the Canadian or German health systems) or a national health service [such as the British National Health Service (NHS)] the recipients of health care do make trade-offs as they choose among available alternatives.

The meaning of ‘market driven’

What the current advocates of ‘market driven health care’ seem to have in mind is two particular versions of a ‘consumer driven’ health system.

In one version, the individual is offered choices at two distinct levels: first, a choice among private health plans that will strictly regulate (manage) the individual’s preventive and acute care and second, a choice among the limited set of health care providers who are part of the particular health plan that the individual had chosen earlier. In the literature, this model is loosely referred to as ‘managed care’, although a more precise label would be ‘managed competition coupled with managed care’. In more illuminating vernacular, one might even call it a ‘pick your own private health care regulator’.

A second, rather different version of ‘consumer driven’ health care eschews the interference of private health care regulators. Under this model, individuals cover with their...
own funds 100% of the cost of their health care up to, for example, US$2000 per year per individual or US$4000 per family. Thereafter, catastrophic insurance coverage is evoked under a policy that the individual has chosen as well. Advocates of this model [1] usually do not recommend that the catastrophic insurance involve ‘managed care’ operated by private health care regulators. Instead, they prefer to style it as a classic indemnity policy that merely reimburses the individual \textit{ex post} for outlays on health care that the individual procured from any provider of his or her choice, without interference by an outside ‘care manager’. To help families to accumulate the funds for the very high deductibles built into this catastrophic insurance model, families would be allowed to set up tax-favored medical savings accounts that might be supplemented by public subsidies for the poor.

Common to these two distinct variants of ‘consumer driven’ health care is that they seek to restore a strong correlation between the health spending actually recorded against the individual’s name and the financial burden for health borne by that same individual. That link is effectively broken under most health insurance systems in the industrialized world whose stated objective is to break that link for the sake of an egalitarian distribution of health care. In what follows, the terms ‘consumer driven’ is arbitrarily reserved for only these types of systems although, as already noted, every health system is in some sense ‘consumer driven’. The underlying credo of the ‘consumer driven’ models under discussion here is that by making individuals suffer noticeably the fiscal consequences of their own use of health care, relatively passive ‘patients’ who receive services paid for by someone else can be re-engineered into vigilant ‘consumers’ who will actively seek value for their own health spending. To do so, goes the credo, these health care consumers will insist on having accurate information \textit{ex ante} on whatever premiums they must pay for their insurance coverage, or whatever prices they must pay out-of-pocket at the time services are received. More importantly, these re-awakened consumers will insist also on information on the ‘quality’ of the health services they are being offered, and they will make judicious trade-offs between the ‘quality’ of their health care experiences and their own health care spending, in accordance with their own tastes and budgets.

In the end, goes the credo, the natural self-interest of properly informed health care consumers, bolstered by the proper incentives, will drive the health system to guarantee that the added benefits yielded by additional health care cover its added cost – that the system will then be ‘efficient’. In the process, it will naturally optimize the ‘quality’ to be had from whatever set of resources are burned up by the health system, where ‘quality’ is a weighted aggregate whose proper weights are determined by the ‘consumers’ of health care, rather than by detached clinical experts or the government.

The word ‘credo’ in this context is advisable, because support for this type of ‘consumer driven’ model of health care rests on nothing other than the mere hypothesis that such a system might produce the desired outcome. As Thomas Rice has argued carefully and persuasively, the hypothesis lacks solid empirical support and is easily questioned even at the theoretical level, because crucial conditions for the proper working of a money-price-competitive market are not usually met in health care [2]. Furthermore, as I have argued elsewhere, the term ‘efficiency’ itself is inherently ideological, because the word takes on meaning only in terms of a clearly articulated goal. In the context of health care, the specification of that goal includes the distributive ethic that the health system is to observe, which is a matter of ideology [3].

Advocacy of these ‘consumer driven’ health systems draws its inspiration from standard neoclassical economic theory. Fundamental to that theory, however, is that the only meaningful output of an economy is not the set of intermediary goods counted in the gross domestic product, but the imaginary something called ‘utils’ – in plain English, human happiness. The argument thus seems to be that these consumer driven health systems will somehow create greater human happiness than will the government-constrained health systems more typical of the industrialized world.

Whereas the USA is still far from the ideal models posited by advocates of ‘consumer driven’ health care, it has certainly developed further in the advocated direction than any other nation’s health system. There is an abundance of choices for the patients with the means to exercise these choices, and there is considerable cost-sharing by patients. The question therefore arises whether, on balance, Americans are happier with their supposedly ‘consumer driven’ health system than are people in nations with more government-controlled health systems. Although that question probably can never be settled conclusively, because its answer is so highly subjective and driven by cultural norms, the responses to cross-national surveys that have attempted to gain such answers have consistently shown that American respondents report considerably less satisfaction with their health system than respondents in other countries report with theirs [4,5]. Nor can American advocates of ‘consumer driven’ health care, who at the same time tend to be opponents of government controls on health care, take solace from a recent ‘American Opinion’ section in The Wall Street Journal [6], whose first headline reads: ‘Americans Tell Government to Stay Out – Except in Case of Health Care’ [7]. The entire section reports on the public’s anger about ‘managed care’ American style and on the public’s clamor for renewed government regulation of the health system.

The American public’s current ire with its health system stands in odd contrast with a mantra widely held among American physicians, health care executives and most politicians, namely, that the American health system is unarguably the ‘best’ health system anywhere in the world. On the public-speaking circuit, that proposition has long been elevated from the status of a mere hypothesis to that of an axiom. The proposition seems to be driven by the thought that anyone who really knows how to navigate the complex American health system, and has the means to pay for the highly sophisticated and luxurious health care its best institutions offer, is unlikely to find health care of superior clinical quality and luxury elsewhere in the world. But that imagery abstracts from several other important dimensions of the inherently multi-dimensional concept of the ‘quality of a health system’.
To appreciate what might fuel the current turmoil in American health care, it will be helpful to explore in greater depth the concept of ‘quality’ in terms of several of its distinct dimensions.

The multiple dimensions of ‘quality’ in health systems

If, in an international group of health policy analysts, each member were asked to write down the top 10 or so distinct dimensions of the quality of a health system, their lists undoubtedly would vary in length and content, but probably the following items would not be controversial:

- the clinical quality of the system;
- its epidemiological quality;
- its distributive ethic;
- the patient's trust in the integrity of the system;
- the ability of the system to protect the patient’s privacy;
- the freedom of choice the system affords the individual;
- the economic quality of the system;
- the financial security afforded by the system;
- the bureaucratic hassle the system visits on patients and providers;
- the system’s physical amenities.

The ‘overall quality’ of a health system is a weighted average of the scores one might award to a system on each of these dimensions. Because these weights are subjective, two observers confronting the same set of empirical information might legitimately rank different nations differently in terms of the ‘overall quality’ of their health systems; this alone could explain why, for example, some Americans and some Canadians will never agree on which nation has the ‘best’ health system, even if there were little disagreement over the empirical evidence on each of the relevant dimensions of quality.

The purely clinical quality of a health care system

It is useful to make a distinction between the purely clinical and the epidemiological quality of a health system, and to think of the former as the degree to which the clinical interventions experienced by those individuals who were actually served by the health system succeeded in enhancing the quality of life enjoyed by those individuals, all other things being equal. That definition of ‘clinical quality’ eclipses from view those individuals who may have been excluded from the health system because of lack of ability to pay or because of cultural barriers to timely care. It focuses strictly on what happened to those persons who were actually served by the health system. The point is that a health system that systematically excludes large segments of the population from appropriate health care and therefore ranks relatively low on the epidemiological dimension of quality can nevertheless rank relatively highly on this more narrow definition of clinical quality.

 Ideally, a high quality health system would be structured so that, for each medical intervention and everywhere in the system, patients experience the most favorable clinical outcome that can be had from the real resources that are being sacrificed as part of the intervention (including the patient’s time). To achieve that goal, the system would have to encourage two distinct activities: (i) a continuous and concerted search for best clinical practices worldwide; and (ii) the quick dissemination of knowledge about best clinical practices to the relevant decision makers in the system. The question at this time is which type of health system would be more likely to be supportive of these fundamental activities: the ‘consumer driven’ health system under discussion here, which relies mainly on financial carrots and sticks to encourage these activities within the health system, or health systems that rely more heavily on a mixture of government regulation, clinical expertise and professional norms as the chief drivers of continuously improved clinical quality.

The most accurate answer is that this question remains completely open at this time. Only very recently has information technology progressed to the point at which consumers could be linked, at least in principle, to data on the clinical outcomes from particular medical procedures [such as coronary arterial bypass grafts (CABG)]. Early indications in the USA are that where such data are available to the general public, neither patients nor their primary-care physicians seem to base their treatment and referral decisions on them [8], perhaps because there are still too many lingering doubts about the quality of the data themselves. Many more experiments need to be studied before it will be known to what extent prospective patients can be enlisted as effective monitors of the purely clinical quality of health care. Ex ante one would expect that the ability of ‘consumers’ to react sensibly to a plethora of quantitative data on clinical outcomes and on the amenities of health care will vary systematically with age and socio-economic status.

If I had to predict which model will drive clinical quality in the next millennium – the ‘consumer driven’ models under discussion here or models driven by a mixture of regulation and professional norms – I would predict the latter.

Figure 1 illustrates how such a model might work in the context of properly functioning ‘managed competition’ among rival health plans (private health care regulators) as it had been conceived by the Jackson Hole Group [9]. Elsewhere I have described how the information system might be adapted to a government-run health system, for example, the British NHS [3].

In Figure 1, the ‘accountable health plan’ could represent either an insurance company that assumes the financial risk of the insureds’ ill health and procures health care under contract from a limited network of health care providers, or it could be a vertically integrated health care delivery system that accepts annual capitation premiums for insured lives and directly assumes full financial risk for the ill health of its enrolled population. These two models will be competing side-by-side in the USA in the next millennium.

Ideally, individuals under this system would have access to the analogue of a farmer’s market for competing health plans, what Alain Enthoven has called a ‘sponsor’ [10]. The
sponsor could be either a large employer, a cooperative formed by employers, a quasi-public not-for-profit entity chartered by government, or even a government agency itself (e.g. a State health department).

Data on the clinical outcomes achieved by the individual providers in the plan’s health network (e.g. mortality rates for CABGs, or re-admission rates) would be extracted from each competing health plan. Also extracted would be data on the plan’s epidemiological outcomes (e.g. immunization rates). These data would go primarily to the sponsor’s clinical experts who could interpret such data properly and who could provide valuable feedback to the providers in the health plans’ networks, along with up-to-date information on currently perceived best clinical practices. Prospective enrollees in the health plan would not be routinely burdened with these complex data, although the data would be available on request to the few ambitious ‘consumers’ who might wish to tackle them.

From each competing health plan data would also be extracted on the degree to which individuals already enrolled in the plan are satisfied with the plan’s own operations and with the individual providers within the plan’s network. Ideally, these data would cover not only the enrolled population as a group, but would provide breakdowns by chronic disease or major episodes of illness. For each plan, prospective enrollees should also receive data on disenrollment rates and stated reasons for disenrollment [11]. Finally, prospective enrollees would have access over the Internet to the complete curriculum vitae of each physician in the network. All of these data presumably could be digested by ‘consumers’ and should go routinely to them, perhaps via the sponsor.

Wherever possible the data on each health plan should not be self-reported but instead be retrieved by an external body, either the sponsor or even a larger body covering all health plans in an entire state. If the data are self-reported, they should be subject to strict audit and health plans should face harsh economic penalties for misreporting.

To the best of my knowledge, it is as yet an open question how tightly the scores on the clinical performance of health plans (or health care providers) are correlated with their scores on patients’ satisfaction. Ideally, one would wish that correlation to be high and positive. But the correlation is unlikely to be invariant to the socio-economic and demographic composition of the enrolled populations providing the patient satisfaction scores. The policy makers’ nightmare is that the correlation might be even negative – that with clever manipulation of enrollees, amenities and other frills might become substitutes for clinical and epidemiological quality. It is an area inviting sustained research worldwide.

Whichever model best drives clinical quality, ‘consumer driven health care’ or the professional norms models, the search for best clinical practices in health care should be truly global and cooperate across national borders, on the premise that nations who are spending much less on health care than do other nations, without a measurable sacrifice in the health status of their populations, may possibly hold lessons on the smart use of health care resources.

It is a safe bet, for example, that once the American ‘managed-care’ revolution has been completed, Americans will have reinvented and updated a good number of practices that have long been used in health systems abroad, among them short stays in hospitals supplemented by careful home care and the separation of the physician workforce into those primarily hospital-based (hospitalists [12]) and those primarily based in the ambulatory setting [13]. After a lengthy study tour of Europe, Donald Berwick (1996), an internationally recognized American expert on quality control in health care, chides his isolationist American colleagues on their penchant for reinventing the wheel in health care [14]. Because of his stature in the field, he merits extended quotation on this point:

I visited Haukland Hospital in Bergen, Norway. It is a first-rate, academic, high-tech referral center where the equipment, access, ambiance, and service levels seem at least as good as in any comparable American facility familiar to me. What is unfamiliar is its costs. Although the exact figures are elusive, the Haukland Hospital seems to be
operating for 25–40% lower cost per unit of service than a U.S. facility would . . . So why are teams of American managers and clinicians not crawling all over Haukland Hospital to seek clues to solve their local problem of cost and quality? . . . Caesarean section rates in several European countries are one-third those in the U.S., or even less, with better maternal and fetal outcomes. One might predict a stampede of [American] clinicians and managers to these ‘benchmark’ systems, curious to study, learn and copy better ways, but we see at best a trickle of inquiry . . . We [Americans] stand to harvest lessons of immense value from the serious study of organizations and systems far from our own . . . When our awareness of our differences impedes our learning [from other nations], we pay a high price in missed opportunity (p. 2).

Several cross-national studies support Berwick’s contention. In their comparative study of spending on hospital care in Canada and the USA, Newhouse, Angerson and Roos (1988) found that Canada spent about 50% less per capita on hospital care than did the USA, leaving the authors to wonder ‘what, if anything, the United States bought for that additional expenditure’ (p. 12) [15]. In a subsequent comparative study on the use of cardiac procedures and outcomes in elderly patients with myocardial infarction Tu et al. found that American patients received far more resource-intensive treatments than Canadian patients. But while the 30-day mortality rate was slightly lower in the USA than it was in Canada (21.4% versus 22.3%), the 1-year mortality rates were identical [16]. Business Week recently reported on the so-called Eurofetus study according to which, of the patients at risk the number of those being tested with ultrasound procedures in the USA is only about one-half of the number of patients being tested in Europe [17]. Even more disturbing was the finding that the procedure, as it is currently applied, ‘is three times as accurate in Europe as in the USA, at a quarter of the cost’. Apparently, according to the study, the difference in accuracy reflects differences in the locus of the procedure. In Europe, the procedure is done mainly in hospitals, by specially trained and certified technicians. By contrast, in the USA ‘any doctor can buy ultrasound equipment and begin scanning without special training’ (p. 85).

Finally, one is struck by a recent, comparative study of health care for the elderly in Canada and in the USA [18] in which the authors conclude:

Canadian elderly receive a higher volume of physician services than US elderly . . . Canadian elderly received 44% more evaluation and management services, but 25% fewer procedures. Canada has a disproportionately lower volume of procedures for which there is a low clinical consensus as to when they are indicated (p. 1410).

This is an interesting finding, and a provocative one, especially because health spending on physician services per elderly Canadian was only about one-half of the comparable figure in the USA and total per-capita health spending in Canada is only about 54% of per-capita health spending in the USA (US$2002 versus US$3768 in 1996) [19]. Unfortunately, findings of this sort rarely impress the defenders of the American health system or the detractors of the Canadian system, because the study did not address directly the clinical quality of care in the two systems. Cross-national studies of the clinical quality of specific treatment modalities for specific illnesses in different nations remains a high research priority.

The epidemiological quality of the health system

The purely clinical quality of a health system refers only to the degree to which medical interventions that actually take place enhance their recipients’ health status and, thereby, quality of life. The epidemiological quality of a health system, on the other hand, refers to its ability to enhance the health status of the entire population at risk.

In as financially and organizationally bloated a health system as the American one, it may be possible to enhance the clinical quality of health care and to reduce costs, which means that superior epidemiological quality could probably be achieved without detracting from the clinical quality experienced by anyone in the system, and without adding to the system’s total resource cost. But eventually, at a given overall resource budget, a health system or a health plan within a system is likely to face a trade-off between these two dimensions of quality. Indeed, the presumption that the USA faces such a trade-off appears to be one reason why the country has been so reluctant to embrace the idea of universal health insurance coverage. As the political rhetoric surrounding universal coverage suggests, the well-to-do fear that universal coverage will inevitably come at the expense of the clinical quality of the health care they now enjoy.

In his seminal work on clinical decision making, David Eddy has wrestled extensively with the problem of making the trade-off between the clinical quality of care experienced by individual patients and the epidemiological quality of the entire health system [20]. In his chapter ‘Rationing resources while improving quality: how to get more for less’ he adopts the perspective of a health plan with a fixed resource base per year and he then shows how, for the population covered by the plan, a reallocation of resources away from low-value uses to high-value (with outcome measured by life expectancy or life-years saved) can enhance the plan’s overall objective, e.g. the average life expectancy of its entire population. But he is also quick to acknowledge that ‘for every case where resources are transferred from no-value and low-value to high-value activities, there will be people who will not be covered or who will be discouraged from using practices they believe have value. Whether their loss is perceived or real, they will be on the short end of the rationing stick’. In his chapter ‘The individual vs. society: resolving the conflict’, he seeks to resolve that conflict by offering the purely normative proposition that, in return for gaining the benefits from pooling the cost of health care, ‘individuals must also accept some responsibilities and limitations. A responsibility is to respect others who contribute to the pool. A limitation is not to withdraw from it an unfair share’.

Eddy’s normative proposition and the policies he derives from it may be neither novel nor controversial in nations
that view health care as a purely social good that is to be collectively financed and to be distributed to all who need care on roughly equal terms. It clashes, however, with the staunchly individualist tradition so deeply ingrained in American culture. Although Americans who choose to enroll in a health plan such as the Kaiser Permanente of Southern California (one of Eddy's consulting clients) ought to accept Eddy's normative proposition in what he calls the 'first position' (when the enrolled do not yet have a health problem), in the 'second position' (when they are ill) and are being denied under Eddy's principle a service they assume to be beneficial, the enrolled usually do not hesitate to gain coverage through America's vaunted tort system, which fuels the nation's individualist tradition and is, in turn, nourished by it. For all of the persuasive power behind Eddy's work, he remains, as yet, a stranger in his own land.

The distributive ethic of the system

Many nations subscribe to the ethical precept that medically necessary health care ought to be available to all members of society, on a timely basis, and without regard to the individual recipient's ability to pay for that care. It is this ethical precept that converts health care from a private consumption good into a so-called 'social good'. Those who prefer to view health care as a social good define the ethical quality of a health system by the degree to which it succeeds in acknowledging its responsibility to adopt that allocative rule.

Within the industrialized world, Canada probably comes closest to obeying this rule, although well-to-do Canadians are able to regard the American health system as their own upper-tier. Most European health systems do have a small, private, upper-tier health insurance system that affords the insured quicker access to wanted health care than they would otherwise enjoy. In all of these countries, however, 90% or more of the population shares one health care delivery system on roughly equal terms and pays for access to it strictly on the basis of ability to pay.

In this respect the USA health system is the odd one out. First, about 17% of the population (about 44 million mainly low-income Americans) do not have any health insurance and face varying degrees of rationing by price and ability to pay when they fall ill. Even elderly Americans covered by Medicare face varying degrees of price-rationing in health care, because that program's benefit package excludes prescription drugs and other important health services, such as long-term care. On average, low-income elderly in the USA still devote about 17% of their own meager income to their own health care.

Because of the manner in which American health care is financed and rationed, Canadians and Europeans generally give the USA a relatively low mark on the dimension of ethical quality. That is, however, a wholly subjective assessment, because egalitarianism is but one theory of distributive justice that could be applied to the allocation of health care. If one sincerely believes that the distribution of wealth and income in the USA proceeds on roughly meritocratic principles, then rationing health care by price and ability to pay might be regarded as more just than the distributive ethic espoused by Canadians and Europeans. For example, libertarian thinkers generally consider it unjust for the state to confiscate justly acquired private property for the purpose of income redistribution.

Americans have never felt comfortable engaging in an open debate over the distributive ethic that ought to guide American health policy. Instead, that ethic is debated implicitly, in code words [22], and implemented piecemeal, as part of the incremental evolution of the American health system. Consequently, there probably would not be a consensus in the USA on two crucial points related to the ethical quality of national health systems: first and most fundamentally, how one ought to score the ethical dimension of a national health system (e.g. should this be done using egalitarian or on libertarian precepts?) and, second, what weight one should attach to that score in arriving at an overall judgment on the 'overall quality' of an entire health system.

Patients' trust in the integrity of the system

A high quality health system fosters among patients trust that their plight will not be exploited for economic reasons by the providers of health care. That trust depends in part on the integrity of the professionals working within the system. It also depends on the process by which professional integrity and the quality of care is formally monitored. However, it is also influenced by the manner in which money is injected into the health care delivery system.

A health system that ties the pecuniary rewards of its professionals very closely to their recommendations concerning medical interventions inevitably casts suspicion on these professionals, regardless of their own professional ethics. Fee-for-service compensation certainly does provide such a tight linkage. It therefore has aroused deep suspicion in recent years, especially in health systems with excess capacity known to be in search of operating revenue for their sustenance. But the same can also be said for payment systems that reward individual health professionals directly for withholding health care from patients. The use of a capitation system by primary-care physicians under the so-called 'gatekeeper models', for example, does set up such conflict of interest. Its spread in recent years has undoubtedly contributed to the growing hostility towards 'managed care' in the USA, which relies increasingly on paying the providers of health care by capitation, forcing the providers to assume full financial risk for their patient's illness. That hostility is a cost to be booked against any economies the gatekeeper model may achieve.

Probably the least problematic method of injecting money into health care is capitation of an entire, integrated health care delivery system that can then distribute that capitation among its constituents in ways that minimize the economic conflict of interest faced by the individual practitioner; for example, by means of salaries that are tied more indirectly to some measure of productivity (including patients' satisfaction scores). If the clamor from the general American public for
information on the financial incentives faced by personal physicians within a health plan is any guide, then making the individual practitioner share noticeably in the cost of his or her treatment decision is unlikely to produce a ‘high quality’ health system, even if it did not impair the purely clinical or epidemiological quality of the system.

**Individual privacy**

Closely linked to patients’ trust in the integrity of the health system is the degree to which that system is able to guard patients’ personal privacy. Americans do not usually fear that their submissions to the Internal Revenue Service are easily accessible to private parties. So far, the privacy of these records seems to have been well guarded. Similarly, Europeans and Canadians do not generally fear that their medical records will fall into the hands of anyone other than their health care providers and their insurance carriers. Although no data bank today is safe from intrusion, citizens in these countries can assume for their medical records roughly the same degree of privacy they (and Americans) assume for their income-tax records. Indeed, Europeans in particular subject their societies in general to rather strict privacy acts, partly in response to the totalitarian governments that have reigned there from time to time.

In this respect, too, the USA is the odd one out. There is mounting concern over the lack of privacy accorded medical records in the private insurance sector, where these records often are easily accessible to the staff of private employers and where they are even openly traded among insurance companies [25]. According to a recent report from Florida, fraud artists can ‘get patient lists from hospitals, doctors or pharmacies, either by computer hacking or by simply requesting them’ [24].

Unlike the ambivalence that reigns over defining the ethical quality of a health system, there probably is little controversy over the proposition that, other things being equal, a health system that accords the medical records of individuals a higher degree of privacy is, in fact, a higher-quality health system. The only difference among different observers would be how much weight one ought to attach to this particular dimension of quality. Persons reared under health systems that afford individuals rather high degrees of personal privacy would probably find the American health system truly frightening on that dimension and marvel at the relative equanimity with which Americans have hitherto tolerated intrusions into their privacy. To be sure, in recent years Americans have begun to view privacy with some concern; but that issue has not yet been accorded the urgency one would have expected in so delicate a matter.

**The system’s economic quality**

Loosely speaking, the economic quality of a health system reflects the benefit–cost ratios associated with its medical interventions. At a sufficiently high and fuzzy level of abstraction, economists usually express this idea with the notion that, in any medical treatment, additional resource use is warranted only if the incremental benefits from that resource use cover its incremental cost. From that requirement flows the idea that an efficient health system will ration health care pervasively, in the sense that it witholds from patients health services (e.g. diagnostic tests) whose demonstrable, positive incremental benefits do not cover their incremental costs.

Whereas economists find this proposition inspirational in the abstract, it is not easily translated into practice, because it is so difficult to assign monetary benefits to clinical outcomes. By way of numerous illustrations, Eddy has shown how the principle might be applied within the collectiveist context of a health plan that seeks to maximize a simple, collectiveist objective deemed worthy of maximizing, such as the average life expectancy of the population enrolled in the health plan [20]. Problems arise when clinical outcomes are multi-dimensional, or when one seeks to optimize the allocation of health care resources for the nation as a whole.

Pauly [25] has argued that this conundrum of collectivist, societal decision making could be sidestepped simply through an application of classical welfare analysis, which would base the relative valuation of outcomes on willingness to pay. That approach, however, makes the value of a clinical outcome a function of the recipient’s wealth, which would not generally be viewed as an acceptable valuation for health care outside of the USA (and is not universally accepted even within the USA).

Even so, one wonders how informed readers in the USA (e.g. Eddy or Berwick) and elsewhere would rank, say, the USA and the UK on the dimension of economic quality, i.e. on the value delivered by the health system in these two countries not in the absolute, but per unit of resources used by the system. For all we know, among objective judges the UK might well win such a contest.

**The freedom of choice offered by the system**

The word ‘choice’ is much used in the debate on American health policy, although not always with the precision that so important a concept warrants. To begin, as noted in the introduction, one must distinguish between two levels of choice in health care: (i) the choice among the insurance contracts that protect the individual from the financial burden of illness and (ii) the choice of providers of health care at the time illness strikes. Within each level, freedom of choice exacts its own price.

Some 43% of employed Americans now are being offered, by their employers, only one insurance plan, which means that they effectively face a private, single-payer system [26]. To exercise the privilege of joining a company’s workforce, the employee must join the company’s preferred health care club. Another 23% of Americans are offered, by their employer, a choice among only two health plans [26]. Even so, these limits on choice notwithstanding, and for better or for worse, by international standards the typical American still does have a wider choice of health insurance options than does his or her counterpart elsewhere in the industrialized world where health insurance is either government-run or tightly regulated by government.

At the time illness strikes, however, Canadians and many
Europeans now enjoy a wider degree of choice among health care providers than do Americans, who increasingly find themselves locked into the network of providers associated with a given health plan. The common assertion in the USA that Americans in general enjoy more ‘freedom of choice’ is probably detracts from the perceived quality of the health system. Europeans, who increasingly find themselves locked into the network of providers associated with a given health plan. The common assertion in the USA that Americans in general enjoy more ‘freedom of choice’ is probably detracts from the perceived quality of the health system.

Other things being equal, a health system that affords individuals a higher degree of choice among insurance options and among health care providers is probably to be preferred to one that offers lower degrees of choice. The word ‘probably’ is used judiciously in the preceding sentence, because not everyone might agree that affording individuals a wide choice among different health insurance contracts is socially desirable, or that affording individual patients complete freedom of choice among providers at time of illness is clinically advisable.

Fundamental to a wide degree of choice among health insurance contracts is the requirement that those who must choose actually can understand the alternative options among which they are to choose. Health insurance is an inherently complicated product that can be made even more opaque through judicious clauses hidden in fine print that are rendered in legal jargon not easily grasped by lay persons. Unless the supply side of the insurance market is forced, through government regulation or other forms of strict supervision, to standardize its offerings to the point that they can be easily understood and compared by the average consumer, freedom of choice in the insurance market carries with it the dangers of a highly imperfect market.

To illustrate, in 1997 the USA Congress sought to liberate the nation’s elderly from the traditional, government-run Medicare program by offering the elderly vouchers for a choice among a plethora of private health insurance products. As the New York Times recently reported, thirty-eight million Medicare beneficiaries will soon be flooded with information about new health insurance options, and most of them are likely to be confused, consumer advocates, members of Congress and Medicare officials say” [27]. If the health insurance market for the nonelderly Americans is any guide, it can reasonably be predicted that, year from now the wider choice offered to the elderly, although beneficial in principle and in intent, will in fact have caused not added human happiness, but palpable anger and frustration all around. It is an experiment well worth studying by policy makers elsewhere (e.g. in Germany) who believe that the salvation of their health system lies in offering ‘consumers’ a wider choice among private health insurance contracts.

Even in an insurance market with strictly supervised, full disclosure, a wide freedom of choice among health insurance products may produce unexpected outcomes, because it will inexorably segregate the insured into distinct risk pools. That tendency conflicts with the apparently widely shared premise (among non-economists and non-actuaries) that one function of health insurance is to redistribute the burden of ill health from the chronically sick to the chronically healthy members of society. In the eyes of the general public, a segmentation of insurance markets by health status probably detracts from the perceived quality of the health system.

There remains the question whether greater freedom of choice among providers at the time of illness is necessarily ‘better’ than more limited choice, leaving aside for the moment the added cost of greater freedom. On this question, economists and clinicians are apt to differ. Many economists would answer this question strictly with appeal to the patient’s own preference [25], regardless of the implication that greater freedom of choice might have for the clinical quality of care. These economists would let the market resolve that issue, trusting the market to cater to all tastes in this matter and trusting individuals to trade off sensibly between the imagined benefits of greater freedom of choice and the known extra premium cost of that freedom. Clinicians and many other policy analysts, on the other hand, might wonder whether the typical patient is actually able to make rational choices among a large set of health care providers whose clinical abilities they may not be able to assess. From that perspective, citizens’ health may be better protected if their choice were limited to alternative health plans, each of which is able to apply clinical expertise and sound judgment in choosing the providers allowed into the plan’s network and each of which presumably will control the quality of these providers’ care on an ongoing basis.

The financial security of the system

Typically, the health insurance of non-elderly Americans is tied to a particular job and is lost with that job. Unemployment in the USA means not only a loss of income, but a simultaneous loss of the health insurance for one’s family.

Once insurance coverage is lost, individuals may not be able to obtain coverage elsewhere, especially if they are chronically ill or have a serious medical episode in their past. As a general rule, until they qualify for the government-run Medicare program at age 65, or have completely pauperized themselves through health bills and become eligible for Medicaid, Americans remain highly insecure over the financial consequences of illness. Unpaid medical bills have become a major source of personal bankruptcy in the USA [28].

Citizens in other industrialized nations take it for granted that they have permanent health insurance and that they will not be driven into bankruptcy by medical bills. One would imagine that they would attach considerable weight to this dimension of quality and consider the American health system of low quality overall on this account alone. Even Americans who have long been accustomed to that state of insecurity often cite it as one of the system’s major shortcomings, which can help explain the low overall quality rating that they accord that system.

The system’s hassle factor

A favorite topic at American dinner parties are the endless battles over medical bills with hospitals, medical practices or insurance companies. It is a uniquely American pastime: in no other industrialized nation is so much paper moved and
so much bureaucratic hassle involved in a typical health care transaction.

A recent study by the American management consulting firm McKinsey and Company illustrates the enormity of this administrative burden [29]. The study was an in-depth exploration of three health systems, conducted under the tutelage of a team of distinguished clinicians and economists (among them Nobel Laureate Kenneth Arrow of Stanford University). The McKinsey research team had followed close-up the treatment of four major tracer diseases in order to detect factors that drive cross-national differences in health spending and outcomes. With these data an attempt was made to isolate the several factors that drive the observed difference in per-capita health spending in Germany, the UK and the USA in 1990. The study is rich and informative in detail. It should serve as a catalyst for critical self-examination in each of the countries studied, especially concerning clinical methods and outcomes.

Particularly relevant for present purposes, however, is the team’s comparison of the German with the American health system. The team found that in 1990 total health spending per capita in Germany was about US$1000 lower than that in the USA (US$1473 versus US$2439; Deutsche Marks converted into US dollars by a purchasing-power-parity exchange rate). Remarkably, in spite of its lower health spending overall, Germany was found to spend US$390 more per capita than did Americans strictly on medical inputs, such as hospital days, physician visits, drugs, and so on. On the other hand, Americans spent US$360 more per capita on administration and another US$256 per capita on an item labeled ‘other’, which may well have been related to administrative complexity as well; these figures do not include the monetary and non-monetary costs American patients bear as they wrestle with the administrative facet of their health system.

The burdensome bureaucratic hassle factor inherent in American health care is probably one more reason why Americans tend to give their health system a relatively low grade in spite of the high clinical quality of care rendered by that system [4]. Choice brings with it complexity and so does cost-sharing by patients at the point of service. Whatever benefits cost-sharing may yield on the purely economic front, it can be asked whether it is civil to visit so much bureaucratic hassle upon families at the time one of their members has been stricken with serious illness or has died. There is something elegant about the idea that families in such situations ought not to be confused and angered by incomprehensible bills, or hounded by threatening notices from bill collectors.

It is not clear that the USA will ever be able to improve significantly its relatively low standing on this particular dimension of quality, for at least two reasons. First, there is what one may call ‘American particularism’, that is, the insistence by Americans that public laws or private contracts be customized to their own individual circumstances, a demand that inevitably breeds complexity. Second, it is a truism that one person’s hassle factor represents another person’s source of income. The complexity of the American health system represents an ever expanding economic frontier for a huge and far-flung consulting industry that stands ready to accommodate ever more complicated arrangements.

The system’s amenities

Finally, among the important dimensions of a health system’s quality are the physical amenities of the system. Included in that dimension are the physical accessibility of health care facilities and their physical appearance.

Although health care facilities located in very poor neighborhoods do, on occasion, take on the appearance of third-world medicine, for the most part the American health system ranks very highly on this dimension of amenities. Competition for paying clients among competing health plans and among individual facilities is likely to keep the American health system at its currently high rank, because it is a dimension highly valued in the market place.

Concluding remarks

Health reform worldwide has one common objective: to hold the providers of health care more fully accountable for the resources they use and to force them into a continuous search for methods that will improve both the health status of the population and its health care experience. Fundamental to a favorable health care experience are, of course, favorable clinical outcomes from medical interventions – a high clinical quality of the health care being delivered. But the quality of the entire health care experience has additional dimensions that must be considered in the worldwide quest for ‘quality’. The objective of this essay has been to explore some of these dimensions and some potential trade-offs among them in greater depth.

Better accountability for the use of health care resources and improvement in the quality of the health care experience can be sought in many ways. It certainly could be sought within the framework of a government-financed, government-regulated system whose professionals are visibly held to the norms of currently known best practices. The British NHS, for example, may choose this path. Canada is likely to choose it as well, within its own system of provincially-run health plans. Alternatively, at the other extreme, better accountability and improved quality could be sought by commercializing the entire health system and letting fully informed, properly incented consumers drive quality. To create a properly incented consumer – i.e. one fortified with the appropriate incentives – a closer link would be restored between the health spending recorded against the individual’s name and the out-of-pocket costs for health care borne by that same individual. For want of a better term, in this essay this approach has been given the generic label ‘consumer driven health care’.

‘Consumer driven’ health care is the approach now favored among American policy makers, and the experiment is being watched around the globe. So far, the experiment has yielded mixed results: while the approach is still supported by policy makers, the general public in the USA seems disillusioned with it.
The preceding survey of several distinct dimensions of the quality of a health system may help explain why the technically sophisticated, expensive and luxurious American health system tends to earn relatively low scores in cross-national surveys that ask respondents to assess the overall quality of their health system. In general Americans tend to perceive the purely clinical quality of their health care to be high, even if they do not know exactly how that quality is to be defined and measured. But the shortcomings of the system on many other dimensions that matter to people now appear to overshadow the system’s assumed achievements in clinical quality. Dissatisfaction with the system as a whole, particularly with the system’s insurance facet, is a staple in daily conversation among Americans.

Policy analysts and policy makers in other countries may learn from the American example. Many useful insights can undoubtedly be had from the system’s myriad local experiments with continuous improvements in the clinical quality of health care, just as Americans can learn from similar experiments abroad. But the awkward complexity of the financial and managerial systems that Americans have put in place to encourage continuous improvement in clinical quality may serve as a negative role model, examples of approaches that other nations might spare themselves. Even if it turned out eventually that with their administratively ever more complex systems of financial incentives Americans did purchase some additional life expectancy or superior clinical quality overall, that achievement may well drown in a chorus of hassled, bewildered and financially insecure citizens who judge their health system inequitable. For the ordinary American, ‘consumer driven’ health care might lead to a rather mediocre health care experience overall.

References