

## Of benchmarking (and bashing) of healthcare systems

It is rather an uncanny coincidence that at the same time that the BMJ reports the latest Euro Health Consumer Index, as produced by the Swedish think tank Health Consumer Powerhouse in the news section, Des Spence, in his regular commentary takes head-on the (so-called) attack of right-leaning papers on the NHS and medical profession.<sup>1</sup> In the Euro Health Consumer Index of 2012, the United Kingdom (i.e. NHS) ranks 12, an improvement over its previous rank of 14 in 2009. Whereas the UK still lags behind the (back-to-back) leaders, the Netherlands, Denmark and Iceland, it is now ahead of Germany and is faring well against Austria, which like Germany in previous rankings placed ahead of the UK.

In this regard, it would be tempting to parlay the results of European healthcare league, as the BMJ called the benchmark, to support Mr. Spence's claims about the NHS as healthcare system that is "very good at dealing with acute, serious, and chronic illness". To do so, however, would be improvident not least because the ranking does not consider the of the role it places on the rights of patients and because it portrays the Dutch healthcare system as a "European model to copy not lease by abolishing single-payer systems".<sup>2</sup>

The Euro Health Consumer Index, in ranking healthcare systems, uses a checklist of 42 indicators grouped into five categories or sub-disciplines as: patients' rights and information (12); accessibility (5); outcomes (8); prevention/range and reach of services provided (10); and pharmaceuticals (7). No country consistently performs well in the individual categories. In fact, top placer, the Netherlands, leads in only two sub-disciplines, patient rights, information and e-Health and prevention/range and reach of services provided. Finland, Switzerland and Sweden also secure top posts in two of five sub-disciplines.

As with the WHO ranking of healthcare systems<sup>3</sup>, the index suffers from scientific and instrumental weaknesses which have to be addressed lest harm be caused by absolute confidence in it. Instead of enumerating the weak spots such as the non-inclusion of "waiting-time from arrival at the practice to consult with the physician" as an indicator of accessibility, inclusion of "informal payments to doctors" as an indicator of prevention/range and reach of services instead of accessibility and focus on specific drugs as well as marketing among indicators of pharmaceuticals, a simple table is presented comparing the UK against selected healthcare systems using data from the World Bank and the WHO.

Table 1. Health Financing, Health Care and Health Indicators Among Five Countries, 2009<sup>4,5</sup>

	Expenditure on health, public (% of GDP) % <sup>1</sup>	Per capita total health expenditure on health (PPP int. \$) <sup>2</sup>	Physicians Density (per 10000 population) <sup>2</sup>	Deaths due to TB among HIV-negative people (per 100000 population) <sup>2</sup>	Measles (MCV) immunization coverage among 1-year-olds (%) <sup>2</sup>	Adult mortality rate (probability of dying between 15 and 60 years per 1000 population) <sup>2</sup>
United Kingdom	6.9	3399	27.39	0.56 [0.56-0.56]	86	77
Australia	6.0	3382	29.91	0.20 [0.17-0.24]	94	62
Germany	8.0	4129	36.01	0.27 [0.23-0.32]	96	76
Italy	6.7	3027	34.86	0.48 [0.42-0.57]	90	59
Netherlands	7.3	4389	NA	0.23 [0.23-0.23]	96	66

Based on Table 1, the favorable outcomes covering prevention, communicable disease and mortality by the Netherlands come with a relatively higher price tag compared to the UK, Italy, Germany, and

Australia, which was included to explore the idea of lessons beyond Europe. Still, adult mortality is lower in relatively low-cost Australia and Italy. On the point of “inexpensiveness” of the healthcare raised by Mr. Spence, which by nature has to be relative, the UK is inexpensive compared to Germany and the Netherlands, indeed, but it is expensive compared to Australia or Italy. The question goes, can we afford to spend as much as Germany or the Netherlands and, ideally, buy better outcomes?<sup>6,7</sup>

Since higher spending does not guarantee better outcomes, and well, resources spent on health care are disinvestment elsewhere, perhaps the challenge that confront us is making do with what we have and still improve on how we deliver care.<sup>8,9</sup> Benchmarking of healthcare systems, to the extent that it spurs debate about health and healthcare between and across healthcare systems is warranted. Failing to recognize the limits of such a process, including the politics behind it, however, augers ill for us all. The same goes for incendiary discussions whether in the US on socialized medicine in Canada and Europe or about the distortions of free market medicine over here and the “sins” of stakeholders.

A difficult patient can be unreasonable. Unrealistic. Entitled. Demanding. However, not one is “unreasonable, unrealistic, entitled, and ridiculously demanding” without reason, (mis)informed, and being cultured into.<sup>1</sup> The same goes for the doctor who is hurried. Authoritarian. Paternalistic.<sup>10</sup> And of health care systems? Some are publicly-funded either by taxation (i.e. Beveridge model) or wage income deductions (i.e. Bismarck model) or privately funded thru premiums for health insurance coverage. One performs well in certain areas while lags in other areas be they spending, productivity and health outcomes. Considering the institutions that shaped and (continue to) define healthcare systems, we tread a fine line in judging values that societies hold in painting healthcare systems as exemplar for the rest to embrace.<sup>11</sup>

#### References:

<sup>1</sup> Spence D. Medicine is our vocation. *BMJ* 2012;344:e3418 doi: 10.1136/bmj.e3418

<sup>2</sup> Health Consumer Powerhouse. Euro Health Consumer Index 2012. <http://www.healthpowerhouse.com/ehci2012>.

<sup>3</sup> World Health Report 2000. Geneva, Switzerland: World Health Organization.

<sup>4</sup> World Development Indicators 2011. Washington, DC: World bank. <http://hdrstats.undp.org/en/indicators/53906.html>.

<sup>5</sup> Global Health Observatory. Geneva, Switzerland: World Health Organization. <http://apps.who.int/ghodata/?theme=country>.

<sup>6</sup> Carrera PM. Investing health care resources. *Health Affairs (Milwood)* 2008; 27: 301-302.

<sup>7</sup> Hills J. Funding of the welfare state. *Oxford Review of Economic Policy* 1995; 11(3): 27-43.

<sup>8</sup> Carrera PM. The importance of public health spending. *Health Affairs (Milwood)* 2011; 30:2027.

<sup>9</sup> Byrne MM, Pietz K, Woodard L, Petersen LA. Health care funding levels and patient outcomes: a national study. *Health Economics*, 2007;16(4):385-93.

<sup>10</sup> Bridges J, Loukanova S and Carrera P. Empowerment and health care. In *International Encyclopedia of Public Health* 2008, K. Heggenhougen and S. Quah (Eds.), pp.17-28. San Diego, USA: Academic Press.

<sup>11</sup> Carrera P and Bridges J. Health financing reforms in Germany: The relevance of all stakeholders. *Harvard Health Policy Review*, 9(1): 17-25.

#### Contact:

Dr. Precivil Carrera  
Health Technology and Services Research Department  
University of Twente  
Drienerlolaan 5,  
7522 NB Enschede  
The Netherlands

Phone: +31 53 4895657

Fax: +31 489 2159