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Understanding the Quality Debate In Health Care
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How does the quality of health care in the U.S. compare with that in other nations?

This is certainly a compelling question, and whichever side you might have championed during the health care reform debate, this “quality” question has not gone away. It is especially relevant for readers of P&T, because the tools and products of the pharmaceutical and biotechnology industries are often maligned as the drivers of increasing costs.

A recent policy analysis from two respected organizations, the Robert Wood Johnson Foundation and the Urban Institute, had shed some light on this urgent health policy topic.1 Authors Elizabeth Docteur and Robert Berenson have put forth a thesis that I believe deserves further review and dissemination.

First, I’d like to present the report’s conclusion and explain its relevance:

Taken collectively, the findings from international studies of health care quality do not in and of themselves provide a definitive answer to the question of how the United States compares in terms of the quality of its health care.

I think most of us would have reached a similar conclusion, but another important aspect of this report is worth noting:

The picture that emerges from the information available on technical quality and related aspects of health system performance is a mixed bag, with the United States doing relatively well in some areas—such as cancer care—and less well in others—such as mortality from conditions amenable to prevention and treatment.

We should take some comfort in knowing that in the high-tech arena, such as 21st-century cancer care, we seem to be on the top of the heap; however, in the day-to-day tasks of promoting the health of our nation’s population, we are still woefully inadequate. From the perspective of our drug and biotech industry leaders, this information could be construed as “positive.” What, then, might be the cause of the apparent differences in quality observed in various countries?

From a survey of primary care physicians in five countries, we know that physicians’ practices in the U.S. are more limited in information capacity and they permit less access for patients outside of traditional work hours. Moreover, physicians are among the least likely to work in teams, and they are not likely to receive financial rewards for quality of care. All of these factors can have a bearing on the quality of health care available.

I feel that the real money lies with our industry leadership: that is, by providing better information capacity, expanding the number of primary care physicians, and including appropriate financial rewards, we could improve that pesky arena of prevention and treatment while maintaining our nation’s leadership role in technology.

Here’s another way to consider a similar view. When policy gurus say that the U.S. has the best quality of health care in the world, they are simply lacking a factual foundation. For example, it’s been stated:

... in light of the fact that the United States spends twice as much per person on health care as its peers, those who question the value for money obtained in U.S. health expenditures are on a firm footing.

I believe that our pharmaceutical and biotechnology corporate leaders should embrace this viewpoint—namely, we are not getting the value for the money we are spending. We ought to be advancing all actions that help us come to grips with the value proposition.

Let’s look at this statement:

... faced with the evidence, one might well ask, why is it that assertions of the superiority of health care in the U.S. are so common?

That is, why do so many think that our health care is so excellent? Perhaps it is the attention paid by the media to our achievements in multiple solid-organ transplantation procedures, the good outcomes from high-risk deliveries of multiple births, or other success stories. However, a public that is less than fully informed comes at a price. The cost is that assertions of our excellence divert attention from the need to inspire better quality throughout the system, thereby presenting an opportunity for our executives in the drug and biotechnology industries.

Thus, our corporate leaders—especially those whose companies design, create, and disseminate lifesaving but expensive new technology—must confront a partly unaware public. In my view, they must directly promote the value equation and must support quality improvement rather than hide behind the widespread, self-righteous mentality of “this is not our problem.”

Here’s another way we can frame the health care reform debate:

In short, health reform can be seen as an opportunity to systematically improve quality of care rather than as a threat to existing levels of quality.

With President Obama’s signing of the health care reform bill (the Patient Protection and Affordable Care Act) on March 21, maybe we can now focus on the systems nature of medical care and the role of pharmacy and biotechnology in these systems. I would like to see our pharmaceutical corporate leaders embrace a different lexicon regarding all existing reform proposals. This lexicon would apply knowledge, meet standards of quality, use technology to reduce errors, and ensure care that enables patients to demand better quality. Imagine what our business leaders could accomplish with a sharper focus.

Our pharmaceutical, biotech, and medical device industries should address how our country’s quality of health care compares with that of other nations, and
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they should use it as a paradigm-shifting lever to focus on value for the money that we spend. This might not be a popularly held view, but I believe that it is the road to redemption.

As always, I’m interested in your views. My e-mail address is david.nash@jefferson.edu. Please also visit my blog at http://nashhealthpolicy.blogspot.com.

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