Quality Gains Key to Health Care Reform

BY JOYCE FRIEDEN

WASHINGTON — Quality improvement must be an integral part of any health reform plan, according to one expert.

Although there have been many improvements in medical care over the past few years, "with the miracles have come burdens," Dr. Donald Berwick, president and CEO of the Institute for Healthcare Improvement, said at the annual meeting of the American Health Lawyers Association. "Miracles and hazards come hand in hand."

Improving the quality of health care doesn't necessarily mean spending more money; in fact, the opposite is often true, Dr. Berwick said. "England spends 8%-8.5% [of its gross domestic product] on health care—about half of what we do—and has equally fine care." And the Dartmouth Atlas Project has found that regions of the United States that spend the most on health care—areas with more hospital beds per capita and more specialists, and where more procedures are done—often have worse care outcomes.

"They have higher mortality and the same functional status among patients" as do those in lower spending areas, he said. "Doctors in these areas report more problems with continuity [of care], and patients are less satisfied."

The biggest predictor of quality of care by far, however, is race, Dr. Berwick continued. "If you are black, that is the biggest count against you for health status; that's not true in the rest of the developed world." A black male child born in inner-city Baltimore this year, for instance, has an 8-year-lower life expectancy than does a white child, he said. Using a strictly market-based approach won't solve quality problems, according to Dr. Berwick. "I simply do not think markets will work in health care," he said. "But I think there is a way out, and it has to do with leadership."

The health care system has to allow for the fact that people see what they expect to see and interpret the world accordingly, which can lead to errors in the operating room and other health care settings, Dr. Berwick said. "If we wish to be safe, we have to engineer dikes around human frailty. And it can be done. It's done in airplane cockpits and in nuclear power plants."

He added that a well-engineered system "does not beat up on the workforce; it does not yell at the nurse for making a mistake; it does not blame [people] for being human." Instead, "it's the design of work that determines the outcomes of work."

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For example, Dr. Berwick said, a big problem in hospitals has been central venous line infections. "We know now that if you adhere strictly to science, if you follow every single one of these five steps [good hand hygiene, maximal barrier precautions upon insertion, chlorhexidine skin antisepsis, optimal catheter site selection, and daily review of line necessity with prompt removal of unnecessary lines], you can . . . essentially abolish central venous line infections."

These infections still occur in hospitals "because we haven't put in the reliable systems that make it go right every single time," he said

Hospital governance boards must get involved to help make these changes happen, he added. "Think about it this way. If it's true that your hospital could abolish central venous line infections—and it can—and a patient tomorrow morning gets a central venous line infection, the board caused it. I know of no other way to think about it."

Many health care organizations and communities working on quality improvement are using the goal of "triple aim": better experience of care, a healthier population (through reductions in smoking, obesity, and other health problems), and reduction of per capita costs. The Institute for Healthcare Improvement "[has] about 40 or 50 organizations that have said, 'I want to achieve the triple aim for my organization,' " Dr. Berwick said. Grand Junction, Colo., and Green Bay, Wisc., are two of the communities working to achieve the triple aim in health care. ■

EVIDENCE-BASED PSYCHIATRIC MEDICINE

Is the Canadian Health Care System Better?

Author's note: *Amid the current debate about whether to overhaul the American health care system, I asked the editors to rerun a column I wrote in October 2005 about the Supreme Court of Canada's ruling in* Chaoulli v. Quebec (Attorney General), *2005 SCC 35. This case illustrates some of the flaws inherent in universal health care systems.*

The Problem

Canadian universal health care system as the model for delivering health care, but is Canada's delivery system really better?

The Analysis

To help us answer this question, we turned to a case decided by the Supreme Court of Canada: *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35. The decision was published June 9, 2005. (Information is taken entirely from the published decision as cited here and is available online at www.lexum.umontreal.ca/csc-scc/en/rec/html/2005scc035. wpd.html.)

BY JAN LEARD-HANSSON, M.D.

The Evidence

The role of public- and private-sector health care in Canada is not uniform across provinces. Ontario, Nova Scotia, and Manitoba prohibit physicians from charging patients more than they receive from the public plan, so there is no financial incentive for physicians to opt for the private sector.

Saskatchewan, New Brunswick, Newfoundland, and Labrador are open to the private sector. Saskatchewan, for example, allows private-sector physicians to set their own fees. These costs are not covered by the public plan (nor by provincial government), but patients can purchase private insurance. In Newfoundland and Labrador, the provincial government reimburses private-sector physicians up to the amount covered by the public plan only.

In Alberta, British Columbia, Prince Edward Island, and Quebec (where this precedent-setting case occurred), private-sector physicians are free to set their fees, but the cost of their services is not reimbursed by the provincial governments, and insurance to cover services offered by the public plan is prohibited. Additionally, services provided by nonphysicians, such as psychologists, are not covered.

In Canada, the public health care system has long been a source of national pride. Criticism, however, has become more commonplace as the demand for health care has risen. One of the tools used by provincial governments to control rising demand and costs has been to allow waiting lists for health care to develop and to then manage these lists. In its analysis, the Supreme Court of Canada wrote that the demand for health care is potentially unlimited and that waiting lists are a form of rationing: "Waiting lists are therefore real and intentional."

In this case, Dr. Jacques Chaoulli, and George Zeliotis claimed that the prohibition on private health insurance and the subsequent waiting lists deprived them of the rights to life, liberty, and security of persons guaranteed by the Canadian Charter of Rights and Freedoms and the Quebec Charter of Human Rights and Freedoms (in essence, their federal and provincial constitutional rights).

Over the years, Mr. Zeliotis suffered a number of health problems. He used health services available in the public sector, including heart surgery and hip operations. He encountered a number of difficulties because of the waiting lists. Dr. Chaoulli had tried unsuccessfully to have his home-delivered medical services recognized and to obtain a license to operate a private hospital. The two joined forces.

In the first trial, the Superior Court of Quebec dismissed the motion for declaratory judgment, finding that—although the plaintiffs had shown deprivation of the right to life, liberty, and security within the meaning of the Canadian Charter—this deprivation was in accordance with the principles of fundamental justice. That is, because the purpose of disallowing private health care is to establish and maintain a public health system available to all Quebec residents, these provisions are motivated by considerations of equality and human dignity; thus, the collective rights of Quebeckers override personal rights. The Quebec Court of Appeal dismissed the appeal. Similar reasoning was applied.

In its analysis, the Supreme Court of Canada distilled the following issue to be decided: "In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state." The Supreme Court then proceeded to reverse the lower court rulings, writing that the prohibition against paying for private insurance "infringes the right to personal inviolability and … is not justified by a proper regard for democratic values, public order, and the general well-being of the citizens of Quebec."

In reaching its decision, the court cited a number of problems with the Canadian universal health care system. Some patients die as a result of long waits for treatment in the public system. One cardiovascular surgeon testified that a person diagnosed with cardiovascular disease is " 'always sitting on a bomb' and can die at any moment," and said that the risk of mortality in such cases rises by 0.45% per month. The usual waiting time is 1 year for patients who require orthopedic surgery and this wait increases the risk that their injuries will become irreparable. Patients also experience considerable pain while they wait for treatment.

The Conclusion

As the American health care system has serious problems, many look to Canada's universal system as the model for health care. But is the Canadian delivery system really better? The evidence presented before the Supreme Court of Canada would suggest not.

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