Comparing Healthcare Systems: Outcomes, Ethical Principles, and Social Values

Eike-Henner W. Kluge, PhD

Abstract

The question of how healthcare should be structured has been at the forefront of public debate for quite some time. In particular, debate has raged over the acceptability of socialized and rights-oriented approaches to healthcare as opposed to privatized and commodity-oriented approaches. The present discussion looks at the underlying logic of the debate and at the use of outcome measures as a primary determinant. It suggests that outcome measures are of limited use in deciding the issue because they ignore important variables and further suggests that outcome measures are inappropriate tools when comparing distinct healthcare systems because they ignore valuational components that are integral to deciding whether a healthcare system is consistent with a society's principles and values.

Key Words: healthcare systems, values, health outcomes, health-definition

Reader Comments on: Comparing Healthcare Systems: Outcomes, Ethical Principles, and Social Values

See reader comments on this article and provide your own.

Readers are encouraged to respond to the author at ekluge@uvic.ca or to Paul Blumenthal, MD, Deputy Editor of MedGenMed, for the editor's eyes only or for possible publication as an actual Letter in MedGenMed via email: pblumen@stanford.edu

Introduction

The question of how healthcare should be structured has been at the forefront of public debate for quite some time. There are literally hundreds of commissions, reports, studies, learned papers, and policy initiatives that deal with the subject in countries all over the world. No country appears satisfied with the healthcare system it currently has in place, yet all seem to believe that proper health is integral to the maximization of individual human potential and that finding the right way to deliver healthcare is the key to ensuring individual and social well-being. Healthy people are productive people, and productive people make for a happy, harmonious, and successful society. The search for the right model of healthcare, therefore, has become something like the modern equivalent of the search for the philosopher's stone -- something that will transmute ailing healthcare systems into perfect vehicles for producing healthy persons.

As we all know, the search for the philosopher's stone was the search for an illusion. There is nothing that will magically transform base materials into gold -- and there is no social service that will ensure a happy, harmonious, and successful society. Healthcare is no exception. Healthy people have the potential for happiness, harmony, and success, and to that degree, access to healthcare lays the foundations for a happy, harmonious, and successful society, but whether that potential is realized still depends on the people themselves. It also depends on whether the structures that are in place are consistent with the resources that are at society's disposal. And above all, it depends on the values and principles that are integral to the moral fabric of that society.

Health System, Ethical Principles, and Social Values

A society that values autonomy and equality and that considers the ethical principles that are integral to the "Universal Declaration of Human Rights" as fundamental to its moral framework will design its healthcare system differently from a society that considers utility and efficiency as primary values and whose ethical perspective is driven by the principle of the greatest good for the greatest number. Both of these, in turn, will take a different approach to healthcare from a society that...
believes that what is right or wrong has nothing to do with individual rights or the greatest good for the greatest number but instead is relative to each individual and depends on her or his personal principles and values -- in a word, a society that has an egoistic ethical orientation.

The first kind of society will structure its healthcare around the notion that there is a social duty to level the playing field in terms of access and use of health services and that each person has the right to a basic level of healthcare but that this right is limited by the equal and competing rights of others. By contrast, the second kind of society will reject the notion of a basic individual right to healthcare. Instead, it will structure its system of healthcare solely with an eye to maximizing the health status of society as a whole, and the balancing of individual access rights will not even enter the picture. Finally, the third kind of society will reject both the notion of a basic right to healthcare and the ideal of maximizing the health status of society as a whole. Instead, it will structure its healthcare on a free-enterprise model and treat healthcare as a commodity. The delivery of healthcare will be designed on a competition approach, and the determinants will be neither individual nor collective rights but the ability of the members of that society to assert their individual claims.

In other words, there is no right model of healthcare. There is only a right model for a particular society's ethical orientation.

**Funding Schemes, Outcome Measures, Principles, and Values**

The relevance of these considerations to the debate on how healthcare should be structured cannot be overestimated. It means that any attempt to assess the appropriateness of a given healthcare system simply by looking at whether healthcare is provided by the private or the public sector, or to evaluate its success by looking at outcome measures, is wrongheaded because it uses the wrong tools to measure the wrong things. It confuses principles with process, ideals with commitment, and perfection with reality.[2]

Let us assume that there is a society that values people as persons and believes that every member of society has the same rights as every other person and deserves the same treatment and respect. In other words, let us assume the first kind of society, a society that accepts the "Universal Declaration of Human Rights" and therefore believes in the principle of the inherent dignity and equality of all persons. Laws aside, health is the greatest single determinant of whether someone can compete on an equal footing with everyone else for the opportunities that exist within that society.[3] The society’s acceptance of these fundamental principles therefore entails a duty to guarantee its members equitable access to health services to minimize health-based differences.

**Ideals, Principles, and Funding**

However, the fact that the society is committed to providing healthcare as a matter of social obligation does not mean that it must provide this healthcare in a specific way. If the society can somehow guarantee that all of its members have sufficient access to healthcare to minimize health-based differences and that all members are therefore able to compete equitably for the opportunities that exist within that society, then it does not matter whether healthcare is delivered in a public, private, or a mixed public-private setting. The key is equal opportunity of access. How this is achieved is logically irrelevant.

For example, suppose that rather than turning healthcare into a state institution, the society decided to dissociate itself entirely from the actual delivery of healthcare and leave it to the private sector. At first glance, this might suggest that the society was merely paying lip-service to equality, dignity, and justice because not everyone has the same resources; therefore, not everyone would be able to purchase the healthcare that would allow each individual to compete on an equal footing.

However, suppose that the society also decided to give each of its members a guaranteed basic income that was sufficient to cover the cost of accessing any healthcare that was necessary, thereby removing health-related differences. To illustrate the point further, let us make this case a bit extreme. Let us also suppose that the society attached no strings to how the guaranteed income could be spent because it believed that all persons, as autonomous beings, have the right to self-determination and should be able to decide how they will spend the resources they have at their disposal. With this approach, it could very well happen that some people would decide not to spend their guaranteed income on healthcare but instead would choose to use the money to live in more comfortable surroundings or to access consumer goods and services that they might otherwise not be able to enjoy.
This would of course mean that health-related differences would still exist, which in turn, would mean that as a matter of actual fact the playing field would not be level. Nevertheless, the society would not have failed in its ethical duty to level the playing field because, by providing each person with sufficient resources to purchase appropriate healthcare if they so wished, it would have honored its basic principles and values. The mechanism that it had put in place would have a leveling effect if it were used properly. The fact that some people might decide to act foolishly and not use the resources properly would say something about those persons, not about the society.

The point is not that this would be a particularly good way for society to honor its commitment to level the healthcare playing field and treat healthcare as a right. Clearly, structuring health as a publicly funded service available to everyone on an equal footing but on a per-need and per-use basis would prevent the potential misuse of funds that would be possible with the approach just discussed. Providing healthcare directly as a government service would also avoid the problem. Rather, the point is that treating healthcare as a right and being committed to leveling the playing field does not entail removal of healthcare delivery from the private sector. In fact, one can think of still other scenarios. For example, one could keep healthcare delivery in private hands but place use conditions on individual publicly funded healthcare accounts. So to reiterate, the point of the example is merely that whether a society's approach to healthcare access is consistent with its principles and values is logically independent of the question whether healthcare should be delivered by the private or the public sector.

One could also make the point by considering the third kind of society mentioned at the beginning of this article: the kind that believes there are no fundamental human rights and what is right or wrong has nothing to do with the greatest good for the greatest number but instead is relative to each individual and depends on her or his personal principles and values. Again, at first glance, it might seem that this ethical perspective locks the society into a particular mode of healthcare delivery; specifically, that the society would be logically committed to staying out of the healthcare field itself and leaving it entirely to the private sector, which would supply health services on a commodity basis.

However, again, this is not necessarily the case. The society could, without contradicting its basic values and principles, treat healthcare as a source of revenue and make it a government service on the model of a government-owned corporation such as Singapore Airlines, the Saudi Arabian Oil Company, or the United States Postal Service. With this approach, access to healthcare would still be determined by the ability to pay, the market place would still rule, and healthcare would still be a matter of individual responsibility, not a matter of right. However, the delivery of healthcare would become a socially controlled function and healthcare itself would not be in private hands.

Of course one might well ask whether a government-owned corporation would be successful in an economic sense. However, in this connection it might be useful to reflect on 4 considerations. First, government-owned corporations such as Singapore Airlines have shown that they can compete extremely well in the business arena if they are run using an appropriate business model. Second, there are many countries in which healthcare is delivered by publicly owned corporate entities. Canada, where these corporations are usually referred to as health authorities or districts, and the United Kingdom, where they are usually referred to as health trusts, here provide good examples. Third, these government-owned health corporations have shown that they can compete extremely well with the private business sector. Thus, on average, they are up to 12% more efficient administratively than private healthcare corporations in the United States.[4,5] Finally, that government-owned health corporations are currently not being run with the intent of generating revenue does not mean that it could not be done. It merely means that, for political reasons, governments have not decided to do so.

Resources, People, and Outcome Measures

Just as there is no logically necessary connection between the fundamental ethical principles and values of a society on the one hand and the mechanism that it chooses for delivery of its healthcare on the other, there also is no logically necessary connection between the appropriateness of a particular healthcare system and the outcomes that are provided by that system. To put it more concretely, it does not follow that a society that believes in a right to healthcare has failed in its social obligations and that it has chosen the wrong kind of healthcare system just because overall health status, life-expectancy, morbidity, and other health measures of its citizens -- including their satisfaction-ratings -- fall below a certain level (and in that sense the system is less than ideal).

The reason is simple. There is a fundamental logical disconnect between the fit of a society's principles/values and the
However, this does not mean that if the outcomes are less than optimal the society should change its approach to produce the desideratum of a completely healthy society. In fact, that will probably always be the case. Several socially mandated endeavors, and it may be that the funding that can be allocated to healthcare is insufficient to healthcare, that is, that it should abandon its belief that healthcare is an obligation and switch to the view that it is an individual and private matter. Instead, it means that society should re-examine the level of resources that it allocates to healthcare compared with other social services. For instance, does defense really require the proportion it receives? If not, does a re-apportionment bring healthcare funding to the level of threshold effectiveness? At a more particular level, is the distribution of funding within the system itself appropriate? Is the acute care sector receiving more than its fair share, with diminishing returns? As McKeown and Lowe[11,12] showed years ago, if one is interested in improving longevity, morbidity, and life expectancy, then the thing to do is invest resources in nutrition, public housing, sanitation, and diverse other public health measures, not in acute care medicine.

Therefore, the fact that a healthcare system does not achieve optimal outcomes because the allocated resources are insufficient to allow its various services to be successfully implemented does not in itself mean that the healthcare system is inappropriate and should be replaced. That would be like saying that if immunization efforts are not funded sufficiently to achieve global immunity, then public health measures should be abandoned entirely and immunization should be left to the financial capabilities of the individual citizen. Instead, one should reconsider the level of funding, and that of course, raises the question of whether society really believes in public health measures or merely pays lip service to an ideal. “By their fruits ye shall know them!” (Matthew 7:20) In other words, outcome measures are meaningful only once it has been determined that society has allocated sufficient resources to implement the services it has instituted.

Of course no society has unlimited resources, and diverse demands are made on these limited resources, each with its own legitimate considerations. Genuine resource limitations impose constraints that no social structure can overcome and that no person can transcend. Moreover, one cannot be obligated to do the impossible. Therefore the demands of competing social endeavors must be balanced. Even for a society that believes in an individual right to healthcare, healthcare is only one of several socially mandated endeavors, and it may be that the funding that can be allocated to healthcare is insufficient to produce the desideratum of a completely healthy society. In fact, that will probably always be the case.

However, this does not mean that if the outcomes are less than optimal the society should change its approach to healthcare, that is, that it should abandon its belief that healthcare is an obligation and switch to the view that it is an individual and private matter. Instead, it means that society should re-examine the level of resources that it allocates to healthcare compared with other social services. For instance, does defense really require the proportion it receives? If not, does a re-apportionment bring healthcare funding to the level of threshold effectiveness? At a more particular level, is the distribution of funding within the system itself appropriate? Is the acute care sector receiving more than its fair share, with diminishing returns? As McKeown and Lowe[11,12] showed years ago, if one is interested in improving longevity, morbidity, and life expectancy, then the thing to do is invest resources in nutrition, public housing, sanitation, and diverse other public health measures, not in acute care medicine.

The society might also wish to develop an equitable mechanism for balancing the competing right claims of individual healthcare users. As the Oregon experiment recognized,[13,14] and as has been made very clear in the relevant ethical literature with respect to smoking-generated needs, some preventable health conditions are linked to immoderate or imprudent lifestyle.[15,16] In other words, not all healthcare claims have equal merit. Moreover, allowing the system to be used in hopeless cases (eg, treating inoperable metastatic cancer acutely instead of palliatively) also exacerbates resource limitations and guarantees that threshold-sensitive interventions that might produce better outcomes if they were better funded will have low outcome quotients. Therefore the effects of resource limitation may be exacerbated because there is no mechanism to evaluate the appropriateness of certain procedures or to evaluate the moral legitimacy of healthcare claims for self-induced conditions. That such mechanisms are not generally in place or that they might be resisted by members of
the public does not mean that they are unworkable or unethical.

The Notion of a Positive Outcome

One might also want to ask what constitutes a positive outcome and, perhaps more importantly, whether it is always reasonable to expect a positive outcome. For example, suppose that a society that believes in a right to healthcare has a high incidence and prevalence of infectious diseases and an average life expectancy of approximately 37 years. It is tempting to suggest that the society should restructure its healthcare system from a rights-oriented approach to an individual commodity-oriented approach. Not only, it is alleged, would that make the healthcare system more efficient because it would then be run on a business model, but it would also result in better outcomes because everyone would have to assume ownership of healthcare issues on an individual basis, which in turn would result in better aggregate performance outcomes.

However, that is not necessarily the correct response. The claim about greater efficiency is highly dubious, and there are no studies that show that primary payers take greater ownership in their health. In addition, the reason for the low life expectancy and high morbidity in this society is a high prevalence and incidence of antibiotic-resistant tuberculosis and opportunistic infections associated with HIV/AIDS. Moreover, this is a very patriarchal society whose belief system demands open-faced communication between persons as a matter of respect, and where unprotected intercourse (and intercourse with multiple partners) is part of the patriarchal value structure. The high incidence and prevalence of antibiotic-resistant tuberculosis and other opportunistic infections (and therefore of high morbidity and low life expectancy) is therefore not something that can be attributed to the society having a rights-oriented healthcare system or not operating on a business/commodity model. It is a function of the values and the overall belief system of that society. Nothing short of changing the values and the belief system will produce better health outcomes no matter what ethical orientation is adopted or what healthcare system is put in place.

In other words, the same outcomes would exist even if the society had privately structured healthcare or defined the right to healthcare in terms of overall utility. Therefore to automatically characterize a less-than-ideal health outcome in terms of overall health status, longevity, or even user satisfaction as a failure of the rights-oriented healthcare system is logically unwarranted. Instead, what has to be determined is whether, within the valuational (and resource) constraints that exist, the system is functioning as well as can be expected. In more general terms, outcome measures are appropriate only when they measure outcomes relative to existing constraints, and these constraints may include principles and values that lie entirely outside the realm of healthcare.

Moreover, it is quite unclear, rationally speaking, whether outcome measures such as morbidity and life expectancy are the right measures to use. Living to 87 years of age with incurable and irremediable schizophrenia or living to 45 years of age with cystic fibrosis may improve the statistics for a given healthcare system, and reducing the infant mortality rates from incurable and irremediable inborn errors of metabolism will certainly count as an improvement in outcomes; however, it is questionable whether this is really desirable. Prolonged suffering may look good from the perspective of longevity, but it palls under the perspective of humanity.

In other words, an increased rating for a particular type of intervention may be a positive outcome in numeric terms but may not in fact be a positive outcome in any other sense. Quality of life is important and has to be factored into any meaningful evaluation. Unfortunately, there is no single quality-of-life measure that is validated and appropriate for healthcare outcomes in general. This means that there is no way to evaluate the success or failure of healthcare systems as systems, which in turn means that, in the absence of any consistent and valid tool for rating healthcare systems, comparisons between types of approaches is inherently meaningless.

The immediate response to this, of course, is that there are quality-focused tools for measuring outcomes. For example, measures such as the Health-Related Quality of Life (HRQOL) developed by the Centers for Disease Control (CDC), when combined with life-expectancy and other measures, provides clear and unbiased information. Not only does it allow the identification of “health disparities” within a given healthcare system, but it also allows a comparison across systems. Therefore outcomes can be used to assess healthcare systems after all.

However, this is more illusion than reality. No matter how quality of life is measured, and no matter whether the relevant measure includes only objective components or subjective parameters as well, what is measured is the quality relative to the...
embedding of the individuals whose quality of life is being measured. That means that if a population has conditions for which there is no treatment or for which the treatment has reduced effectiveness, then the quality of life of the affected population will be reduced.[2]

Moreover, whether a particular treatment is available or effective depends not merely on the condition itself but also on research and development. Unfortunately, research for and development of treatment modalities -- particularly those that involve the use of pharmaceuticals -- is not determined by an individual healthcare system but by industry. This means that if there is insufficient profit in developing a particular treatment, then either there will be no treatment at all or treatment will be insufficiently developed -- the Orphan Drug Act[18] notwithstanding. Therefore, basing an assessment of a healthcare system on any measure that involves quality-of-life considerations will incorporate a hidden but profound bias, and rejecting a particular approach to healthcare because quality-of-life measures are not sufficiently high may be to reject the approach for the wrong reason.

People as Confounding Variables

Moreover, the ethos of the people who are involved in implementing an enterprise is crucial to whether the enterprise will succeed and achieve the desired outcome.[19] That is why corporations engage in team building, why they encourage their employees to develop an esprit de corps, and why they try to motivate their employees to adopt and share the values of the corporation itself. As the expression has it, throwing sand into the gears can bring an engine to a halt. However, that does not mean that there is something wrong with the engine itself. Research has also shown that managerial attitudes have a profound effect on work outcomes[20] and can affect staff turnover, which itself contributes significantly to less-than-optimal outcomes.[21-25] Therefore, unless the human variables are controlled for, outcomes will provide a very insecure basis for evaluating the appropriateness and effectiveness of a given approach to healthcare. Currently there are no tools that evaluate outcomes and include these considerations. Therefore to use outcome measures to judge the appropriateness or acceptability of a particular approach to healthcare, or for accepting or rejecting a particular way of implementing a particular healthcare philosophy, is to make a decision using inadequate tools.

Finally, there is this to consider. A totalitarian regime may set up health services that are entirely successful in achieving the desirable outcome of a healthy population. However, it does so by strictly regulating the interaction of its citizens with healthcare providers, by instituting and enforcing medical surveillance standards and behavior patterns that regiment the daily lives of its citizens, and by enforcing healthy habits and lifestyles that leave no choice to its individual members. Such an approach to healthcare could certainly boast excellent outcome measures in terms of average health status, life expectancy, morbidity, quality-adjusted life years (QALYs), disability-adjusted life years (DALYs), HRQOLs, and any other health-related quality-of-life measures that one might care to name. For all that, however, such a healthcare system would not be in keeping with the principles of respect and equality that underlie the Universal Declaration of Human Rights.

The Definition of Health

There is a further flaw that besets current comparison between healthcare systems, and indeed the evaluation of any healthcare system on its own. It has to do with the definition of health. To appreciate the depth of the problem and its insidious nature, it is perhaps best to begin in general terms.

No matter what the structure of a particular healthcare system, the reason for the system is to provide healthcare and to advance the health of its target population. One might therefore naively suppose that when it comes to evaluating a particular healthcare system or when comparing the effectiveness of one healthcare system with another, the common measure is the health status of the relevant populations.

The problem is that there is no consistent and usable definition of health.[26-29] As has been pointed out, the World Health Organization (WHO) definition of health as "a state of complete physical, mental and social well-being" is hopelessly flawed, even though the definition was accepted by the CDC and other organizations.[2, 30-34] Although various other definitions have been attempted, none has received general acceptance. In real terms, this means that all of the measures that have been developed for evaluating individual healthcare systems or for comparing one healthcare system to another measure something that is in fact undefined or that is defined in such general and ambiguous terms that the resultant quotients are effectively meaningless. This is not to say that there are no specific measures for evaluating the effectiveness of a particular
treatment modality within a given context or for comparing the resources that are being spent to bring about certain specific outcomes within distinct healthcare systems. However, it does mean that it is currently impossible to evaluate the success of a given healthcare system as healthcare system. It also means that the claim that a particular approach to delivering healthcare is better or more effective than another approach is mere "puffery" because what would turn such a claim into a meaningful assertion, namely a consistent and usable definition of health, is missing.

Conclusion

The debate over the correct model of healthcare delivery has been at the forefront of public and professional debate for quite some time. Comparisons are drawn with respect to cost, public satisfaction, professional satisfaction, and outcomes to mention but a few of the variables that have figured in the debate. In one sense, however, the debate has been curiously unscientific. It has ignored the fact that measures are relevant only when they are standardized and validated, when they measure the same things, and when the variables that affect what is being measured are controlled in a rigorous fashion. Above all, however, comparison measures are meaningful if and only if they measure the right things and when what is being measured is clearly and consistently defined. The current debate fails on all of these counts. It also ignores the more central issue: does the healthcare system honor the fundamental principles and values of the society itself? As Croesus found to his regret, a philosopher's stone that turns base materials into gold can kill you. A healthcare system that is effective in producing a materially ideal outcome but violates its basic principles will spell the death of that society as a moral community.

What does all of this mean? Two things. First, it may be appropriate to view with extreme caution any claim that a particular approach to healthcare is better than another. Second, it may be appropriate to restructure the entire debate over which approach to healthcare is ideal by paying more attention to a society's fundamental principles and values. If a society's approach to healthcare is consistent with its principles and values, then the issue is not whether that system should be replaced but how to make it more efficient or more effective -- which has nothing to do with the healthcare system itself but has to do with its implementation. (And here the preceding comment will once again be germane.) Of course it is an entirely different matter whether the society's principles and values themselves are ethically defensible; that is a subject for another debate.

References

2. Reidpath DD, Allotey P, Kouame A, Cummins RA. Social cultural and environmental contexts and the measurement of burden of disease: an exploratory study in the developed and developing world. Melbourne, Australia: Key Centre for Women's Health in Society, University of Melbourne; 2001.
Abstract


25. Aarons GA, Sawitzky AC. Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. Adm Policy Ment Health. 2006;33:289-301. Abstract


