US healthcare international comparisons: what are we comparing?

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Abstract: International comparisons between the US quasi-market and other nations' nationalised healthcare or insurance models have, and continue to generate significant debate. Discussions inevitably cite the World Health Organization's or Commonwealth Fund's work, but what these comparisons actually examine is somewhat unclear when examining the complexity of what is being compared. Often international healthcare comparisons are presented as one based on the quality of healthcare in subject national systems. This paper discusses some of the complexities associated with international comparisons, provides some additional perspectives for metrics often cited in international comparisons, and suggests we may be served better by adjusting the premises of continued discourse in the matter. If the purpose of international comparisons is to evaluate the world laboratory of healthcare policy and processes, which it should, this paper suggests the discussion needs redirected in both focus and content.

Keywords: international healthcare comparisons; US healthcare; healthcare model comparisons; quasi-market versus nationalised healthcare insurance or socialised healthcare; single payer versus quasi-market healthcare; international healthcare quality comparisons.

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1 Introduction

This paper explores comparisons of US healthcare system quality and associated factors that inform, or fail to inform, such with other developed nations. Comparisons in the literature commonly cited suggest the US healthcare system costs the most and ranks low in quality relative to other developed nations (Davis et al., 2014; Du and Lu, 2016; Squires and Anderson, 2015; World Health Organization, 2000; Claxton et al., 2015). This also suggests the US system represents poor value, as it is a function of quality, outcomes and cost. The USA in this view has become the standard bearer for inefficiency and poor allocation of resources associated with healthcare. The World Health Organization (WHO) ranked the US healthcare system 37th among developed nations in a report cited to this day, the Commonwealth Fund more recently ranked the US healthcare system last of 11 developed nations, and the online executive master of health administration program at George Washington University compared 16 Organization for Economic Co-operation and Development (OECD) nations to identify similar findings (Davis et al., 2014; World Health Organization, 2000; Staff, 2016). These comparisons have become popularised in both media and peer reviewed journal articles (Murray and Frenk, 2010; Munro, 2014; Davis et al., 2014; Du and Lu, 2016).

Although comparisons suggest the US healthcare system compares poorly with other developed nations, a divide persists in societal opinions as to the quality of the US healthcare system. A 2015 Gallup survey finds a large majority of Americans rate their healthcare as excellent or good, 57% are satisfied with the cost, and 67% express satisfaction "… with the way the healthcare system is working for them" (Gallup, 2016). Indeed, approximately 73% of US senior citizens report that they are in good health (Centers for Disease Control and Prevention, 2013). In contrast, 54% have a "very or somewhat negative" view of the actual US healthcare industry (Gallup, 2016). This negative view also holds true for the Patient Protection and Affordable Care Act (PPACA) with up to 58% of respondents in favour of repealing the hallmark legislation of the Obama administration (Gallup, 2016). The 2016 presidential election results appear to lend some support for discontent with the PPACA, and efforts continue under the current United States Congress and President Trump's administration to make

significant changes to the US healthcare system in some incremental form (Kodjak, 2016; Roy, 2016). The key question is why does the US healthcare system fare so poorly in international comparisons, yet public opinion appears generally favourable?

International healthcare system comparisons assess varied attributes of both the systems and their respective populations. Common comparisons heavily weight metrics such as life expectancy, infant mortality, cost and efficiency. These factors are discussed next, followed by additional factors often discussed regarding system quality, however not often discussed relative to the aforementioned international comparisons.

2 Life expectancy

Average life expectancy in the world has steadily increased over the past century, including in the US from 49 to 79 years (Arias, 2016). However, it has been argued that much of this is associated with the improvement of sanitation, nutrition and mortality decline from tuberculosis and pneumonia, and not medical intervention (Nbunker, 2001; McKinlay and McKinlay, 1977; McKeown et al., 1976). Only over the past several decades have medical interventions begun to influence average life expectancy (Haughom, 2016).

Increased obesity rates and the prevalence of conditions such as diabetes, heart disease, stroke and cancer have moderated such gains, yet has led to the development of improved interventions to the extent that age adjusted mortality from heart disease has decreased by 56% since 1960 and by 70% for stroke since 1950 in the US (Haughom, 2016; Brookings Institute, 2011; Centers for Disease Control and Prevention, 2011; Bradley et al., 2008; Lichtenberg, 2010). Improvements aside, life expectancy is routinely cited as an indicator that the US healthcare system lags behind other developed nations (Davis et al., 2014; World Health Organization, 2000; Roser, 2016; Kaiser Family Foundation, 2015). With an average life expectancy of 79 years of age, the US indeed ranks last of comparable Organization for Economic Co-operation and Development (OECD) countries (Kaiser Family Foundation, 2015). However, life expectancy is dubious at best as a measure of healthcare system quality or effectiveness. Life expectancy is a gross measure that includes many factors well beyond the influence of a nation's healthcare system. Education, ethnicity, behavioural factors, culture, violent crime rates, disease incidence rates and geographic variations contribute significantly to life expectancy (Kaneda and Adams, 2008; Ohsfeldt and Schneider, 2006; OECD, 2015c; Grinshteyn and Hemenway, 2015; Kitawaga and Hauser, 1973; Ferlay et al., 2014; Hogberg, 2006; Baicker et al., 2004). In fact, Americans of Asian descent share similar life expectancy with Japan's average of 83.7 years, which is highest in the world (World Health Organization, 2015). Average Asian American life expectancy is 92.4 in Connecticut, 81.7 in Hawaii and 87.3 overall (Kaiser Family Foundation, 2015; Aid, 2014; OECD, 2015c; Worldlifeexpectancy.com, 2016). One study that controlled for non-health related premature deaths due to accident, crime or injury, finds the adjusted US life expectancy rate was the highest in the world (Ohsfeldt and Schneider, 2006; Manton and Vaupel, 1995). US life expectancy from those who are seventy years and beyond are actually highest among developed OECD nations; such years are those most likely to benefit from medical interventions (Ho and Preston, 2010). This suggests medical intervention in the US may provide greater quality and effect. Life expectancy measures many factors of a nation's health and well-being; however, it serves as a poor

proxy measure for the quality of the healthcare system (Preston and Ho, 2009; Crimmins, et al., 2011; Manton and Vaupel, 1995).

3 Infant mortality

As with life expectancy, infant mortality is often cited as an outcome measure for healthcare system quality (Du and Lu, 2016; Davis et al., 2014; World Health Organization, 2000; Staff, 2016; Kaiser Family Foundation, 2015; Ingraham, 2014; Fox, 2015). Infant mortality is a measure that ostensibly captures an outcome after direct access to medical services, which suggests a suitable measure for the quality of care. The US infant mortality rate lags behind other developed nations. The WHO ranks it 41st in OECD nations, The CIA Factbook ranks the US 58th, and the United Nations Population Division ranks it 40th (CIA, 2016; World Health Organization, 2015; Atlas, 2011a; Oestergaard et al., 2011). Infant mortality rates suggest the US healthcare system lags in its level of quality at the point of services rendered in that birth is a point of significant interface with the provision of care in developed nations. This measure however suffers from multiple validity issues. Similar to life expectancy, infant mortality is influenced by ethnicity, geography, income and education (MacDorman et al., 2007; Avasakar, 2012; Goodman et al., 2004; Grady, 2009; Jamison et al., 2004). Variations in infant mortality can differ significantly ranging from 9.6 deaths per 1,000 lives to 4.18 based on geography, and 11.11 to 3.02 based on ethnicity in the US (MacDorman et al., 2007; Centers for Disease Control and Prevention, 2016). Similar variations exist in the UK and Canada as well based on geography (Dorling, 1997).

Infant mortality, as a quality metric, suffers poor or inadequate reporting (Goodman et al., 2004; Woods, 2008). Research finds that three quarters of the world's neonatal deaths are not counted reliably or at all (Lawn et al., 2006; Richardus et al., 1998). However, perinatal mortality rates vary by up to 50% depending on the definition used to define an infant death (Richardus et al., 1998). Graafmans et al. (2001) finds differences in terminology among developed nations accounts for variations between 14 to 40% (Graafmans et al., 2001). Infant mortality is 25 times greater for infants under 2,500 grams at birth (Centers for Disease Control and Prevention, 2016). The US counts infant mortality for all births at the point of care including low weight infants and premature births, while countries such as Switzerland deliberately omit low weight infants from mortality statistics (Atlas, 2011a; Zylbersztejn et al., 2017). There is a higher incidence rate of premature births in the USA that significantly increases the risk of death (MacDorman et al., 2007; Wilcox et al., 1995). Birth weight and premature births are associated with ethnicity, particularly for African American teen females, within the highly heterogeneous US population (MacDorman et al., 2007; Centers for Disease Control and Prevention, 2013; O'Neill and O'Neill, 2007; Kleinman and Kessel, 1987; Tuljapurkar and Boe, 1998; MacDorman et al., 2007; Centers for Disease Control and Prevention, 2016). Chen et al. (2016) find that the US actually has a lower prenatal (less than 28 days old) mortality rate than other developed nations when adjusted for birth weight, yet may still lag for post neonatal (28 days to 12 months) mortality rates that they postulate to be associated with socioeconomic disadvantages, which suggests access issues and not quality issues of the care itself (Chen et al., 2016). US population heterogeneity, the reliability of data collection, measurement criteria disparities, the incidence rate for high-risk pregnancies and high risk behavioural factors contrasted

across nations makes infant mortality a poor measure for healthcare system quality. Furthermore, when adjusted for demographics, measurement disparities and socio-behavioural variables, the US neonatal infant mortality rate is lowest in the world (Chen et al., 2016). However infant mortality is often reported without delineation of such key factors.

4 Cost and efficiency

There is very little debate that the US has the highest cost healthcare system in the world. The US healthcare system is the most expensive in the world per capita and percentage of gross domestic product (GDP) (Squires and Anderson, 2015; OECD, 2015b). A 2010 report by the Kaiser Family Foundation indicates a 100% differential between the lowest cost per capita state and the US cost per capita (Kaiser Family Foundation, 2009).

The question of whether healthcare is a luxury good or a necessity is largely dependent on the level of analysis, if it is examined at the individual risk pool group level versus national system level (Getzen, 2000). Although the level of cost sharing has continued to increase, Americans who are insured at the individual risk pool group level are largely and artificially insulated from the cost of healthcare and enjoy an elasticity of near zero making it a luxury good (Getzen, 2000; Arrow, 2004; Kaiser Family Foundation, 2007; Centers for Medicare and Medicaid Services, 2014). However, at the national level of analysis a nation's healthcare system cost is based on the aggregate spending, in part derived by the supply and wealth of the nation, while considering the percentage of the population who have access to the system (Newhouse, 1977; Getzen, 2000). Getzen (2000) argues that healthcare is both a luxury and a necessity in the US, largely due to the nation's wealth and the willingness to spend at a very high level. Indeed, research suggests a nation's income accounts for 90% of the variation in healthcare spending among developed nations (Newhouse, 1977). Additionally, a country's level of individual consumption and disposable income are key determinants in national healthcare expenditures (Laakmann, 2017). American households not only spend more on healthcare, however spend more on goods and services overall with greater accumulated wealth than comparative nations (Laakmann, 2017). These characteristics translate to greater healthcare spending, however the OECD Health Purchasing Power Parities (PPP) data suggests such spending is only about 10% greater than comparative nations when examining the average price of healthcare (Laakmann, 2017).

The US has the largest GDP in the world and the highest level of healthcare supply in terms of technology, specialists, pharmaceuticals, elective surgeries and specialty care along with the most expensive mix of healthcare services including diagnostic screenings and more aggressive end of life forms of care (International Monetary Fund, 2016; Squires and Anderson, 2015; World Health Organization, 2004; Squires, 2012; Fuchs, 2014; Anderson et al., 2003). The US cost of healthcare is also affected by physician pay, which is highest in the world (McAllester, 2012). Higher physician salaries both attract the most qualified and talented, but also drive the cost of care higher. US physicians earn over a third more than Canadian physicians and more than double many others (Laugesen and Glied, 2011; Anderson et al., 2003).

Without question inefficiencies and poor allocation of resources exist in the US healthcare system. However, the willingness or demand, for spending the most on healthcare in the US is not related to poor allocation or inefficiency as much as

consumers' collective national appetite for what level and types of healthcare is consumed. One factor associated with high cost, or as some may view as inefficient allocation of scarce resources, is the number of orthopaedic procedures that improve functionality and a higher standard of living for many facing non-life-threatening medical conditions. One study examines total knee replacement incidence rates across 31 developed nations for which the US was the highest by a significant margin (De Fatima De Pina et al., 2011). Americans also have a much higher incidence rate of surgical procedures such as costly back surgeries (Cherkin et al., 1994). US healthcare consumers access the healthcare system for procedures covered through government and private insurance that improve their comfort in addition to 'necessary' and lifesaving care. Americans pay more for comfort and convenience (Weeks et al., 2014). Inefficiencies certainly exist; however, they are not unique to the US healthcare system, and in some ways the US performs better (Anderson et al., 2003; Feachem et al., 2002). Countries with lower healthcare spending have largely accomplished this through global budgets and rationing of technology, procedures, specialists and services in general; yet they experience significant inefficiencies in allocation of resources and bureaucracy (Department of Health, 2013; Triggle, 2016; Elliott, 2002; Dobson, 2007; National Health Service, 2012; Deber, 2000; DeCoster et al., 1996; Anderson et al., 2003; Lemieux, 2004; Weeks et al., 2014). Furthermore, the percent of GDP healthcare spending that is government funded is approximately 36% of US healthcare spending, making the percent of GDP similar to other countries (Centers for Medicare and Medicaid Services, 2014; OECD, 2015b; Lemieux, 2004). This suggests spending over and above this level is driven by consumer demand and the ability to seek such via a quasi-free market. From 2009 to 2013 growth in healthcare per capita spending has remained similar across OECD developed nations, including the US (OECD, 2015b). US consumers actually spent less out-of-pocket than the Swiss, yet spend considerably more than all other nations for private health spending inclusive of insurance premiums, however this metric does not include taxes paid by employees, employers and other specialty taxes that subsidise their systems (OECD, 2007;OECD, 2015b; Squires and Anderson, 2015). One can argue that those costs are quite significant and can influence the alternative use of capital by organisations and individuals. Furthermore, factors associated with US healthcare costs measures are not always represented by other nations. Canada per capita spending does not include capital costs of building and equipment (as in the US); Britain does not include nursing home care costs; costs are hidden such as under-the-table spending in socialised systems to access care more quickly and hidden government administrative or tax revenue collection costs that are included in that recorded by private insurance in the US (Towse and Sussex, 2000; Hensher et al., 1999; Pauly, 1993).

As with life expectancy and infant mortality, demographics and socio-behavioural factors impact healthcare spending. The US has the second highest obesity rate in the world to Mexico, the greatest prevalence of high cost teenage pregnancies, high rates of cigarette smoking, increasing levels of healthcare spending on war veterans, and crime related medical spending in addition to higher rates of R& D (OECD, 2014; Sedgh et al., 2015; NCVC, 2005; Grinshteyn and Hemenway, 2015; Auerbach et al., 2013; Sotak, 2014). It can be argued that the high prevalence of many conditions and high incidence rates of health risk/high cost associated behaviours in the US are representative of our heterogeneous population and comparatively lower spending on social services. Indeed, the US spends the least percentage of GDP out of eleven nations examined by Bradley

and Taylor (2013) on social services, and highest on healthcare (Bradley and Taylor, 2013; Squires and Anderson, 2015). The level of a nation's healthcare expenditure does very little to evaluate the quality of the system and more to do with the societal characteristics, consumer demand, wealth, genetic composition and behaviours. In short, the cost of a nation's healthcare is most representative of what the citizens demand and choose to afford as a society, and societal opinion is almost always divided on such key issues.

5 Measuring quality

The Institute of Medicine (IOM) defines healthcare quality as the extent health services are provided with improved desired health outcomes for patient populations based on evidence-based knowledge. The IOM also identifies six dimensions or aims: safe, effective, efficient, timely, patient centred and equitable care (Agency for Healthcare Research and Quality, 2017). Of note when discussing national comparisons, four of the six (safe, effective, timely, and patient centred) dimensions receive little analyses, one (efficient) is not frequently discussed from an objective position that includes hidden costs and population characteristics and behaviours, and another (equitable) is highly political and opinion-driven by nature. Varied definitions, processes, reporting infrastructure, and poor quality administrative data challenge international comparisons (Burnett et al., 2013). Of the measures that are available, quality comparisons of healthcare systems internationally may be more objectively assessed via metrics that arguably better represent the six dimensions of quality espoused by the IOM.

5.1 Safe care

Iatrogenic care and medical errors are an issue for all countries, however one of the difficulties in assessing safety using such metrics is the failure to report or accurately report either or both. Medical error reporting needs significant improvement yet is relatively robust in the USA compared to other nations, however there are still states that do not require reporting (Schappach, 2014; Unal and Seren, 2016; Howie, 2009). Another metric compared internationally is the incidence rate of Hospital Acquired Infections (HAIs). HAI prevalence is considered to be representative of safe care in high-risk healthcare environments with 20% of all occurrences considered avoidable (Magill et al., 2014; OECD, 2016). In 2011 one of every 25 US acute care hospital inpatients acquired a HAI, which is lower than all the European Union member states (Magill et al., 2014; OECD, 2016). The European Prevalence of Infection in Intensive Care Study (EPIC) identified a 20.6% intensive care unit prevalence rate of HAIs (Inweregbu et al., 2005). The US compares favourably with a robust quality-reporting infrastructure in acute care hospitals, even as some nations lack a similar quality management infrastructure and underreport due to lack of associated resources (OECD, 2016; Foley and Burns, 2013; Shaw et al., 2009).

5.2 Effective care

Effective care may be viewed from many perspectives, however minimal data is available for international comparisons, and is often in conflict across reporting organisations.

Outcomes such as breast cancer and prostate cancer post five-year survival rates suggest the US performs well. According to the International Agency for Research on Cancer, affiliated with the WHO, the US ranks ninth both in breast cancer incidence rates (92.9 per 100,000) and five-year post diagnosis survival rates at approximately 63% versus the top country at of Belgium at 66% (Soerjomataram et al., 2012). The National Cancer Institute cites breast cancer incidence rates in the US as 125 per 100,000 and post five-year survival rates of 89.7% (Canadian Institute for Health Information, 2012). The US has the 14th highest incidence rate for prostate cancer with one of the best post five-year survival rates of 98.9% (Soerjomataram et al., 2012).

5.3 Timely care

Timely access to healthcare is one of the more distinct contrasts between the US and other nations. Timeliness is also a factor in cost, efficiency and equity because of the method of rationing associated with different healthcare systems. Socialised healthcare systems ration scarce healthcare resources largely by restricting the availability of technology, pharmaceutical products and specialty care through global budgets, whereas the US has historically rationed by cost. The greater availability of technology, specialty care and healthcare infrastructure increases cost. However, that availability includes lower wait times for 'necessary' care, including access to specialists, and elective care such as cataract surgery or hip and knee replacements (Siciliani et al., 2013). Canada, the UK and other socialised healthcare nations historically have long wait times to access diagnostic and specialty care (Canadian Institute for Health Information, 2007; National Health Service, 2016; Shaw et al., 2009; Siciliani et al., 2013; Barua and Ren, 2015; HOPE, 2004). In many cases, wait times extend beyond that which physicians considered clinically reasonable (Barua and Ren, 2015).

5.4 Patient centred care

Patient centred care is difficult to measure and compare internationally. The Agency for Healthcare Research and Quality describes it as "(p)roviding care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Agency for Healthcare Research and Quality, 2017). One study surveyed adults who were sixty-five or older in ten countries and the US (Osborn et al., 2014). Osborn et al. (2014) finds that US respondents were the most likely to have discussed "…health-promoting behaviours with a clinician, to have a chronic care plan tailored to their daily life, and to have engaged in end-of-life care planning" (Osborn et al., 2014). Bekelman et al. (2016) find in a study that examines end-of-life cancer care of seven countries, that the US and Netherlands have the lowest proportion (22% and 29.4% respectively) of persons who die in an acute care facility versus alternative settings and the use of palliative care, respecting patient rights, while also accessing the ICU more commonly in the last 180 days of life (Bekelman et al., 2016). The US also has a robust tort system that likely increases acute care admissions at the end of life associated with physicians' concerns to protect against medical malpractice if they fail to make all medical resources available. This and overuse of diagnostics have led to significant ongoing yet unresolved tort reform debates (Sekhar and Vyas, 2013).

5.5 Efficient care

Lower cost does not equal a more efficient healthcare system. Greater use of advanced technology, cutting edge pharmaceuticals and procedures improve care in the US, however increases cost. In most industries, technology brings efficiencies, however healthcare is one of the few industries that much of new technology increases production costs due to additional specialists, capital investment and additional services rendered (Burns et al., 2011). This too has led to significant debate in the US regarding the cost of technological innovation driven by prohibitive regulatory barriers that drive cost and inhibit disruptive innovation (Graboyes, 2014). Allocation of resources to technologically advanced and cutting-edge care may be a policy debate, however does not equate to inefficiency. Other socialised healthcare systems restrict the use of such advances due to global budget limitations, while they fund such things as spa respites, cooking classes, and ambulance rides to the pharmacy (Department of Health, 2013; Triggle, 2016; Elliott, 2002; Dobson, 2007; National Health Service, 2014; Deber, 2000; DeCoster et al., 1996; Anderson et al., 2003; Lemieux, 2004; Weeks et al., 2014). The focus on primary or preventive care in socialised systems as a more efficient allocation of resources is questionable as only some preventive care is found to be cost effective (Coffield et al., 2001; Cohen et al., 2008; Tengs et al., 1995; Cohen and Neumann, 2009). Other examples of resource allocation, aka 'rationing', in other nations include 'bed-blocking' and the politicisation of resource allocation (Meadowcroft, 2008; Shannon and French, 2005; Maino, 2010; Ross, 2013; Triggle, 2016; Costa et al., 2012). One measure that suggests efficiency in the utilisation of acute care facilities is length of stay (LOS). Shorter LOS represents patient care provided with the least use of costly healthcare resources. LOS in the US is one of the shortest across developed nations at 5.4 days while the OECD average is 8.1 days (OECD, 2015a; American Hospital Association, 2015).

5.6 Equitable care

The equitable delivery of medical care is a challenge in most countries on a number of different levels. In the USA, the Joint Commission requires that accredited facilities render care on a single plane without regard or differentiation to the patients' fee-sponsorship. In principle, this suggests that care is rendered in most US hospitals equally regardless of patients' ability to pay. In practice, this is not always the case, especially for elective care. Patients presenting to US hospitals with truly emergent needs are protected via federal statute by the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. As noted previously by the authors, certain types of care (i.e., an outpatient, non-emergent MRI of the knee) are almost considered staples in the US and are readily available in urban and suburban areas within a week or less. Consumers of healthcare in countries that largely rely on public options for medical care (e.g., Canada and Australia) experience wait times in excess of multiple months for this level of non-emergent care (Sicilian et al., 2013). In other countries like Thailand and Costa Rica, this level of care is readily available for local patients with sufficient income to cover the cost, though generally at prices 85% lower than in the USA. These countries enjoy a much lower regulatory burden and capital structure (Haskins, 2016).

5.7 Challenges in comparing quality

Comparing medical quality amongst providers in the USA is in itself a significant challenge; the effort is even more daunting with international comparisons. In the US, many states require licensed providers, including hospitals, to regularly report certain datasets to assist in documenting credentials, licensing and patient experience information availability. CMS has moved to incorporate patient experiences and value-based metrics in reimbursement levels more vigorously after the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (Centers for Medicare and Medicaid Services, 2014). The Commonwealth of Pennsylvania is one such example of timely and thorough reporting (Pennsylvania Department of Health, 2017). A related challenge pertains to both educating and engaging consumers to the level where they actively seek out quality providers through readily accessible channels and to then understand the data they read and act accordingly. US consumers generally place more emphasis in their daily lives on seeking knowledge related to the latest smart phone technology or social media trends, than on identifying a quality healthcare provider as a regular source of care. Although significant challenges of levelling consumers and providers asymmetry of information are very real, it could be argued they are more within the auspices of education, public health, social services and personal responsibility than the actual healthcare delivery system. That said, healthcare experts must continue to focus on new ways to engage and encourage healthcare literacy, to in turn improve consumer adherence to medical recommendations and healthy behaviours.

Other than comparing anecdotal opinions from hospital patient satisfaction surveys (and related posts in social media), comparing specific process and outcome data between hospitals in different countries is nearly impossible with the lack of valid data available that persists today. There are no international data-collecting organisations which share this data with the public. The International Society for Quality in Health Care (ISQuA) accredits the various accrediting bodies such as the Joint Commission International (JCI) and Det Norske Veritas (DNV), but they do not publicly display comparative data. Patient satisfaction stalwart Press-Ganey Associates and outcomes aggregator The Leapfrog Group have little or no international presence. Furthermore, organisations such as the WHO have dubious data, methodology, conclusions and ideological motives to be very informative for an objective analysis (Atlas, 2011b; Whitman, 2008).

Are we really looking at marginalised public health and social services and omnipresent subsidisation of the US social composition and demands for healthcare, the nonmedical factors related to healthcare (Gawande, 2011)? Or does the US healthcare system truly offer inherently low-value healthcare relative to other nations (high cost and inefficient)? The call to acknowledge the imbalance between social services, public health and healthcare delivery is not new, but is too often not central in the debate (Gawande, 2011; Stainton, 2016). Current political debate on US healthcare reform in the US Congress focuses on Medicaid and insurance coverage provisions. The focus on the market distortions caused by payers (government and private insurers) is not new, and is arguably not what measures if the US healthcare system is one of high-quality comparative to other countries; it is one of prioritisation associated with societal demands. The important distinction is between quality provision of care and the access to such care. While it has been demonstrated that the availability, accessibility, and the acceptability of emergent medical care in the USA is, for the large majority of Americans, reasonable, it could be argued that asserting the same for non-emergent,

elective care would be myopic at best and disingenuous at worst. The confounding factor is another adjective beginning with an 'a': affordability. Perhaps the largest impediment to satisfying all four of these ideals is to first temper, or 'right-size' the expectation of the American consumer. We actually get what we demand. High cost healthcare in the US has many sources such as lifestyle, a heterogeneous population, the melting pot that makes us so – well – American, regulatory burdens, rights and freedoms that lead to propensities toward costly torts and a greater need of acute care, and non-emergent quality of life care that is at arm's reach within less than a week.

Many would argue that Americans expect the biggest and best of everything, we all want it right now, and when it comes to medical care, none of us want to pay the true price. If we obscure the price through government healthcare and rationing, we may see many individuals benefit, while many others open their eyes to modes of unavoidable (and incontrovertible)rationing that they didn't anticipate. Single payer healthcare in the US would not be 'US healthcare' paid by a single payer, it would be what is available under a single payer system. But the WHO and others continue to frame the US system as 38th in world quality rankings (or something similar) without the honest discussion regarding national and societal priorities, whatever they may be beyond 'healthcare is a right', which itself can be argued vigorously (Williams, 2010). Such comparisons are largely opinion based and biased in their assessment. The most productive analysis and discourse include all legitimate positions of the issues, including the WHO's often cited assessment of equity and justice *AND* of quality and value within the context of what is being paid for, demanded and why. They are both valuable and legitimate positions/arguments, but all need to be honestly and accurately presented for what they are with the best evidence available. The generic comparisons/rankings of US healthcare quality have been presented as clearly as mud assuming most will identify with their predetermined passions or needs. We need to debate the different facets of healthcare honestly and transparently to improve the system, including the provision of care, payment, regulation, societal/market demands, social services and public health. Healthcare is not comprised of isolated silos independent of one another. A good start to a healthier debate would include valid and reliable domestic and international constructs and measures for comparison, if we continue to insist on the current us-them analysis.

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