

Rough Week For Government-Run Healthcare



By *Jamie Wells, M.D.* — August 11, 2017



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Recently, I published an article [More Bad News for Single Payer Health System](#) [2] detailing the reasons for a disastrous report recently generated out of London by the National Health Service (NHS) about poor quality of care for the sickest patients. Care that was deemed less than good for every four out of five cases with a climbing mortality rate of one in three all being attributed to sub-standard practices. (See [here](#) [2]). (1)

Then, news came out from NHS England that the number of people waiting for routine surgery exceeded 4 million. The highest in a decade. The [BBC went on to report](#) [3] “Other targets missed include the four-hour target in A&E and urgent referrals for cancer care.” [Sky News wrote](#) [4] “Dr Mark Holland, president of the Society for Acute Medicine, said the latest figures were “shocking” and represent “another damning indictment of the crisis we are experiencing in the NHS.” The sentiment further echoed by “Danny Mortimer, deputy chief executive of the NHS Confederation, which represents health organizations in England, Wales and Northern Ireland, and chief executive of NHS Employers, called the system “unsustainable.””

In March, 2017, NHS England head [Simon Stevens told BBC News](#) [5] people with certain types of pain would need to wait for surgery in a “trade off” for improved care in other areas. This is called rationing of care. It is antithetical to the oath a physician takes to do the absolute best for his/her patient. The [response at the time by Clare Marx](#) [5], president of the Royal College of Surgeons in England, was “Our concern is not only for hip and knee patients but those patients who perhaps are waiting for heart surgery. They may have a heart attack whilst they are waiting.” Translation: Delays can contribute to a cascade of even more serious consequences.

[Recruitment and staffing crises](#) [4] are amplifying the problems, putting a strain on the current employees and system. Between [January and March 2017](#) [4], over 86,000 personnel, full-time

vacancies were advertised. This is up 10% from the same time period last year with more than 33,000 for nurses and midwives and over 11,000 for doctors and dentists.

Waiting lists are not access (2). And, they certainly aren't any measure of high (or any) quality. In fact, they perpetuate suffering and compound, in many cases, the inciting event. Ultimately, this generates greater psychological, physical and monetary costs. This is agony for the patient and their physician, providers or caregivers-- wonder why there are such shortages?! Rationing of care interwoven in this mix serves the same deleterious ends. Using bureaucratic and governmental mindsets to manage the reality of busy clinic and hospital medical practice is routinely at odds with a doctor's main consideration in health care of providing actual health care. Functioning from behind and with perpetual shortages as their baseline, it might be time for the NHS to stop reinventing the wheel (and so poorly).

(1) UPDATE (9:15pm EST, 8/11/17): The NHS study out of London revealed the following about those with delayed use of noninvasive ventilation (NIV): "National NIV audits over the last three cycles have shown worsening mortality rates, rising most recently to 34%... mortality rate from the overall cohort of patients 35.3%. When NIV was initiated in the first 24 hours of admission, mortality was 25.1%. If it was used at a later stage of the admission, the mortality in this group was 55.4%."

To give a frame of reference for use of NIV and mortality in the COPD population in the United States, refer to this study as a helpful resource [Comparative Effectiveness of Noninvasive and Invasive Ventilation in Critically Ill Patients with Acute Exacerbation of COPD](#) [6]. (IMV=invasive mechanical ventilation).

"Hospital mortality was 7.4% for patients treated with NIV; 16.1% for those treated with IMV...The receipt of NIV was associated with lower ICU and hospital mortality compared to the receipt of IMV (3.1% vs 10.5% and 7.4% vs 16.1% respectively)...” as per the thirty-eight hospitals participating in the Acute Physiology and Chronic Health Evaluation (APACHE) database from 2008 through 2012 published here: [Crit Care Med. 2015 Jul; 43\(7\): 1386–1394](#) [6]. [7]

(2) This concept came from a decision by the Chief Justice(s) of the Canadian Supreme Court, see [here](#) [8]. In 2005, they overturned a "Quebec law preventing people from buying private health insurance to pay for medical services available through the publicly funded system."

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[2] <http://www.acsh.org/news/2017/08/10/more-bad-news-single-payer-health-system-11673>

[3] <http://www.bbc.com/news/health-40886598>

[4] <http://news.sky.com/story/nhs-england-missed-ae-waiting-times-target-every-month-for-last-two-years-10982112>

[5] <http://www.bbc.com/news/health-39420662>

[6] <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4470719/#!po=1.19048>

[7] <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4470719/#!po=1.19048>

[8] http://www.cbc.ca/news2/background/healthcare/ruling_reaction.html