

Who's afraid of American health care?

Brian Bedkober

It is not uncommon to hear a politician or medico-politician say, usually with a contemptuous sneer, that we would not want to introduce into Australia any of the features of the American health care system. This kind of comment is usually made while defending the Australian system and denigrating suggestions that Australia should place more reliance on market-based solutions to the provision of health care.

Australia and the US have the two least socialised (or most mixed) systems of health care in the world. Any comparisons that are to be made should be made, therefore, between these two systems and the rest. It is natural, however, for those who prefer a more socialised Australian system to attack the less socialised US system.

Although there is much to be criticised in the American system, those features that are most vulnerable to legitimate attack are those that arise as a result of the increasingly heavy hand of regulation (in particular, Medicare and Medicaid). It is not more regulation and less competition that both health care systems need, but less intervention and a healthier dose of competition. Nevertheless, the American system generally works better than the Australian system and a good deal better than the systems of the UK and Canada with which it is more usually compared.

But, as in the Australian system, these

advantages are under continual threat by those who believe that they know best how to organise other people's lives and are prepared to use the authority of government to do so.

The easiest caricature of the American system, and one which we see in Australia far too often, is the belief that the poor and unemployed are refused treatment if they are without health insurance. But to do so would be against Federal law—hospitals are required to provide examination or treatment for emergency medical conditions, regardless of an individual's ability to pay. Additionally, a range of State and Federal medical programmes provide coverage for low-income individuals and families. The result is that the per capita spending rate for individuals is the same for those above and below the poverty line.

One of the criticisms commonly made about the US system is the amount of money Americans spend on health care. Australians often refer to the lower percentage of GDP that is spent on health care in Australia as a mark of the excellent management of the Australian system. The first point that ought to be made here is that the percentage of GDP that is spent on health care should not be decided centrally. The person best able to decide the proper proportion of his assets to spend on health care is the individual—not the State that taxes citizens into a condition where they have little or no disposable cash and then decides for them what proportion of their assets will be spent on what services.

Second, the fact that people spend more on health care doesn't matter—provided people get what they pay for. If spending less was better, then the best system would be one where nothing at all was spent.

Moreover, the principal reason that the US spends a greater percentage of GDP on health care is that it supplies more of what US economist Arnold Kling refers to as 'premium health care'—high cost technology and pharmaceuticals, 'super specialist' physicians and super treatments. Those countries that have lower health care expenditures have a smaller investment in technologically advanced care. In Australia, the lower percentage of GDP is in no small part due both to the limits placed on available services as well as to the reduction in capital stock.

Most of the world's best doctors and facilities are to be found in the US. As Cato Institute scholars Michael Cannon and Michael Tanner report:

In the past 10 years, 14 of 25 recipients of the Nobel Prize for Medicine have been US citizens. Four more practice in the United States. American research and development, particularly in the pharmaceutical field, has produced the majority of medical breakthroughs over the past 50 years. Of the 152 major medicines introduced worldwide over the past 20 years, US companies developed nearly half. Eight of the 10 top-selling drugs worldwide in 2002 were produced by US firms, and Americans played

Brian Bedkober is the Editor of The Australian Private Doctor.

a key role in eight of the ten most important medical advances in the past 30 years.

As for facilities and technologies, when compared with its neighbour, Canada, on which Australia's system is modelled, the much less socialised US system has eight times more MRIs (magnetic resonance imaging units), seven times more radiation therapy units, six times as many lithotriptors, and three times more open-heart surgery and cardiac catheterization units per patient. There are more MRI units in the state of Tennessee than in the whole of Canada.

not always a good thing, spending more money is clearly not always good either. Less benign contributory factors to increased costs in the US are the much greater cost of malpractice litigation, and the effect that the current tax bias favouring excessive health insurance has on total health expenditure. Nevertheless, the costs of litigation, of pharmaceuticals and of free-riders (the uninsured who obtain health care on an emergency basis for which others pay) amount to less than one-half of one per cent of GDP when total health spending is 15 per cent of GDP.

The higher American expenditures

Institute estimates that people currently on the NHS waiting lists will collectively wait about one million years longer to receive treatment than doctors deem acceptable.

While only about 5 per cent of Americans have a wait of more than four months for surgery, the figure for Australians, New Zealanders, Canadians and Britons ranges from 23 per cent to 36 per cent.

Similarly, in a study by Canada's Fraser Institute, it was found that, in 2003 in that country's system, the median waiting time from referral by a general practitio-

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Spending more money on technological advances, while not always affecting outcomes, is generally a good investment. For example, the mortality rates from breast, prostate and colon cancer in the US are very much lower than in Australia (or anywhere else for that matter). According to Cannon and Tanner, 'every additional dollar spent on treating heart attacks yielded the equivalent of \$7 worth of increased longevity and quality of life'. Similarly,

Lichtenburg estimates that the benefit-cost ratio of general medical expenditures is nearly 14 to 1 while the ratio for pharmaceutical research and development is more than 100 to 1... at the same time technology often lowers prices. The inflation- and quality-adjusted price of treating heart attacks declined at a rate of just over 1 per cent each year from 1983 to 1994. Other studies have found similar effects with prices for cataract surgery and depression.

This is not to suggest, of course, that waste does not occur in the American system or would never occur in a perfectly competitive system (if such a system were possible).

While spending less money is clearly

are also related to the fact that, the wealthier people are, the more money they spend on health care—in much the same way in which the environment generally only becomes a concern when people are wealthy enough to worry about it.

The other problem with undercapitalization and the increased demand in systems with 'free' (or heavily subsidised) services is the inability to gain access to whatever services are available. The unavailability of services in the socialised Canadian system has meant that the risk of dying on the waiting list for cardiac surgery is greater than the actual operative mortality. In just one year, the Canadian province of Ontario removed more than 120 coronary bypass surgery candidates from its waiting list because they had grown too sick to benefit from the procedure.

Similarly, in the nationalised British health system, each year about 9,000 patients fail to receive renal dialysis or a kidney transplant and die as a result, about 15,000 cancer patients and 17,000 heart patients fail to receive up-to-date treatment and 7,000 elderly patients are denied hip replacements. At the end of 2001, 43,900 British patients, many of them needing hip or knee replacements, had been waiting for more than a year for surgery. The London-based Adam Smith

ner to treatment by a specialist was 17.7 weeks. Patients also waited one month for a CT scan, three months for an MRI and three weeks for an ultrasound. Furthermore, 44 per cent of Canadians found it somewhat or very difficult to access a specialist (35 per cent for Australians), 63 per cent waited one to four months or more for non-emergency surgery (49 per cent for Australians) and yet only 12 per cent rated their overall medical care as only fair or poor (10 per cent for Australians).

Another factor that the critics usually overlook when comparing costs is that different countries measure health care costs in different ways—some include outpatient services and the capital costs of building and equipment and some don't, some measure out-of-pocket expenses and include nursing home care and some don't.

Different countries also have different health problems—different numbers of AIDS sufferers, different numbers of old people, different numbers of single young pregnant women, different numbers of war veterans and different numbers of obese people. Other factors that affect costs are the considerable quantity of clinical research that takes place in American teaching hospitals (which inflates their patient care costs), the higher nurse-to-patient ratios, the greater space

Recent major technological advances in medicine

MRI (Magnetic Resonance Imaging)

A radiology technique that uses magnetism, radio waves, and a computer to produce images of body structures. It is useful for imaging of soft tissues such as the brain, spinal cord, muscles and ligaments and detecting abnormal tissues such as tumours. During an MRI Scan, the patient lies on a moveable bed within a strong magnetic field.

**Cost: Over \$2,000,000 per unit.
\$10,000 per month in upkeep.**

Selective serotonin reuptake inhibitors (SSRIs)

A class of antidepressants that affect the chemicals that nerves in the brain use to send messages to one another. SSRIs work by inhibiting the 'reuptake' of serotonin, an action which allows more serotonin to be available to be taken up by other nerves.

Cost: Over \$100 per patient per month. Treatment is normally for 12 months but can be indefinite.

Tamoxifen

A Selective Estrogen Receptor Modulator (SERM). It is used for the prevention and treatment of early and advanced breast cancer. Tamoxifen has very weak estrogen activity. In the bloodstream tamoxifen takes the place of the body's natural estrogen cells and binds with many types of breast cancer cells therefore blocking estrogen-stimulated cancer cell growth.

Cost: Mean cost per patient is over \$8,000 across their lifetime.

Statins

A type of drug used to lower LDL-cholesterol levels in people suffering from, or who are at risk from, cardiovascular disease. Statins inhibit the enzyme HMG-CoA reductase which controls the rate of cholesterol production in the body. These drugs lower cholesterol by slowing down the production of cholesterol and by increasing the liver's ability to remove the LDL-cholesterol already in the blood.

Cost: Over \$400 per patient per year. Treatment averages 1-2 years.



per patient in hospital wards, the higher salaries paid to medical specialists, and an excess of supply which eliminates most of the need for surgical queues.

These measurement differences also play a role in two other common criticisms of the American system. Despite spending such a high percentage of GDP on health, it is often claimed that the US fares poorly on measures of infant mortality and life expectancy.

Although how a nation spends its health dollars is certainly important, we cannot learn much from the way in which these particular factors are commonly examined. Cross-nation comparisons often do not measure the same thing. Live births, fetal deaths and infant deaths are recorded differently in many countries. The US, for example, includes extremely low-weight infants in its measure of live

births. If the survival of infants of a given birth weight is measured, the US actually outperforms other nations.

There is, moreover, little correlation between life expectancy and health expenditures across countries. For example, Korea and Turkey spend roughly the same percentage of GDP on health care and yet the life expectancy of Turkish females is about 10 years less. Even the actual amount spent per person on health care shows little correlation with life expectancy. Japan and the UK spend about the same per person on health care, but life expectancy in Japan is about five years longer than in the UK. Average life expectancy tells us virtually nothing about the quality of the health system.

Furthermore, as Arnold Kling points out, not only are the statistical gains in longevity attributable to the operations

of the health system relatively small at the margins, but

aggregate longevity is affected by deaths in which medical intervention would make no difference (e.g., homicides and traffic fatalities), by behavioural factors (e.g., smoking and nutrition), and by circumstances at birth and early childhood (e.g., genetic factors), regardless of subsequent health care.... The effect of health care spending on longevity is dissipated further by the fact that some medical treatments are dedicated solely to relief from suffering. From a longevity perspective, every dollar spent on relief from allergy symptoms, pain, depression, disability, or discomfort is 'wasted'.

Demonstrating the influence of genetic

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factors, Goodman et al. point out that, in 1999,

male life expectancy at birth ranged from 80.9 years for an Asian American, 77.2 years for an Hispanic, 74.7 years for a white non-Hispanic, and 72.9 years for an American Indian down to 64.8 years for an African American. That same year, female life expectancy ranged from 86.5 years for an Asian, 83.7 years for an Hispanic, 82 years for an American Indian and 80.1 years for a white non-Hispanic down to 75.1 years for a black.

The average US life expectancy of 74.1 years is, therefore, a composite of the contributions made by each of these groups. The different life expectancies of these groups cannot be explained by variations in group access to health care either. If, for example, we look at the Japanese in Japan, we find that they have the longest life span of any industrialised country—78.6 years, or three years longer than for Americans. If, however, say Goodman et al., it was the American health system that was the major contributor to shorter life spans, we would not expect the Japanese in America to live as long as their counterparts in Japan. But they do.

So while the monetary costs of US-style health costs may be higher (and even this is doubtful, particularly when allowance is made for higher American wages) the rationing in more heavily socialised systems, by denying access to particular treatment modalities or by increasing waiting times, produces serious costs of a different kind.

Furthermore, to the effects on morbidity and mortality caused by budgetary restraints must be added the fact that whatever is actually provided in more socialised systems is inevitably provided at a higher cost than the equivalent ser-

vices provided by private industry. That patients believe that they are able to obtain cost-effective treatment in the US is demonstrated by the large numbers of patients who come from all over the world in order to access American facilities. Cannon and Turner report that:

the Mayo Clinic treats roughly 7,200 foreigners every year. John Hopkins University Medical Centre treats more than 6,000. Nearly one-third of Canada's doctors have sent a patient abroad for treatment, often to the United States, and Canadian governments and patients spend more than \$1 billion every year on medical care in the United States.

Obviously, in purely utilitarian terms what we would like to achieve in our health care system is the lowest amount of overuse of services while at the same time achieving the smallest disincentive to seeking necessary care. A universal public system is based on the egalitarian belief that not only do poorer people deserve a standard of health care that is greater than they can afford with their current incomes, but that they should have a standard of care no different from that of the more wealthy members of the community.

With that belief, however, comes a crippling distortion of the balance between over- and under-use.

On the other hand, private health insurance schemes are not only far more morally acceptable, they are best able to achieve this utilitarian balance—because there is a significant incentive not to overuse the system: the cost is fully (or substantially) borne by the patient and his insurer (the cost of the premium and any co-payment).

Those who cannot afford to insure become (principally) the subject of pri-

vate charitable efforts.

A private system does not prevent the most productive members of society from gaining one of the most important rewards (increased access to health care) of their increased productivity, and it improves the likelihood of the development and wider availability of innovative technological improvements (given that expensive technologies are initially financed into existence by wealthy individuals and become generally available as their price progressively falls). This is a legitimate method of redistribution in which the rich suffer price discrimination in order to gain first access, with the not-so-rich benefiting from the resultant more widespread use of the technology.

A private system also provides a wider range of health care choices, rather than the one-size-fits-all formula of universal schemes.

The American system does not deserve many of the brickbats it commonly receives. It is, however, hardly a shining example of the free market at work and, as in Australia, it is becoming less so. It would be nice to be able to say that the American inclination to resist overbearing authority and the willingness to try ideas such as Medical Savings Accounts gives some hope for the future. The logic of the democratic system, however, suggests otherwise.

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