

Keeping Health Care Afloat

The United States Versus Canada

By Uwe E. Reinhardt

For most of the 20th century, Americans basked in the unquestioned faith that theirs was the best health system in the world. That belief was not totally unfounded. No nation trains physicians better than the United States. Its hospitals set the standards in terms of technical sophistication and sheer luxury of accommodation. The nation's pharmaceutical, biotech and medical-device industries remain global leaders, both in terms of technology and the sheer volume of innovations. Finally, for terminally ill patients who can afford the bills, America is often viewed as the last hope.

Doubts, though, are surfacing. Most notably, the rapidly rising cost of health care has begun to price more and more Americans out of the private system. Less noticed but equally disturbing, there is reason to believe that the average quality of care is slipping.

THE COST

Measured in terms of purchasing power, Americans spent almost twice as much per capita on health care in 2003 (\$6,100) as Canadians (\$3,200) and Germans (\$3,000), and half again more than the Swiss (\$4,100) – even though both Germany and Switzerland have much older, and thus medically needier, populations than the United States.



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According to the widely respected Milliman Medical Index, the average American family with private insurance consumed \$13,382 in medical services in 2006. Yet about one-third of American families have an income below \$40,000 per year. Thus, it is not surprising that the number of Americans without health insurance has risen inexorably during the past two decades, even during periods of economic boom. The total stood at 37 million in 1993; it is now 46 million and expected to exceed 50 million within a few years. In the Sun Belt states, roughly a quarter of the population is uninsured.

CITIZENS' VIEWS ABOUT HEALTH SYSTEMS

	SYSTEM WORKS WELL, ONLY MINOR CHANGES ARE NEEDED	FUNDAMENTAL CHANGES ARE NEEDED	SYSTEM NEEDS TO BE COMPLETELY REBUILT
ALL ADULTS, 2004			
Canada	21%	63%	14%
United States	16%	47%	33%
PATIENTS WITH HEALTH PROBLEMS, 2005			
Canada	21%	61%	17%
United States	23%	44%	30%

SOURCE: Cathy Schoen et al. *Health Affairs* 2003/2005.

THE QUALITY

In a 2003 report in the *New England Journal of Medicine* on a nationwide research project, Elizabeth McGlynn and her RAND colleagues reported that U.S. adults received on average only about 55 percent of the care generally recommended for their conditions. Earlier, John Wennberg and his associates at Dartmouth had published data showing that total Medicare spending per beneficiary varied across regions by a factor of close to three, even after adjustments for differences in fees, age, gender and severity of illness.

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Remarkably, these enormous variations in spending don't track independent measures of the quality of care, medical outcomes or even patient satisfaction. Indeed, a study by Katherine Baicker (Harvard) and Amitabh Chandra (Harvard) suggests a *negative* correlation between a state's Medicare spending per person and an independent ranking of quality of care. The authors conclude that states relying more on general practitioners tend to have more effective care and lower spending than states more dependent on medical specialists.

This paradox extends to international comparisons. A 2005 survey by Commonwealth Fund found that 34 percent of American patients reported that they had been victims of various sorts of medical errors, compared with 27 percent in Australia, 30 percent in Canada, 23 percent in Germany and 22 percent in Britain. And many of those errors are far from trivial: a 1999 report by the National Academy of Science's Institute of Medicine estimated that 44,000 to 98,000 Americans lose their lives in hospitals each year because of avoidable medical snafus.

Smarter use of modern information technology is thought to be the most effective way to reduce medical errors. Yet America's primary-care physicians now lag behind their colleagues in Europe in use of electronic clinical information systems. It is no small irony that one notable exception is the U.S. Department of Veterans Affairs health care system, the only model of purely socialized medicine left in the world outside of Cuba. Indeed, the Institute of Medicine concluded that the VA was the national leader in the smart use of information technology and quality control.

By the same token, the pride Americans take in their easy access to high-tech medical equipment and procedures is probably misplaced. As the Institute of Medicine puts it,

“there is substantial evidence documenting overuse of many services – services for which the potential risk of harm outweighs the potential benefits.”

A glaring example of this tendency has been the precipitous use of autologous bone marrow transplantation, which had been used profligately in the treatment of breast cancer. More than 30,000 women suffered through that expensive, highly risky and painful procedure before careful studies showed it to be ineffective.

LOOKING ACROSS THE BORDER

With growing evidence that American health care promises more than it delivers, Americans have begun to look elsewhere for lessons on how to finance and manage health care. In this inquiry, neighboring Canada is particularly apt for a number of reasons.

First, the training of physicians and nurses in Canada and the United States is similar, greatly facilitating the movement of health care professionals between the two countries. Second, with the exception of Quebec, Canadians and Americans share many cultural traits that affect behavior toward the health system – in particular, language and media. Third, Canada has consistently spent only about half as much per person on health care in real terms as the United States, yet often ranks higher in measurable health outcomes. Finally, opinion surveys suggest that Canadians are happier with their health care system than their counterparts south of the border. One in three Americans say their system should be “completely rebuilt,” compared with just one in seven Canadians.

A SNAPSHOT OF CANADA’S HEALTH SYSTEM

Canada’s health system actually consists of 13 distinct provincial tax-financed single-payer

health-insurance systems that operate within guidelines set by the federal government in Ottawa. The federal rules encourage uniformity through the mechanism of cost sharing, just as the Medicaid system for the poor does in the United States. It is why so many outsiders speak of “Canada’s national health system,” as if it were a single entity.

The tax-financed provincial insurance systems procure physician services, hospital services and sundry other health services from a mixed for-profit and not-for-profit delivery system that is not drastically different from the American delivery system – although it is much more constrained by the market clout characteristic of systems in which a single government payer does the negotiating on behalf of consumers.

For the comprehensive set of services covered under the Health Canada Act, patients typically enjoy first-dollar coverage. The public insurance systems cover about 70 percent of total health outlays, with the remainder paid through private insurance or out-of-pocket. These latter services include dental and vision care, long-term care and home care, and prescription drugs for the non-poor and non-elderly.

In June 2005, the Supreme Court of Canada ruled that the prohibition of private insurance for medically necessary services to which access is restricted by waiting time infringes on citizens’ rights. That ruling has opened the door to the development of two-tier health insurance and health care in Canada, a development generating heated debate.

The Advantages of Single-Payer Systems

Although much maligned by free-market devotees, single-payer (typically the government) health insurance systems do have a number of advantages over market-oriented systems. First, by virtue of their administrative

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simplicity, single-payer systems are the ideal platforms for a uniform information infrastructure, based on common nomenclature and technical processes. The single-payer system of Taiwan, for example, can track health spending by provider and patient virtually as they happen. In the United States, the lag between delivering service and recognizing its expense can easily exceed one year.

Second, because the administrative structure of single-payer health insurance tends to be simple, the administrative cost of operating such systems tends to be low. Taiwan's system, for example, spends less than 2 percent of outlays on administration – as, incidentally, does the U.S. single-payer Medicare program for the elderly. By contrast, private insurers in the United States spend 15 to 25 percent on administration, marketing and profits.

The McKinsey Global Institute found that in 1990 Americans used \$390 less in real medical resources per person than Germans did, but spent \$737 more on higher prices, \$360 more on administration, and \$256 more on other forms of overhead. In their more recent study of administrative costs of the Canadian and U.S. health systems, Steffie Woolhandler (Harvard), Terry Campbell (Canadian Institute of Health) and David Himmelstein (Harvard) estimated that in 1999 the U.S. system consumed \$1,059 per person in administrative costs, compared with just \$307 in Canada. The researchers also found that from 1969 to 1999 the fraction of the total health care labor force accounted for by administrative workers grew 18 to 27 percent in the United States, but only from 16 to 19 percent in Canada.

While one can quibble with these numbers, there is no doubt that the virtues of America's health insurance system come at a stiff price. As the Brookings economist Henry Aaron put it, the U.S. health system is "an ad-

ministrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reasons, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird."

Third – and very important – a single-payer system is the ideal platform for an egalitarian distribution ethic in health care. Canadians seem sincerely to believe that good health care is a right. And though Americans pay lip service to this ideal too, socioeconomic status plays a major role in access to basic human services.

Consider the legislators of my home state, New Jersey, who apparently think nothing of limiting compensation to a pediatrician to \$30 for a Medicaid office visit, while bestowing upon themselves insurance that pays that same pediatrician \$90 or more for treating their children.

Economists teach their students that prices signal value to suppliers. Not surprisingly, large fractions of American physicians fully understand that signal and refuse to treat Medicaid patients altogether. Most Canadians, who support a system that pays the same fee for the same service regardless of who is being treated, would probably consider these pricing practices ethically unacceptable. Nor, for that matter, would Canadians tolerate the common practice among American hospitals and pharmacies to charge more to uninsured Americans lacking bargaining power – in most instances, members of low-income families – than they charge private health insurers.

The Disadvantages of Single-Payer Systems

As noted earlier, Canada spends only about half as much per person on health care as the United States, in spite of the fact that Canada

is part of the high-cost North American market for health professionals and other health care inputs. The provincial plans achieve these low costs through three mechanisms.

First, by virtue of their monopoly power as buyers of health care, they can set prices just high enough not to lose out too much to the neighboring United States market. Second, the provincial health plans use global caps on hospital and physician outlays. Third, the plans constrain physical capacity through

become the Achilles' heel of a single-payer system and destroy the egalitarian social contract underlying a single-payer system.

A number of Canadian commissions recently have examined the queues and suggested remedies. Last year, Canada's Federal Wait Times Advisor and the Health Council of Canada proposed evidence-based benchmarks for tolerable queues. Here it should be noted that experts do not consider some waiting time per se as a sign of a health system's shortcom-



mandated limits on the number of high-tech, high-cost facilities and procedures allowed to bill the system.

Each of these cost-containment mechanisms carries with it the danger of being applied to excess. The global caps can trigger undesired incentives in the process of creating a zero-sum game for providers – for example, making it financially advantageous to prolong convalescent stays. The restrictions on physical capacity have created fairly long queues for elective surgery, for a variety of diagnostic procedures, and for cardiac-care and cancer-care procedures that Americans would consider urgent. If such queues grow too long – as they appear to have in Canada – they can

ings if clinical evidence indicates that the waits do not have untoward health effects.

Still, critics of the Canadian health system have seized upon the queues as ammunition. For example, Nadeem Esmail and Michael Walker of Canada's free-market-oriented Fraser Institute wrote last year in the *Review* that “rationing services by imposing longer waits is inherently inefficient. The very existence of chronic delays in delivering services implies that the system is failing to use prices to equate supply and demand.” That proposition invites critical comment.

STYLES OF RATIONING HEALTH CARE

The idea that a market approach to health

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care can avoid rationing is a time-hallowed, but in my view fallacious, cliché in the American debate on health policy. The price system constitutes just one of many ways to ration scarce resources. As Michael Katz (Harvard) and Harvey Rosen (Princeton) write in their textbook *Microeconomics*:

“If bread were free, a huge quantity of it would be demanded. Because the resources used to produce bread are scarce, the actual amount of bread has to be rationed among its potential users. Not everyone can have all the bread that they could possibly want. The bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.”

If readers substitute “health care” for “bread” in this passage, they will have an idea about how a price system works in health care.

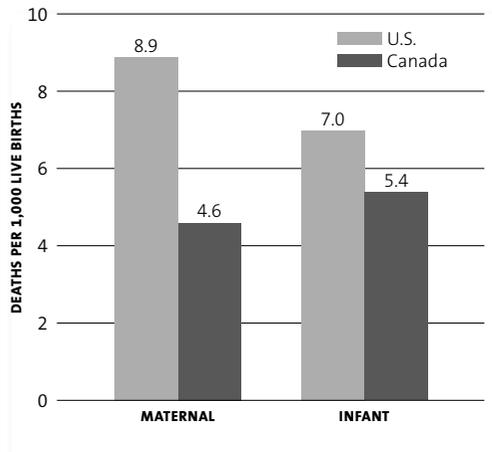
The effects of price rationing at its extreme can be inferred from *Hidden Cost, Value Lost*, a 2003 report from the Institute of Medicine. The panel estimated that some 18,000 Americans die each year prematurely for want of health insurance.

To be sure, most uninsured Americans eventually do receive needed care from their neighborhood hospitals when they are critically ill. But there is solid research showing the price system rations uninsured Americans out of the timely, early-stage primary and secondary care that might have avoided their serious or fatal illnesses. For example, far more uninsured children with asthma end up in the hospital in serious condition than insured children do. Yet roughly nine million American children are not covered.

It is not clear to me on what ethical or scientific basis one could judge this approach to rationing health care to be more “efficient”

than rationing by queue. Indeed, the word “efficient” cannot ever be meaningfully defined in abstraction of the goal that is to be attained efficiently. Why move efficiently toward a goal one does not wish to reach?

INFANT AND MATERNAL DEATH RATES, 2002



SOURCE: OECD 2006

As already suggested, few Canadians would consider it ethically acceptable to pay a pediatrician much less for treating a poor child than for treating a rich child. Similarly, one can understand why so many Canadians look askance at the establishment of an upper-tier private health care system that can draw professionals and other resources away from the public system, merely to allow Canadians with superior ability to pay to jump the queue in health care.

Given this egalitarian ethos, Canadians would probably be aghast at the latest turn of American health policy, as promoted by President Bush. The thrust of that policy is to drive consumers into health insurance policies with very high deductibles and copayments. To that end, the president would allow Americans to make tax-deductible deposits into personal Health Savings Accounts to

cover out-of-pocket costs and health insurance premiums – but only if they purchase a high-deductible insurance policy.

With a progressive income tax, this tax preference is more valuable for high-income families than for middle-income families in lower tax brackets. At the same time, it is elementary logic that an annual insurance deductible of, say, \$5,000 per family is likely to

insurance coverage would probably not occur to Canadians – or, for that matter, the citizens of any other affluent country. Perhaps it partially explains why so many more United States babies and mothers die in birth than the Canadian counterparts. That members of the Congress, who not long ago felt ethically compelled to rush back to Washington to second-guess the treatment of Terry Schiavo, so

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induce a family with a moderate income to cut back more on discretionary health care than a high-income family.

In effect, then, those who back the president's approach are looking to moderate-income groups to bear the brunt of price rationing in health care and to shift more of the financial burden of ill health from the healthy to the chronically ill.

To understand how this brave new world would work, check out www.eHealthInsurance.com, an electronic market for individually purchased (that is, nongroup) health insurance policies. Enter your family's composition, ZIP code and the type of policy desired (Health Savings Account-qualified or not), and you get a menu of customized offerings. Most of the policies listed are medically underwritten – that is, the premiums vary with the insured's health status. Many of them have deductibles up to \$10,000 per year for a family, and most of them have sundry limitations and exclusions, the most common of which is maternity care.

Excluding maternity care from health in-

passively accept high levels of infant and maternal mortality must astound Canadians.

WHAT THIS ALL MEANS

I don't view the Canadian health care system as a model for the United States for at least two reasons. First, the highly egalitarian precepts inherent in the Canadian approach do not seem compatible with Americans' preference for letting money talk when it comes to health care – or, for that matter, education or the administration of justice. Second, single-payer government-run health systems are especially difficult to administer well in a political system so open to influence through campaign contributions.

By the same token, though, I don't buy the argument that government-run single-payer health systems are inherently less efficient than market-oriented health systems. In the end, each nation must decide which style of rationing – by the queue or by price and ability to pay – is most compatible with its culture. Mantras about the virtues of markets are no substitute for serious ethical conviction. **M**