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Second Thoughts on Public Systems

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Abstract: With increased angst about American health care, policy makers increasingly consider some type of single payer system. Dr. Gratzer reviews evidence from Canada and Europe, concluding that these systems are plagued by low standards and poorer health outcomes.

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Second Thoughts on Public Systems

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Rex Morgan has done battle with many a medical problem – from epilepsy to AIDS, from organ transplantation to depression – but he feels that he must tackle a new one: American health care. Dr. Morgan may not have the name recognition of former Surgeon General C. Everett Koop or the political skill of Senator Bill Frist, but he certainly is a prominent physician. Having practiced since 1948, the handsome and affable Dr. Morgan used to be thoroughly apolitical. Nowadays, Morgan champions a very political cause: single-payer, state-sponsored health care.

What would drive Morgan into the heavy world of health policy? Try the death of a close friend. Dick Coleman, Morgan's best friend, lost his job after being diagnosed with colon cancer. Without a job, he had no insurance. The medical bills threatened foreclosure on the mortgage of the family home. By the time Coleman ultimately died, his personal health insurance crisis had pushed his wife into suicidal thoughts and his daughter into drug use. Morgan sums it up: "All because they couldn't afford health insurance."

Of course, Dr. Morgan wouldn't be attending any rallies or lunching with prominent policy makers. Dr. Morgan is a fictional character – the main character in a comic strip that bears his name. The comic strip appears in some 300 newspapers in 15 countries.

Government-run health care – what proponents now euphemistically call "single-payer" – is *not* poised to sweep the body politic this year and transform the nation. Indeed, it is an idea that exists in the shadows. When Oregon voted in 2002 on a ballot-initiative promising Canadian-style health care, voters in the liberal bastion responded with uncharacteristic resolve. Measure 23 was defeated by a 4 to 1 margin

A few months later, Congressman John Conyers proposed the United States National Health Insurance Act. The response was equally unenthusiastic in the nation's capital. Even the sympathetic *New York Times* failed to run a single story on the motion.

But national health care is not a dead idea. Rather, it lies dormant, quietly capturing the imagination of esteemed intellectuals and frustrated Americans. Rex Morgan, after all, may not be real, but the frustration the character exhibits is. Consider this: the author of *Rex Morgan, MD* is an Arizona Republican who cast a ballot for George W. Bush in 2000. Conyers' attempt at national health insurance may have been a fleeting liberal tilt against the conservative leadership windmill in the House of Representatives, but his support was striking – nearly 4,000 physicians endorsed the proposals including two former Surgeon Generals, a Nobel Laureate, several authors of respected medical textbooks and the organizer of emergency services in New York on 9/11.

Government-run health care is the on-going temptation. Since the death of Clinton-care in 1994, there has been a quiet but growing movement to re-embrace some type of publicly funded system. And no wonder: the problems with American health care are very real. Dr. Marcia Angell, the former editor of the *New England Journal of Medicine*, reviews the woes in an opinion piece for the *New York Times*:

Private health insurance premiums are rising at an unsustainable average of about 13% per year and as much as 25% in some areas of the country. Coverage is shrinking, as more employers decide to cap their contributions to health insurance plans and workers find they cannot pay their rapidly expanding share. And with the rise in unemployment, more people are losing what limited coverage they had...¹

And as Americans grow more aware of the shortcomings of their system, the desire to look elsewhere for answers becomes more tempting. For Dr. Angell, it's enough to consider a serious overhaul of the system – to recognize the “fatal flaw” that “we treat health care as a commodity” – and to embrace single payer.

What we need is a national single-payer system that would eliminate unnecessary administrative costs, duplication and profits. In many ways, this would be tantamount to extending Medicare to the entire population. Medicare is, after all, a government-financed single-payer system embedded within our private, market-based system. It's by far the most efficient part of our health-care system, with overhead costs of less than 3%, and it covers virtually everyone over the age of 65. Medicare is not perfect, but it's the most popular part of the American health-care system.²

Drs. Himmelstein and Woolhandler, tireless proponents of single payer health care, describe the siren song well by looking North:

Canada's single payer health insurance plans provide universal coverage and are far more efficient than U.S. healthcare. Despite spending about one half as much per capita as Americans, Canadians receive more of most types of care. They live longer, enjoy unfettered choice of doctors and hospitals, and a quality of care that is on a par with the care of insured Americans. Finally Canadians are secure that their healthcare will be covered.³

If that sounds like a welcome break from the misery of American medicine – the swelling ranks of the uninsured, the unease of the middle class, the frustration of everyone – it is.

Even prominent politicians recognize the angst of middle America and flirt with single payer. “I think we've reached a point where the entire health care system is in impending crisis. I have reluctantly come to the conclusion that we should begin drafting a single-payer national health plan,” former Vice President Al Gore stated in the fall of 2002. His comments weren't greeted with a sea of enthusiasm but the fact that a serious contender for the Democratic presidential nomination would flirt with the idea suggests that single-payer health care is at least a possibility.

And it is. True, there is limited enthusiasm on the part of federal politicians to take on a sweeping new initiative after the grand failure of Clinton-care – especially for a

¹ Marcia Angell. “The Forgotten Domestic Crisis.” New York Times. 13 October 2002.

² Ibid.

³ David Himmelstein and Steffie Woolhandler. *Bleeding the Patient: The Consequences of Corporate Healthcare*. Common Courage Press. Monroe, ME: 2001. 183.

Republican-dominated Congress. True, too, that American journalists increasingly report the problems of single-payer systems like Canada's medicare. But Americans wouldn't completely dismiss the idea.

It lives on because of its simplicity. Those who promote single payer present the idea as a magic bullet. Why fuss with the sticky economics of health care when all you need is a simple government initiative? Indeed, the word *simple* (and its derivatives) seems to appear as often in Himmelstein and Woolhandler's book as motivation speakers shower their talks with the word *empowerment*.

In this paper, we explore the government temptation. Far from being an elegant solution, we find that government-run health care systems are universally plagued with deep problems. Whether we look to Canada or Britain or Germany, we find that single payer is a fanciful temptation, like hoping that a new house will save a troubled marriage.

Confessions of a Former Believer

He had the arrogance, but I had the knowledge. Some years ago, a Canadian organization invited me to debate Theodore Marmor, a Yale professor, on the future of single payer health care. Marmor is a tireless proponent of the Canadian-model for the United States. After a particularly heated exchange, Marmor looked up at the audience and declared, "well, I've been an observer of the Canadian system for 25 years." Marmor immediately smiled, as though he had just placed a full house on the poker table. Perhaps Marmor temporarily forgot one thing: I'm a Canadian doctor.

My thoughts on Canadian health care aren't based on casual observations, the sort of opinion one gathers by reading the occasional article in the *New York Times* or discussing the topic with like-minded graduate students. Personal experiences are the basis of my views – as a doctor and a patient.

My interest in health policy grew from these experiences. As a college student, I remember thinking little about medicare; I have a degree in Microbiology and Zoology. Like so many schooled in Canada, I simply accepted that medicare was a major success story, the fusion of compassion with pragmatism. All this changed on a crisp February day during my medical training.

Emergency rooms overcrowd in every city of the world. Usually there is some system of patient referral. Most Canadian hospitals will accept all patients when they aren't overtaxed; they will accept only very ill patients (such as those suffering heart attacks) when on "redirect"; they will decline all patients when on "critical care bypass." Obviously, the latter is used only when the ER is completely overwhelmed. On that February day in 1999, every hospital in Winnipeg went on critical care bypass for an eight hour period. "It's just this simple," an emergency doctor commented, "you just don't get a heart attack in Winnipeg." Winnipeg, incidentally,

isn't a small village buried in the Great White North – it's a town of roughly 800,000.

What was more alarming about that February is the extent to which Canada's health care system collapsed from coast to coast.

A few examples:

- At Cité de la Santé, the largest hospital in suburban Laval, Quebec, staff took the unusual step of issuing a press release early in the month. The sick were asked not to come to the hospital.
- In Montreal, nurses at Sacré-Coeur staged a wildcat strike to protest the overcrowding, a problem experienced by every hospital in the city. For instance, at Maisonneuve-Rosemont — a hospital that had drawn national attention the year before because an elderly patient had died while waiting to be seen in its overcrowded emergency room — 79 patients jammed into a room designed to accommodate only 34.
- In Nelson, British Columbia, a 74-year-old ER patient was placed in a hospital storage area. No other room could be found for him at a time when patients were routinely placed in hallways and linen closets. And, in Victoria, facilities were running at 110% capacity — since the summer before.

Witnessing the overcrowding personally had a profound impact on me – no longer was health policy remote; the problems with Canadian health care were very real.

Over the years, there have been countless experiences that have re-enforced my concern. A quick example: a provincial government promised to abolish “hallway medicine” (the phenomena of hospital hallways being littered with patients on stretchers); by the end of its first term in office, it had established oxygen prongs in the hallways of various hospitals so that patients could at least get oxygen on their stretchers.

Slowly, over time, I reconsidered Canadian health care. No longer was I willing to accept that medicare functioned relatively well. And no longer was I willing to accept our politicians' prescription of more funding. These are the hard observations made by a medical student and, later, a physician.

Waiting for Care

If angst is a reason to seek psychoanalysis, Canada's medicare seems to have transformed that nation into one ripe for a therapist's couch. Consider: in 2000, a survey involving 1,500 people suggested that a full 8 out of 10 Canadians consider their health care system “in crisis.”⁴ Since then, polls consistently show health care as the top concern of voters.

No wonder. Consider stories that are all too commonly reported:

⁴ Ipsos-Reid Media Release. “Healthcare in Canada: Eight in ten (78%) of Canadians agree that the healthcare system in their province is currently in a crisis.” 2 February 2000.

The long, long wait in great pain: From being put on list for hip replacement to operation may take 15 months

Montreal Gazette

'Patients deserve better,' fed-up Canadian says

Edmonton Journal

Patient pays \$6,000 to skip surgery wait list

Vancouver Sun

Heart-surgery wait claims 3 lives: 47 more patients languishing on list

Winnipeg Free Press

Provinces spend millions on U.S. care for patients

Globe and Mail

And for those familiar with health care, there's no difficulty giving examples of patients waiting too long for care. The head of family medicine at a large Montreal hospital told me that the system is so overwhelmed that emergency surgeries are often delayed. He relates the tale of an elderly man with a broken hip. While his orthopedic surgery was postponed for three days, he developed a blood clot and a potentially life-threatening pulmonary embolism.

In his speech to the Canada Club, Dr. Albert Schumacher, a former President of the Ontario Medical Association, neatly describes the situation:

When I began practising medicine nearly twenty years ago, the very idea of waiting for care in Ontario would have seemed farfetched. How the world has changed -- waiting lists have become the norm rather than the exception. They are now a fact of life.

Ask anyone who serves on the front lines of the health care system. And compare their recent experiences to the way things used to be.... People are on waiting lists just to get onto other waiting lists for the treatment they need. So it has come to the point where we have waiting lists to get on waiting lists.⁵

⁵ Dr. Albert Schumacher. "A prescription for health care reform: From myth to dialogue to solutions." Address to the Canadian Club of Toronto. 19 March 2001.

Schumaker goes on to describe his own community:

[In] Windsor, for example it now takes: six months to obtain a hip replacement; five months to get a CAT scan; one of my patients waited more than a year for cardiac surgery. And some of our cancer patients still have to go to the United States for their treatment.

All these are anecdotes. But major studies, too, have documented problems in the availability and timeliness of care:

- In the fall of 2000, the Canadian Association of Radiologists released a report suggesting that 63% of X-ray equipment is out of date, as is a majority of all diagnostic machinery in Canada.⁶
- In a five-country survey of health care, the Harvard School of Public Health asked specialists if the quality of care had declined in their country. 63% of Canadian specialists responded in the affirmative, the highest percentage of all nations surveyed.⁷
- In a major international study, the Heart and Stroke Foundation of Canada finds that Canadian heart attack survivors have a dramatically lower quality of life than their U.S. counterparts.⁸

And there are, of course, many other studies pointing in the same direction.⁹

Canadian politicians repeatedly promise that soon people wouldn't need to wait so long for care. It's a reassuring campaign pledge. The reality is, however, that waiting lists serve a very important function: they help ration health care.

Health care is expensive. And, with all expensive services, there are hard decisions to make. In the United States, the rise of managed care was an attempt by insurance companies to contain rising expenses. Single-payer proponents suggest that public system can avoid such harsh decision-making. In truth, Canadian bureaucrats don't – they just find other ways to limit expenditures.

Therein lies the dirty truth of Canadian health care. It is just like the old Soviet system: everything is free, nothing is readily available. Of course, it's entertaining to

6 Canadian Association of Radiologists, Special Ministerial Briefing - Outdated Radiology Equipment: A Diagnostic Crisis (Saint-Laurent, QC: September 2000), p. 7.

7 Robert J. Blendon, Cathy Schoen, Karen Donelan, Robin Osborn, Catherine M. DesRoches, Kimberly Scoles, Karen Davis, Katherine Binns, and Kinga Zapert, "Physicians' Views on Quality of Care: A Five-Country Comparison," *Health Affairs* 20(3): 233-243, May/June 2001.

8 Brad Evenson. "Cardiac care better in U.S., study shows: Fewer are dying, but Canadian heart attack patients have poorer quality of life." *National Post*. 8 February 2001. A4.

9 For a more extensive discussion, please see: David Grutzer. *Better Medicine: Reforming Canadian Health Care*. ECW Press, Montreal: 2002.

talk about people queuing for toilet paper in Moscow in 1976. It's far less funny to think about Canadian breast cancer patients waiting months for radiation therapy in 2006.

Nowhere is this clearer than in the technology gap. Canada lags badly behind the United States in terms of basic diagnostic machinery. Indeed, Canada lags behind *most* Western countries. The OECD analyses the availability of such machinery and ranks the various countries. Canada's results are striking: it ranks 21st of 28 OECD nations for CAT scanners, 19th of 22 in availability of lithotriptors (used to treat kidney stones and gallstones), and 19th of 27 in availability of MRIs. Canada ranks 6th of 17 in availability of radiation equipment.¹⁰

Such statistics, however, fail to illustrate the aged state of Canadian diagnostic machinery. Neil Seeman writes extensively on Canadian health care. A Torontonian who holds a Masters in Public Health from Harvard, Seeman is particularly interested in the technology gap.

In a recent essay, Seeman lists other examples:

Toronto doctor Mark Prieditis, said his colleagues are wont to cope with an antideluvian machine by "kicking it on the side or using duct tape, or turning it off and on 10 times until it finally turns on." In Prince Albert, Sask., Dr. Holy Wells reports that both of her hospital's fluoroscopy machines "die on a regular basis" so she is forced to ration barium enemas, a test to help detect colon cancer. At the Queen Elizabeth II Health Sciences Centre, the largest training and referral centre in Atlantic Canada, almost 45% of imaging equipment needs replacing, according to Dr. Paul LeBrun, chief of imaging. In P.E.I., cancer-treatment technology consists of a 25-year-old cobalt therapy unit, and there is no diagnostic MRI. All the way over on Canada's other coast, Dr. Phil Malpass, a general-practice physician in the B.C. Kootenays, describes his practice environment thus: "Our 1954 hospital is dilapidated and termed "functionally obsolete"... Equipment, including a secondhand fluoroscopic unit for pacemaker insertion and a 1947 autoclave for sterilizing debris, is frequently broken. We do not even have access to standard technology, like a CT scanner..."

* * *

If patience is a virtue, some Canadians are less than virtuous: with waiting lists for practically any diagnostic, procedure, or surgical intervention, some cross the border for care.

Government statistics on cross-border shopping are hard to come by. A few academics have suggested that the number of Canadian patients seeking American medicine is limited. Their studies, however, are steeped in methodological flaws and

¹⁰ OECD Health Data 1998. OECD, Paris.

tend to reflect more their bias than the actual situation. Jane Fulton, who served as Alberta's deputy minister of health, ballparked Canadian patient spending at about a billion dollars a year.

The fact of the matter is that there is a Canadian market for private medicine – in the United States. Open the *Vancouver Sun* or a host of other papers and you are likely to see ads for “no wait health care,” glossy promotions of American clinics offering their neighbors something they can't get at home: fast access to health care.

Some Canadians have gotten into the business as well. Doug Hitchlock runs a small company that offers Canadians discounted rates for medical care in the United States. The Free Trade Medical Network has contracts with various US hospitals from Florida to Hawaii, along with ties to numerous diagnostic centers. The Free Trade Medical Network works to cut expensive American health care bills. Hitchlock's group claims that “if we don't save you money, we don't make money.” They brag about discounts of up to 40% for Canadian patients. And Hitchlock's company provides full packages, including air and hotel discounts. The Free Trade Medical Network offers, in one sense, surgical holidays.

When the *Toronto Star* profiled Hitchlock's business, Dr. Michael Rachlis called Hitchlock a “parasite.” Dr. Rachlis, a physician, left his practice in order to defend Canadian medicare, largely by doing contract work for unions. Hitchlock also left his original career to involve himself in health care, but for different reasons. He stopped working as a stockbroker after almost 40 years because of his daughter's illness. She needed an angioplasty for a weak heart. She didn't get it – she died waiting for the procedure. Hitchlock's daughter was 9.

British and European Health Care

If we accept the opinion of former Chancellor of the Exchequer Nigel Lawson – that the British National Health Service is that country's religion – then Pam Hardyment is an agnostic. Ms Hardyment let her views be known in the pages of the *Guardian*. Unlike the many other invited participants in the health series that paper ran in 2002, she isn't a prominent politician, physician or hospital administrator. Ms. Hardyment is a patient. And her perspective on the NHS is very personal.

Over a three painful years, I had been in a ‘queue’ in London awaiting gall bladder removal. Despite being taken by ambulance to the emergency room on three occasions during this time, I was returned home with painkillers. Finally, unable to move, jaundiced and prepared to die, I endured a five-hour wait, vomiting on the floor of my local hospital while the harassed nurses searched for a bed. I got my operation. It was free. But at what price?¹¹

¹¹ Pam Hardyment. ‘Yes my operation was free, but the wait took three painful years.’ *The Guardian*. 25 April 2002.

Proponents of government-run health care tend to look beyond Canada when they cite a potential model for the United States. European systems now serve the role that Canada once did. A paper in the prestigious journal *Health Affairs* opens with the following: “Americans have often looked with envy at the German health care system where citizens enjoy universal access to a comprehensive set of health benefits, all for about half of what Americans pay per capita. As if that weren’t enough, outcomes and satisfaction in Germany are at least as good as (if not better than) those in the United States.”¹² The editors of journals aren’t the only ones with a keen interest in Europe – a young governor from Vermont, Howard Dean, saw the continent’s social insurances as the inspiration for his health reforms. But while the woes of these systems are less appreciated in the United States, public health care is anything but a success story in Europe.

Britain’s NHS may be the most plagiarized health care system in the western world – decades ago, it was the British model that served as the inspiration for politicians in the Sweden, Canada, Australia and New Zealand. These days, Britain’s NHS doesn’t seem like much of a model for anything – except, perhaps, frustration. Consider that Britain’s NHS has roughly a million people waiting for care and two hundred thousand wait longer than six months. So overstretched is the system that horror stories litter British papers.

I decided to see the state of the NHS by looking in on a small hospital in Southern England. My choice of Dover’s Buckland Hospital was not random – several years ago, the *Spectator* ran a cover story on the NHS that had mentioned the institution. The writer vividly described the dirty, dark waiting room of the hospital that came complete with an overwhelming odor (the nurse suggested that a dead rat was the source and promptly sprayed air freshener).

Was the NHS hospital as bad as it had been described? Actually, it’s worse. Single payer proponents consider government-financed health care to be wonderfully compassionate. In East Kent, unclean would be a better adjective. Years before I set foot in Dover, I toured D.C. General in Washington with an Englishman by the name of Tim Evans (now president of a European think tank). D.C. General was in such dire straights that it was eventually closed, an embarrassment to local administrators. Dr. Evans commented to me: “This is nicer than any British hospital I’ve visited.” Standing in Buckland Hospital, I now understood the attraction of D.C. General.

So bad is the British NHS that some look across the Channel for ideas. In contrast to the top-down model of the NHS, France and Germany have a social insurance model for health care – essentially, workers contribute part of their wages for coverage. And, on the surface, France and Germany are doing well – waiting lists plague neither health care system. In contrast to dark and dreary Buckland Hospital, the facilities in Calais are clean and modern. Obviously, they sit in a different country (France, as opposed to Britain) – but it feels like a different world.

¹² Alison Evans Ceullar and Joshua M. Wiener. “Can Social Insurance For Long Term Care Work? The Experience of Germany.” *Health Affairs*. Volume 19, 3. May/June 2000. 8.

But neither country is exactly a utopia of health care. True, the French run circles around the English – decision-making is more decentralized; little distinction is made between public and private facilities (allowing patients choice); modest user fees are charged, cutting down on some frivolous expenses; care is timely.

However, all European systems have major problems. But, then, so does American health care. Let's ask a very simple question: How do they stack up to American health care?

International comparisons are few and far between. Such analysis is rare – but not unknown. The WHO's World Health Report 2000, for example, ranks the performance of the health systems of several nations. For proponents of a single payer plan, the WHO is the smoking gun, definitive proof that American health care just doesn't measure up.

What does the WHO find? "In terms of total results, the U.S. health care system ranks 37th in the world, as measured by the WHO, the worst performance of any affluent democratic nation."¹³ So writes Dr. Rudolph Mueller, a New York physician, in his book calling for government-run health care. Dr. Mueller considers the WHO finding so revealing that he mentions it on page two.

The WHO study may make for good speaking points, but the work is anything but definitive. Indeed, like a book review written by a biased reviewer, the WHO report says more about those drafting the study than the health care systems that they analyze.

Consider that according to this study, the United States has some of the best doctors and nurses in the world, but has a health care system that ranks behind those of Columbia, Oman, Morocco, Cyprus, Andorra, Malta, and the United Arab Emirates. Now, it would seem that in a proper comparative study, the better systems (that is, say, Columbia rather than the United States) actually boasts the best care. In other words, looking at the WHO report, if your daughter develops a cough late at night, you'd rather take her to a hospital in Bogota or Medellin than in Boston or Memphis.

But before packing up your daughter for the long plane ride to South America, remember that the WHO criteria are soft – and ideological. Nations are marked down for having private medicine or user fees. Fairness – that is, everyone gets the same treatment regardless of income – is important. Competition, WHO officials believe, is bad since it leads to "fragmentation and duplication in health services." If the criteria aren't skewed enough, the WHO report also considers how well countries perform compared to what experts feel they ought to be doing. It's a bit like giving a gold medal to the eighth fastest runner because he has the shortest legs and tried harder.

¹³ Rudolph Mueller. *As Sick as it Gets*. Dunkirk, NY: Olin Frederick, Inc. 2001. 2-3.

It is beyond the scope of this paper – or, perhaps, any paper – to attempt to produce a meaningful and comprehensive ranking of different health care systems. A couple of simple conclusions, though, can be made. First, the problem of uninsured citizens is unique to the United States. Canada, Britain, France and Germany may have shortcomings; citizens don't lack basic coverage, however. That type of predicament, however, is not seen in other western countries to the extent it is in the U.S. Second, Americans receive better care than people in any one of those countries – or any other.

The latter point deserves some explanation. Most comparisons confuse health with health care. As a result, much attention is focused on measures like life expectancy. But a good health care system is only one part of life expectancy – indeed, it could be argued that compared to diet, exercise, and genetics, it is less important. But quality health care is all about the treatment of the sick. And looking at various studies comparing treatment-related issues, American health care comes out on top.

Consider the following cancer studies:

- Women who get breast cancer in Europe are four times more likely to be diagnosed when the tumor has spread and are less likely to survive the disease than women in the United States.¹⁴
- The WHO, in partnership with the International Union Against Cancer, compiles 5 year survival rates for various types of cancers. The United States consistently bests Europe. For leukemia, for example, the American survival rate is almost 50%. The European rate is significantly lower, at just 35%. Esophageal carcinoma is often deadly – but American patients far much better than those across the Atlantic. 5 year rates in the U.S. are 12%; European, just 6%.¹⁵

Looking at other areas of medicine, we find similar results: American health care bests state-financed systems. For example, the Heart and Stroke Foundation of Canada study looking at quality of life post-heart attack in the United States and Canada finds that American heart attack survivors are significantly healthier.

Why do American patients fare so much better than those in Europe or Canada? Oliver Schöffski's paper on European pharmaceuticals provides some answers. Schöffski, chair of Health Management at the University of Erlangen-Nuremberg in Germany and the author of 8 books, looks at the treatment of twenty illnesses across Europe incorporating nearly two hundred studies. He paints a picture of non-treatment and under-treatment for common diseases like schizophrenia, heart disease, and asthma. The reasons are complex and not exclusively related to government policies – but he finds governments are a major source of the woes.

¹⁴ Richard Woodman. "Breast Cancer Diagnosed Late in Europe." Reuters Health. March 3, 2003.

¹⁵ Global Action Against Cancer. World Health Organization, Geneva, Switzerland: 2003. Available at: <http://www.uicc.org/index.php?id=497>.

He finds in France, for example, 9 in 10 patients with acute asthma do not receive adequate care. One million people in Germany suffer from migraines unnecessarily. Under-treatment, of course, speaks to more than just the quality of health care. Studies in the United States have noted, for example, that some patients suffering from depression don't reach a family doctor, let alone a psychiatrist. Still, Schöffski's comparative work hardly puts European medicine in a favorable light.

Consider statins, the drug group that lowers fats in the blood, are a major weapon against the harmful effects of heart disease. In the United States, Schöffski suggests that about 44% of patients who could benefit from the drug actually get it. But in Europe, far fewer people take statins. In Germany, 26% take the medicine; in Britain, 23%; and in Italy, 17%.

Treatment of mental illness is surprisingly different in the United States and across the Atlantic. Antipsychotics, the main treatment for schizophrenia, have been revolutionized in the past decade. Newer drugs are linked with fewer and more benign side effects. In the United States, 60% are on the newer drugs. In Spain, only 20% are, while in Germany, fewer still at just 10%. Some patients, of course, may opt for the older medications but studies suggest most prefer (and do better on) the new so-called atypical antipsychotics. Thus, when it comes to the treatment of mental illness, Europeans get the best the 1970s provided.

Schöffski sees Europe's drug problem as being multifactorial. In general, specialists are more difficult to refer to, for example, meaning that family doctors handle more complicated problems – and yet, may not have the expertise to do so. He also suggests that governments haven't helped the situation.

In Europe, EU drug approval is relatively speedy – but individual nations throw up their own hurdles to slow the introduction of new drugs. In a recent paper, University of Pennsylvania Professor Patricia Danzon finds that in regulation-heavy countries like Greece, Belgium, and France, medications take an extra 9 months after EU approval to finally reach patients.¹⁶

Some drugs are delayed longer still. Taxol, a medication used to treat advanced breast cancer and refractory ovarian cancer, was approved for use in Europe in 1995. It didn't reach British cancer patients, however, for another half decade.

Why are all these governments working feverishly to keep doctors from prescribing proven and effective medications? It's a matter of money. In the Canadian province Ontario, for example, the state pays more than 40% of prescription drug costs; in Germany, public spending approaches 70%. To bureaucrats eager to keep within budgets, new drugs are seen only as new expenses – even if they save lives.

¹⁶ Patricia M. Danzon, Y. Richard Wang, Liang Wang. "The Impact of Price Regulation on the Launch Delay of New Drugs – A Study of Twenty-Five Major Markets in the 1990s," *Health Economics*, 14(3), 2005, pp. 269-92, also available at Prof Danzon's web site, <http://hc.wharton.upenn.edu/danzon/>. The paper is under review by the *Journal of Law & Economics*.

Government Systems, American Lessons

Will it ever be realized? With disappointment, Stanford economist Victor Fuchs writes in the *New England Journal of Medicine*: “National health insurance will probably come to the United States after a major change in the political climate - the kind of change that often accompanies a war, a depression, or large-scale civil unrest. Until then, the chief effect of the new plans will be to make young and healthy workers better off at the expense of their older, sicker colleagues.”¹⁷ Professor Fuchs may be overly pessimistic. It was under circumstances not unlike today’s that Clinton-care became an option in the early 1990s.

Let’s leave the political prognostication to others. Instead, let’s consider a more pertinent question: is single payer really the magic bullet?

Advocates of a single payer system suggest simply that American health care fails to deliver on its promise. Though their arguments are often complex (and frequently eloquent), the thrust of their point of view on the American system can be summarized in 7 words: too much too poorly for too few. The single payer crowd suggests that American medicine costs more than any other system on earth, falls short in basic standards and, finally, fails to deliver care to everyone.

These arguments are so often made that they require little elaboration. Besting 15% of GDP, the U.S. health care system soaks up considerably more money than, say, the Canadian (10%) or German (10%) systems. Yet, despite the robust spending, basic health statistics like life expectancy and infant mortality are poorer. Finally, there is the issue of the uninsured.

But beware the siren song: American health care may have its deep flaws but the alternatives may be far worse. Just as the cancer patient looks to alternative medicines that offer the promise of recovery without the pain of chemo, it’s easy to be seduced – and not necessarily advisable.

A quick rebuttal to the three criticisms. First, American health care does cost more than the public systems. But such statistics must be read carefully. Consider: the M. D. Anderson Cancer Center in Texas spends more money than all of Canada on research & development. There are other cost drivers that can be overlooked in straight comparisons, such as the costs of America’s litigious culture.

Second, as noted in the last section, crude health statistics often speak more to cultural and economic factors than to quality health care. Yes, Canadians live longer than Americans – but this probably has very little to do with their respective systems. Consider that studies looking at infant mortality rates among American ethnic groups find that Hispanics do better than African-Americans, yet the latter have better

¹⁷ Victor Fuchs. “What’s Ahead for Health Insurance in the United States?” *New England Journal of Medicine*. 346:1822-1824. 6 June 2002. Number 23.

access to health insurance, relatively speaking, and are more likely to birth in hospitals. . In other words, the individuals with limited access to health care tend to do better than those on Medicaid. The bigger issue: how do people do when they are actually sick? Whether looking at cancer care or heart attack prevention, Americans come out on top – and that’s why people from around the world come to the U.S. when they are sick.

Finally, there is the issue of the uninsured. Obviously, the lack of universal coverage is a serious problem. But let’s not confuse a lack of health insurance with a lack of health care. Single payer advocates point to the uninsured and damn the whole system. It would be more appropriate to conclude that the U.S. health care works very well for most Americans – but that reforms are still needed.

Of course, single payer proponents bristle at such a suggestion. After all, they see utopia abroad, why not wish for it at home? Government-run health care, however, is anything but utopian. Whether it’s the decentralized German sickness funds or the top-heavy National Health Service, public systems suffer from similar woes.

A common question people ask: why don’t their systems serve their citizens better? In a way, they do what they are supposed to – most people (and thus most voters) have access to the care they need (simple primary care) and at a relatively low cost. It’s true that these systems tend to fall short on more complicated treatments. But how many voters suffer from cancer in any given year? How many people are concerned about access to sub-specialists or high-tech diagnostic tests?

Public systems ultimately serve the interests of the majority of voters – who tend to be healthy. Americans should remember that – and beware.