Health Scare: Six Myths about the U.S. Health Care System (IP-23-1993)

December 1, 1993

Issue Paper

By Linda Gorman

Myth no. 1: *The U.S. health care system is inefficient*. This myth is supposedly proved by the "fact" that the U.S. spends more on health care than other industrialized countries both on a per capita basis and as a percentage of gross domestic product.

The U.S. does *not* spend more per capita than other countries when proper corrections are made for differences in national accounting systems, income, the age of its population, drug abuse, violent crime, population density, malpractice liability, and spending for medical R&D. When proper corrections are made, the U.S. spends *less* than Canada on a per capita basis.(1)

By most measures the U.S. has the highest per capita income in the world. Wealthier people buy more health care. Even if all health care systems were the same, the U.S. would still spend more on health care. To put things in perspective, in 1990 12.2% of gross national product was spent on health care. People are fond of claiming that this will bankrupt the republic. If that is true, what about the 9.2% spend on private automobiles in the same year?(2)

The private U.S. health care system is administratively efficient when compared with Canada and other national insurance schemes. Many who have studied the issue have ignored important costs. The methodology is equivalent to estimating the cost of owning a car by adding up the expenses for gasoline and oil while ignoring maintenance, insurance, and depreciation. "Private health insurance has built-in incentives to minimize its total overhead costs, while public health insurance constrains total budgets but ignores real social costs, including the time patients must wait for treatment and the lost productivity that results."(3)

A dollar spent in the U.S. buys a much higher standard of care than a dollar spent in other countries.(4) In Great Britain, the average general practitioner has over 3,000 patients (compared to 500-600 for the average American physician). National Health Service physicians spend an average of 5 minutes with each patient who usually wait hours to see them.(5) In 1989, Ontarians had to wait seven months for heart surgery.(6) A Japanese woman is *four times* more likely to die during childbirth than an American woman because complex medical technology is more likely to be available in the U.S.(7)

Myth no. 2: *U.S. health care costs are out of control*.

Since 1960, health care spending in the United States has been rising at a *slower* rate than in other countries.(8) This includes Canada where the provincial governments cap total expenditures for medical care.

Some statistics overstate health care cost increases. When innovation and competition allow treatments to switch from an inpatient to an outpatient basis (at far less expense than previously), they are dropped from the medical price index. Also, the index only includes "list" prices which almost no one pays.(9)

In 1984-1987, businesses increased the number of insured employees. Business payments for health services and supplies *decreased*.(10)

What is out of control is the cost of health care programs run by government. While private expenditures for health services and supplies rose from $30.3 billion in 1965 to $430.4 billion in 1990, government expenditures jumped from $7.9 billion to $212.9 billion.(11) Government is far less able to control costs than the private sector. Casting government as better at cost containment is ludicrous.

Careful studies indicate that medical cost increases result from two things: The enormous increase in insurance coverage since 1960, and technological advances in medicine. Widespread health insurance has made sophisticated care affordable, and we spend more because more can be done.(12) In light of these facts, government can cut costs only by reducing access to expensive care or reducing quality. This is borne out by comparisons of the cost and quality of the health care delivered by the Veteran's

Administration, the U.S. military, Canada, and the United Kingdom. They suggest that the private U.S. health care system delivers far better care at lower cost than government can.

Myth no. 3: *The U.S. health care system does a poor job of delivering care as evidenced by the "fact" that its infant mortality rates are higher than those of 23 other industrialized countries.*

Low birthweight babies (5.5 pounds or less at delivery) are roughly 20 times more likely to die. The U.S. has a higher proportion of low birthweight babies than other countries because it has more unwed mothers and a higher proportion of pregnant women who engage in irresponsible behavior such as ingesting large amounts of alcohol and other drugs while pregnant. As a result, proportionately more babies in the U.S. die. At any given high-risk birthweight, however, perinatal chances of survival are better in the U.S. than in other countries.(13)

Myth no. 4: *"Managed care" can lower health care costs by reducing "unnecessary" tests and procedures.*

The notion that "unnecessary tests" are a problem resulted from a RAND corporation study published in the *Journal of the American Medical Association* in 1988. Further research indicates that the 1988 study grossly overstated the number of unnecessary procedures. "Unnecessary" is a matter of judgement. Even experts often disagree on the proper course of treatment and what a healthy second party may consider unnecessary a sick person may consider vital.(14)

The Federal Employee Health Benefits Program is one example of how well government manages costs. During the 1980s, the federal government's spending on employee health benefits grew at a rate that was more than a percentage point faster than that of employer-provided health insurance generally, and 25% faster than private sector plans when adjusted for the number of employees.(15)

Politically managed care will not provide the kind of care that individuals want. There is no universally desired "basic plan." Different people want different things and have different views of risk. Politically managed systems only provide those things that bureaucrats want--lower expenditures and simple administrative systems.(16)

Myth no. 5: *Under a national health plan run by government, people could afford better preventive care. This would reduce medical care expenditures.*

A large fraction of current advice on preventive care consists of lifestyle changes: stop smoking, exercise moderately, eat properly. There is no evidence that national health care would have any more influence on individual behavior than the current avalanche of information provided by voluntary groups, the media, and the thousands of special programs targeted at selected groups of people.

Most people would consider immunizations obvious examples of cost-effective prevention. Although relatively few good empirical studies exist, those that do suggest that prevention may increase overall medical expenditures. For example, estimated direct medical expenses for measles between 1963 and 1968 were higher with a vaccination program than without.(17) This is not to argue that immunization is bad--only that it may not provide major cost savings.

Many of the claimed benefits from preventive care probably are statistical mirages, particularly in mental health and substance abuse counseling. For example, one researcher noted that "Hundreds of studies [of treatment for alcoholics] have been conducted over many years testing the effectiveness of various forms of treatment...to date, no form of treatment has been rigorously shown to be superior to any other, or superior to no treatment at all."(18)

The coercive power that national health care would give the government should be cause for concern. In Britain, some hospitals treat smokers as second class citizens for medical care. There is no guarantee that future bureaucrats will not decide to penalize other types of behavior, like mountain climbing, motorcycle riding, or gun ownership, that they deem irresponsible and likely to increase costs.

Myth no. 6: *Making people join HMOs responsible for all of an individual's health care and paying that organization a flat fee (prospective payment) for each person enrolled will lower costs because it gives the managers of the system an incentive to economize.*

There is no solid empirical evidence that HMOs really do control costs, particularly when the fact that

younger, healthier people tend to enroll in them is taken into account.

Prospective payments create a conflict-of-interest between physician and patient that is far more dangerous than that existing in fee-for-service medicine because HMOs put cost control before patient care. Northern California Kaiser Permanente, for example, has already decided not to pay for Cognex, the only drug that offers help for Alzheimer's patients, on the grounds that it only helps some patients, and that some people who take Cognex develop liver problems that the HMO would have to treat.(19)

Prospective payments create huge incentives to reduce the quality of care. Existing HMOs do not necessarily place the patients' interest first. "Gatekeepers" receive bonuses based on their ability to cut costs. This often results in pressure to discharge patients from hospitals before they are ready, to delay the use of sophisticated lab tests in diagnoses, and to waste patient time by requiring multiple visits to a generalist before the patient can see a specialist.

Burton Weisbrod points out that forcing a change from fee-for-service (retrospective payment) to prospective payment could freeze medical R&D and innovation. The reason for this is that new technologies are typically expensive. Under fee-for-service consumers who could be helped by a new technology would push to have it covered by insurance.(20) In a prospective payment system, gatekeepers shy away from new technologies precisely because they increase costs. This explains why national health care systems like those in Canada and Britain lack modern equipment and innovate more slowly than the U.S. For comparison, consider the problems of the public schools. Now funded on a prospective basis with big government the single payer, the quality of their output is infamous.

Notes

1. Jacques Krasny. February 17, 1992. "The Wrong Health-Care Model," *National Review*, 43 ff. Joseph L. Bast, Richard C. Rue, and Stuart A. Wesbury, Jr. 1992. *Why We Spend Too Much on Health Care*. Chicago: The Heartland Institute, p. 28-50.

2. *Statistical Abstract of the United States*. 1992. various tables.

3. Patricia M. Danzon. Spring, 1992. "Hidden Overhead Costs: Is Canada's System Really Less Expensive?" *Health Affairs*, pp. 21-41. Another article on the same topic is Anne K. Gauthier, Deborah L. Rogal, Nancy L. Barrand, and Alan B. Cohen. Fall 1992. "Administrative Costs in the U.S. Health Care System: The Problem or the Solution?" *Inquiry*, 29, pp. 308-320.

4. For a more extensive discussion see Bast, *et. al.* pp. 83-90, and Wollstein.

5. Jarret B. Wollstein. October 1992. "National Health Insurance: A Medical Disaster," *The Freeman*, pp. 381-387. This article has an extensive bibliography.

6. Marcia Berss. 24 May, 1993. "Our System is Just Overwhelmed," *Forbes*, 40-41.

7. Harmeet K.D. Singh. May 1, 1990. "To Lower Infant Morality Rate, Get Mothers Off Drugs," *The Wall Street Journal*, p. A18.

8. Bast, *et. al*. p. 19-27.

9. Suzanne Tregarthen. August 18, 1993. "Statistics Overstate Health Care Costs," *The Wall Street Journal*, p. 10; Lindley H. Clark, Jr. 8 October 1993. "Drug Price Rise May Be Exaggerated," *The Wall Street Journal*, p. A12.

10. Regina E. Herzlinger. August 1991. "Healthy Competition," *The Atlantic Monthly*, p. 69-81.

11. Katharine R. Levit and Cathy A. Cowan. Winter 1991. "Health Care Financing Trends," *Health Care Financing Review*, 13, 2, p. 86.

12. Weisbrod, Burton A. June 1991. "The Health Care Quadrilemma: An Essay on

Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature*, 29, 2, 523-552.

13. Nicholas Eberstadt. January 20, 1992. "America's Infant Mortality Problem: Parents," *The Wall Street Journal*.

14. Brant S. Mittler. March 1, 1993. "The Myth of Unnecessary Care," *The Wall Street Journal*.

15. John C. Goodman. January 7, 1993. "Managed Competition--Too Little Competition," *The Wall Street Journal*.

16. Richard L. Stroup, "Political Behavior" and Tyler Cowan "Public Goods and Externalities" in *The Fortune Encyclopedia of Economics*, David R. Henderson, editor. New York: Warner Books, 1993.

17. Louise B. Russell. 1986. *Is Prevention Better Than Cure?* Washington, DC: The Brookings Institution, p. 35.

18. Louise B. Russell. 1987. *Evaluating Preventive Care: Report on a Workshop*. Washington, DC: Brookings Institution, p. 58.

19. Harry Schwartz. October 5, 1993. "HMOs--Another Roadblock for Alzheimer's Drug," *The Wall Street Journal*, p. A16.

20. Burton A. Weisbrod. June 1991. "The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality or Care, and Cost Containment," *Journal of Economic Literature*, 29, 2, 523-552.

Please send comments to Independence Institute, 14142 Denver West Pkwy., suite 185, Golden, CO 80401
Phone 303-279-6536 (fax) 303-279-4176 (email)webmngr@i2i.org