PAYING MORE

BUT GETTING LESS

MYTHS AND THE GLOBAL CASE FOR U.S. HEALTH REFORM

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Abstract: Despite the clear need to improve the health system, policymakers and the public sometimes underestimate its problems and overstate the concerns about solutions. This is especially apparent in views about the U.S. system relative to those of other nations. Many believe wrongly that we have the best health system in the world, and changing it will lower quality, reduce access, and impose added costs on our businesses. I aim to dispel these myths through global comparisons. Honest debate will help create climate for reform which is essential to our nation's health as well as its economic vitality and global leadership.

One of the most urgent priorities in this nation is making its health system accessible and affordable for all. According to the Institute of Medicine, the lack of a comprehensive coverage system drains the economy, burdens our businesses, and limits providers' ability to deliver efficient, high-quality care to patients.[1] Typical Americans know this: their stories of hardship and system-inflicted suffering are as compelling as the litany of statistics that we all know: 46 million uninsured, 9 percent annual premium growth, over $1,500 in health costs per General Motors car, and 15 percent of the economy dedicated to health spending.[2] This translates into consistently strong support for policies to insure all and reduce costs.[3] However, some argue that this support is shallow and easily dissipates when tested further.[4] Others argue that public opinion matters less to elected officials than special interest influence and campaign financing once they have achieved positions of influence.[5] I offer a different explanation: support for improving the nation's health care system has been eroded by myths about the strengths of the status quo and weaknesses of alternatives.

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One of these myths is that, even with its flaws, we have the best health system in the world – and changing it will lower quality, reduce access, and hurt our businesses. The perception of excellence stems, rightly, from the exceptional performance of many of our health professionals, researchers, and institutions. Yet, some of our self-image results from the mistaken belief that we get what we pay for – which, in health care, is a lot.

And views on how our system would work after reform tend to be shaped by the most draconian reports about waiting lists, under-paid physicians, and impersonal care in out-dated and inefficient systems. As such, the concern about changing our current system is powerful. This fear of change is similar to the decisions that patients face every day. People often forego recommended surgery because they underestimate the likely disability without it or blow out of proportion the potential surgical complications. The same is true with health reform: misjudging the debilitating effects of our current health crisis and overstating problems with the solution have blocked needed change.

The fact of the matter is, the U.S. health system is ailing. It needs major reform worthy of the superpower nation it serves. But such reform cannot be achieved without first allaying some of the misperceptions about our current system. An honest assessment of the severity of the problems here and the effects of the solutions elsewhere is essential. Clearly, other actions are needed to propel health reform to the top of the policy agenda. Business leaders need to press policy leaders for a practical, affordable, and fairly-financed system. Physicians and other health providers need to assure patients and the public that quality and outcomes will be better with seamless coverage in a results-oriented system. And the American people, ultimately, need to create the groundswell for change. But, in my experience, powerful myths cannot be dispelled in the heat of the debate. Now is the time to lay the factual foundation and disarm the "landmines" that have derailed past efforts to create a universal, value-oriented health system.

Myth #1: Americans are The Healthiest People in the World

Compared to people in less developed nations, Americans generally fare better in their overall health status. Yet, few Americans realize that we are far behind and falling relative to comparable nations in the basic measures of the health of our citizens. For example, life expectancy for Americans has been marching upward, so that, in 2002, the average American could expect to live 77.3 years – a 7.6-year gain between 1960 and 2002.[6] However, this increase was less than the 8.4-year increase in Canada and 14-year increase in Japan.[7] And an American can expect to die younger than citizens of 34 other nations, including Cyprus and Singapore. (See Exhibit 1).[8] Similar surprises exist in statistics on infant mortality. In 2002, the U.S. infant mortality rate increased for the first time since 1958 to 7.0 infant deaths per 1000 live births, up from 6.8 in 2001.[9] Estimates suggest that, in 2005, the United States' infant mortality rate will be higher than that of 41 other nations, including South Korea, Slovenia and all other major European nations.[10]

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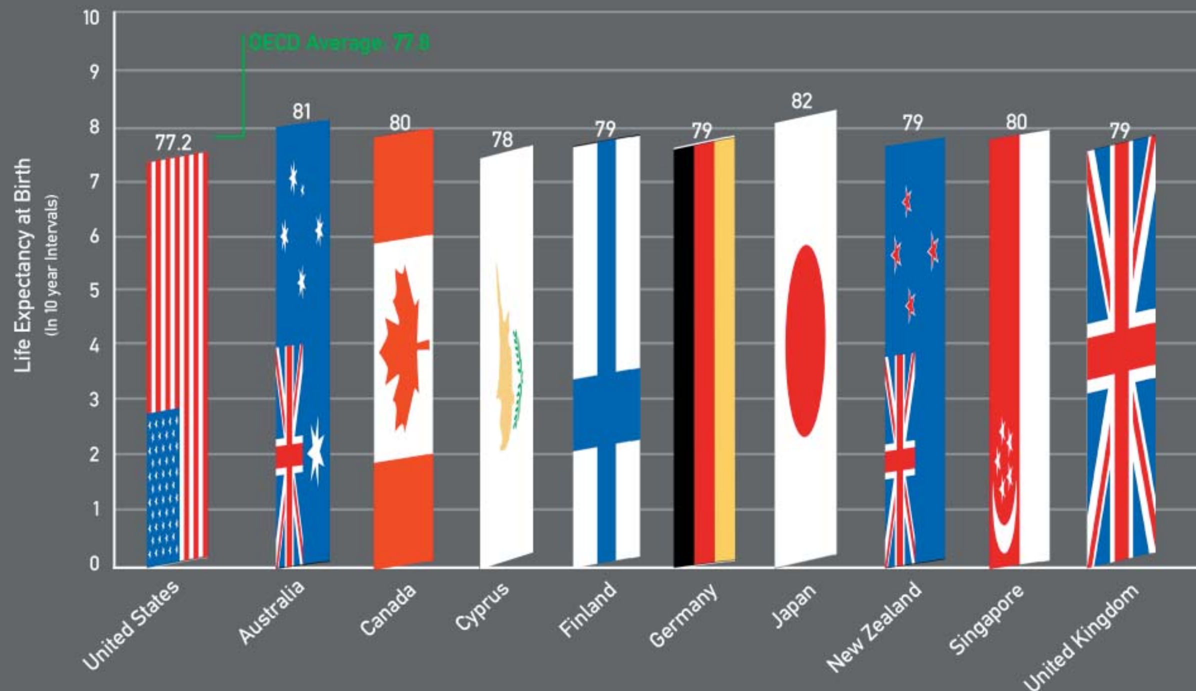
Americans' poor health status is not just determined by our health system. People with lower incomes tend to have worse health.[11] In 2002, the percent of Americans living in poverty increased for the first time since 1993.[12] Public spending on assistance for housing, nutrition, and mental health has declined, contributing to the strains facing low-income families. Poor health status also is symptomatic of persistent racial inequalities that surface most shamefully in disease burden and mortality statistics.[13] Black American and American Indian infant mortality rates remain approximately 2.5 and 1.5 times higher, respectively, than rates for whites.[14] Overall mortality was 31 percent higher for black Americans than for white Americans in 2002.[15] The Institute of Medicine's study *Unequal Treatment* names a wide set of factors that contribute to, but do not completely explain, health inequalities.[16] Different treatment, even when insured, is one factor. A recent study found that, among Medicare beneficiaries, white patients were more likely to receive high-cost procedures than black patients, and the disparity had increased, in some cases and places, between 1992 and 2001.[17] Another found that the lack of health insurance among racial and ethnic minorities is a major reason for disparities in access to care.[18] Irrespective of its causes, given the growing diversity in this country, the failure to address racial inequalities will inevitably keep us in the lesser ranks of nations in terms of health and health care.



Additionally, Americans can also expect to die younger than citizens in the following countries:				
Andorra	Cuba	Ireland	Malta	San Morino
Austria	Denmark	Israel	Monaco	Slovenia
Belgium	France	Italy	Netherlands	Spain
Chile	Greece	Kuwait	Norway	Sweden
Costa Rica	Iceland	Luxembourg	Portugal	Switzerland

Source: World Health Organization, *World Health Report 2005*, Annex Table 1.

Myth #2: The U.S. is the Best Place to Get Sick

Our substandard health status is often explained away by factors outside of the health system. Indeed, for those who have access to it, parts of our health system provide the best quality and outcomes of care in the world. Yet, evidence suggests that high-quality care is sporadic and that the U.S. may not be the best place to seek care for certain types of conditions. For example, American adults receive recommended care only about half the time, with under-utilization more common than over-utilization.[19] Outcomes of care vary dramatically from area to area.[20] And the Institute of Medicine has suggested that up to 98,000 people die annually from medical errors, such as bad physician handwriting, incomplete charts, and other "low-tech" problems.[21]

Turning to global comparisons, the World Health Organization ranked the U.S. 37th in the world on health system performance (e.g., service provision, funding of the system, standards). This is below the rankings of most countries that cover all their citizens, like Australia and the United Kingdom. One reason for this low score is gaps in our prevention and care management systems. Relative to the U.S., Australia's comprehensive health system has vaccinated more seniors against flu and children against polio.[22] The U.S. has a higher incidence of Hepatitis B, a vaccine-preventable disease, than do Australia, Canada, and New Zealand.[23] On care management, the United States has fallen behind in reducing

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asthma-related deaths, which can be avoided in many cases. In 1990, the U.S. had the lowest asthma mortality rate in comparison with Australia, Canada, New Zealand, and the United Kingdom. Yet, by 2000, it was higher than in Australia and Canada.[24] And despite the growing obesity problem, roughly half (48 percent) of U.S. adults report that their doctor has not recently provided advice or counseling on weight or exercise, significantly lower than in the United Kingdom (72 percent) and New Zealand (67 percent).[25]

In terms of treatment of illness, despite the U.S.'s technological advances, Americans have lower odds of surviving colorectal cancer and childhood leukemia than Canadians. Our survival rates are lower than Australians for cervical cancer and non-Hodgkin's lymphoma. And the likelihood of surviving a kidney transplant is 6 percent higher in Australia, 13 percent higher in Canada, and 4 percent higher in the United Kingdom and New Zealand than in the U.S.[26] In addition, over 30 percent of adults in the U.S. – more than the rate in comparable nations – have problems with coordination of care, meaning test results or medical records were not available at the time of a scheduled appointment; patients received duplicate tests or procedures; patients received conflicting information; or some combination. (See Exhibit 2).[27] Furthermore, 15 percent of American patients reported being given incorrect test results or had experienced delays in being notified about abnormal results, again more than in comparable nations.[28] These outcomes are even worse for sicker people. One in three sicker Americans who seek care suffers some type of error. This rises to nearly half of sicker Americans who have multiple doctors, compared to only a quarter of sicker adults in the United Kingdom.[29] Given that these countries are comparable to the U.S. in their demographics, these results reflect, in part, differences in the quality of care.

Exhibit 2: Problems with Coordination of Care

Myth # 2: The U.S. is the Best Place to Get Sick.

Problems experienced:

Over 30% of adults in the U.S. - more than the rate in comparable nations - have problems with coordination of care, meaning test results or medical records were not available at the time of scheduled appointment; patients received duplicate tests or procedures; patients received conflicting information; or some combination.

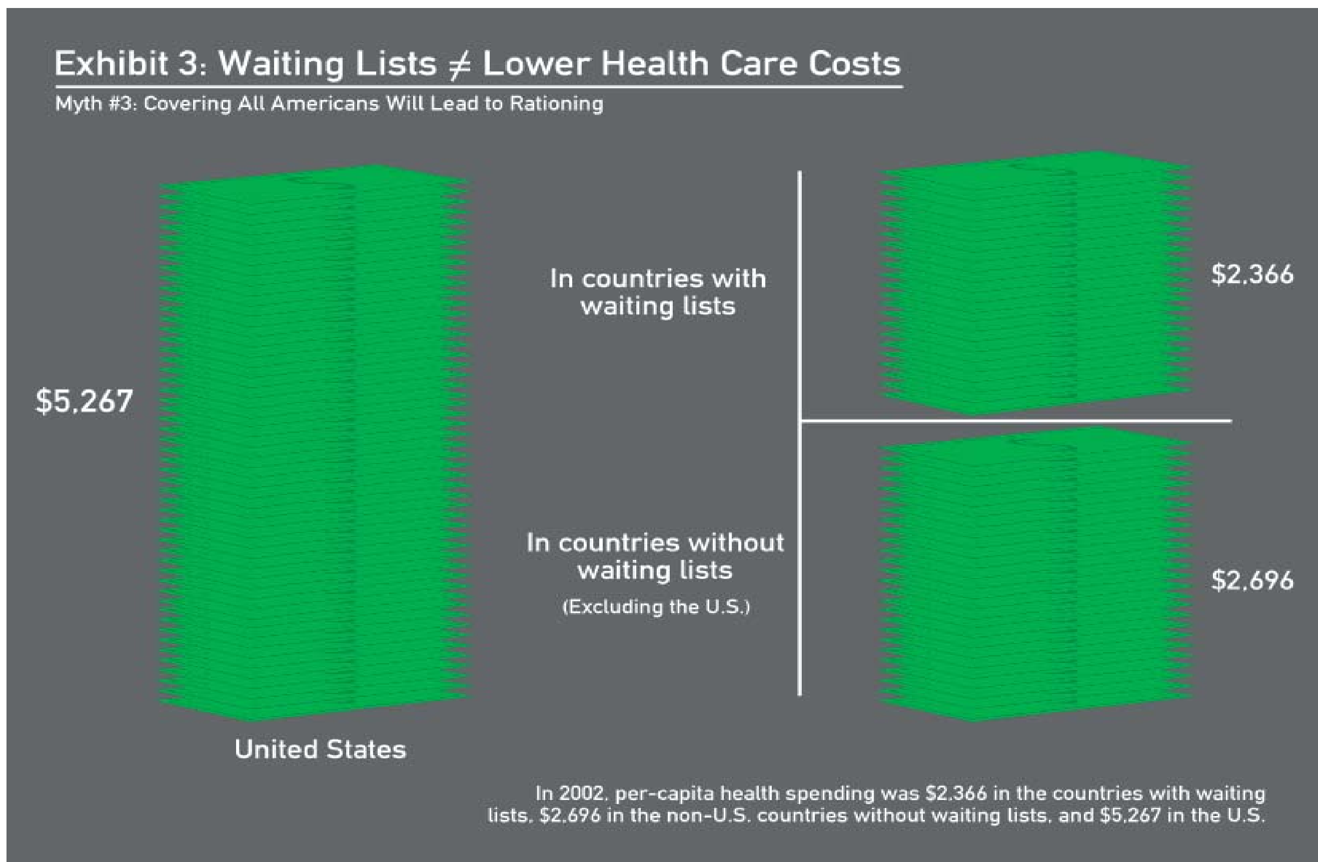
Source: C. Schoen et al., "Primary Care and Health System Performance: Adults' Experiences in Five Countries," *Health Affairs*, 8 October 2004.

Lastly, satisfaction with our health system is relatively low. Americans are least likely to report that the system needs only minor changes and are most likely to say that it needs to be rebuilt completely, relative to Australians, Canadians, New Zealanders, and the people in the United Kingdom.[30] Americans whose incomes are below average are much more likely to be dissatisfied with the American health care system than similar populations in these same countries.[31] Furthermore, hospital administrators report dissatisfaction levels over four times higher than those in the United Kingdom.[32] Thus, even though excellent care is provided in parts of the U.S. health system, quality is not systemic and people tend to know this.

Myth #3: Covering All Americans Will Lead to Rationing

As with the positive aspects of the U.S. system, the negative aspects of other countries' systems are frequently exaggerated. One such myth relates to waiting lists. Americans typically fear that any universal coverage system will require them to wait longer for needed services. Yet, only a third of sick Americans have same-day access to their primary-care physician, less than people in the United Kingdom (41 percent), Australia (54 percent), and New Zealand (60 percent).[33] Three times the proportion of Americans and nearly four times the proportion of sicker Americans find it difficult to get care at night and on weekends without going to emergency rooms as those in New Zealand.[34]

Additionally, among developed nations, waiting lists are not a major factor in explaining lower costs. Examining Organization for Economic Cooperation and Development (OECD) nations, one study identified twelve countries that had waiting lists for elective surgeries and seven countries besides the U.S. that did not have these waiting lists. Per capita health spending averaged $2,366 in the countries with waiting lists, $2,696 in the non-U.S. countries without waiting lists, and $5,267 in the U.S. (See Exhibit 3).[35] Thus, waiting lists are neither inevitable nor necessary in systems that cover all of their people.



Source: G. F. Anderson et al., "Health Spending in the United States and the Rest of the Industrialized World," *Health Affairs* 24, no. 4 (2005).

In fact, on many measures, resources are greater in comparable countries that have comprehensive health systems. There are relatively more hospital beds, physicians and nurses, magnetic resonance imaging (MRI) and computed tomography (CT) scanners in other countries belonging to the OECD than in the U.S. Specifically, in 2002, the U.S. ranked below the median of these countries in its number of hospital beds per capita (2.9 compared to 3.7), physicians per capita (2.4 compared to 3.1) and nurses per capita (7.9 compared to 8.9).[36]

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Yet, by failing to have a coherent, coordinated health system, the U.S. has its own type of rationing: rationing based on income, illness, and insurance status. People who are uninsured or have low incomes but high cost sharing have less access to health care than people in comparable nations with universal coverage systems. About 30 percent of below-average-income Americans reported problems accessing specialists compared to 14 to 21 percent in Australia, Canada, New Zealand and the United Kingdom.[37] More disturbing is the report that 57 percent of lower-income adults and 51 percent of sicker adults in the U.S. went without needed medical care, did not get recommended tests or follow-up care, or went without prescription medications due to cost.[38] This is twice as high as the access problems reported in Canada (26 percent) and four times as high as that in the United Kingdom (12 percent). This is not just a problem for low-income people; overall, the U.S. has the highest percentage of adults reporting some type of cost-related access problem.[39] It is hard to believe that, in the wealthiest nation on the planet, 77 million people – 37 percent of all adults – report having difficulty paying medical bills or medical debt.[40] In this regard, we do stand out among the world's leading nations; we are the only one that fails to ensure that health care is affordable for all.

Myth #4: Global Competitiveness Is Hampered in Comprehensive Systems

Health care costs are not just a burden and barrier to care for individuals; they are taking a heavy toll on American businesses. The U.S. is relatively unique in its reliance on employers to voluntarily sponsor health insurance for its citizens. The number of people getting coverage from their employers is over twice that who receive coverage through Medicare and Medicaid. Yet, the strain of this cost for employers is growing, possibly to a breaking point. The average total premium for an employer-based family plan was $9,979 in 2005[41]—representing nearly the entire annual income of a full-time, minimum-wage worker. The cost of premiums for employer-based plans has outpaced wage growth by nearly fivefold since 2000.[42] According to one report, by 2008, health costs will exceed profits at Fortune 500 companies.[43] Yet, despite these warning signs, some still fear the alternative even more. Distrust of government leads some businesses to believe that they will pay even more under a reformed system, losing their competitive edge. In addition, the large health care industry claims that innovation will be stifled with greater government involvement.

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Again, facts get in the way of these claims. Most of our competitor nations finance their health systems through broad-based revenue sources that rarely involve corporate taxes or employer mandates. This helps explain why automobile manufacturers have been moving across the border to Canada since health costs there are not primarily loaded into the price of each car. Moreover, despite our world-class businesses and extensive policies that

support them, the U.S. is not rated as the best place in the world to do business. Last year, New Zealand, with its comprehensive, fairly-financed health system, received this top honor from the World Bank.[44] Similarly, the World Economic Forum named Finland, another country with a health system that is seamless and relatively efficient, as the number-one nation in global competitiveness. (See Exhibit 4).[45] Countries with universal coverage differ in their use of private insurance and providers, systems for containing costs, and financing. But, in general, their predictable and broadly-financed costs along with their outcomes – improved health and productivity of workers – tend to benefit their businesses, and give them a competitive advantage over ours.

Exhibit 4

TOP 10

Best Countries in which to do Business	Countries with the Most Competitive Markets
1. New Zealand	1. Finland
2. United States	2. United States
3. Singapore	3. Sweden
4. Honk Kong, China	4. Denmark
5. Australia	5. Taiwan
6. Norway	6. Singapore
7. United Kingdom	7. Iceland
8. Canada	8. Switzerland
9. Sweden	9. Norway
10. Japan	10. Australia

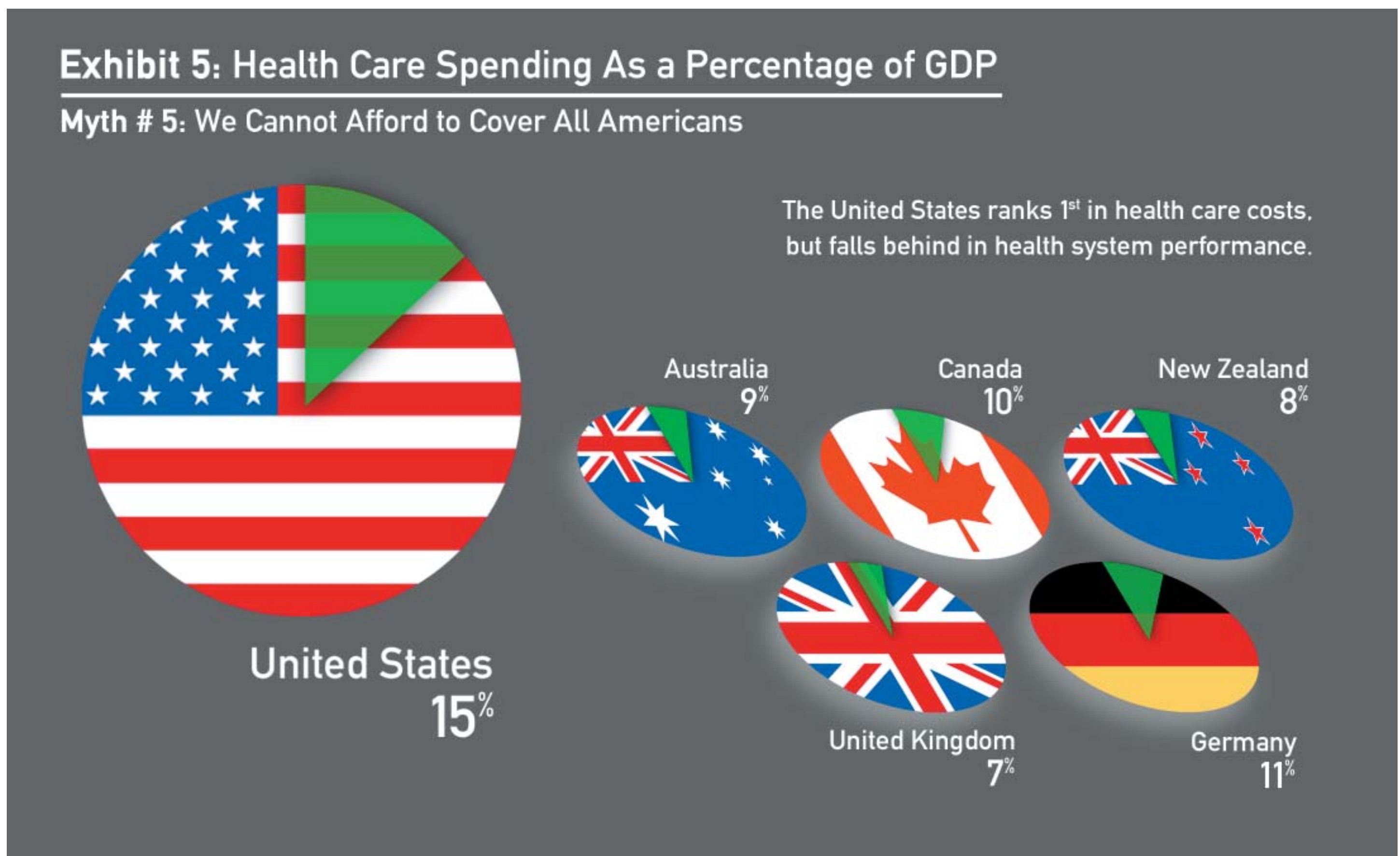
Source: World Bank, *Doing Business in 2005* and World Economic Forum, *Global Competitiveness Report*, 2005.

Reducing cost and covering all would have a unique effect on one industry: the "medical-industrial complex." Millions of Americans are employed in and around the health industry, which helped sustain our economy during the last recession.[46] Yet, the impact of reform does not have to be dramatic or disruptive. Some proposals, like that of my colleagues at the Center for American Progress, would build on the existing mix of public and private coverage.[47] This plan, by reducing uncompensated care and promoting information technology, could increase provider satisfaction and quality as it decreases paperwork and complexity. And reforming the financing of the system could ease the pressures on providers and free up resources to focus on innovation. Indeed, a large and growing number of medical and technological breakthroughs are emerging from countries with universal coverage. For example, Germany has pioneered less-invasive laparoscopic surgery and "brain labs" that use computer-guided magnetic resonance imaging to improve neurosurgery. And in the U.S., some of the truly significant drug breakthroughs have come not from the investor-driven manufacturers but from taxpayer-funded research at academic institutions, small biotechnology companies, or the National Institutes of Health (NIH).[48] A well-designed health system could promote this type of innovation.

Myth #5: We Cannot Afford to Cover All Americans

The most difficult myth to address relates to costs. Last year, the Institute of Medicine issued a challenge: that America provide health coverage to all people by the year 2010. The response of some conservatives was that universal coverage is "impossible" to achieve in the U.S. because it is too expensive.[49] They argue that medical malpractice and defensive medicine are the real problems; people already use too much health care; and costs will skyrocket if we have more government involvement.

The truth is, we cannot afford to not reform the health system. The U.S. – by any measure – already spends more on health care than any other nation in the world. Over 15 percent of our economy, or $1.7 trillion, is spent on health care which, on a per person basis, is 50 percent higher than the second most costly nation. (See Exhibit 5).[50] This cost is not just borne by businesses and the government; in fact, the government share of health spending in the U.S. is the lowest among all OECD nations.[51] Nearly twice as many Americans as Australians spent more than $1,000 out-of-pocket on health care in 2003 (26 compared to 14 percent).[52] Again, sicker Americans fare worse. Over one-third of sicker Americans have medical expenses exceeding $1,000, compared to 14 percent of sicker Canadians and 4 percent of sicker adults in the United Kingdom.[53]



Source: Organisation for Economic Cooperation and Development (OECD), "How Does the United States Compare," in *OECD Health Data 2005: Statistics and Indicators for 30 Countries*.

The obvious answer is that we need to create a new model for our health financing infrastructure that can provide better health care quality and access at a lower per capita cost. Whether those costs are financed more from public premium support than what is currently paid in the present model is not nearly as important as bringing down overall costs to the system.

Yet, we must be wary of simplistic solutions that promise dramatic reductions in costs. For example, while reforming the medical malpractice system could ease some of the burden on doctors, it is unlikely to solve the cost problem. A recent study found that when all of the United States' malpractice costs are tabulated, including awards, legal costs, and underwriting costs, they account for 0.46 percent of total health spending. This is the same percentage in the United Kingdom and Canada, although it doesn't include the cost of "defensive medicine," which could raise the U.S. percentage.[54] Nor, as described earlier, is it due to more technology like CAT scans or higher use of services like hospitals; on both accounts, the U.S. ranks lower than many other nations.

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One study suggested the answer in its title: "It's the Prices, Stupid": higher prices for prescription drugs, hospitals and other providers – more than higher use of services – account for the cost difference between U.S. and comparable nations.[55] The fragmented and uncoordinated system for insuring people in the U.S. gives purchasers little power to negotiate for lower prices. As a result, half of the profits in the drug industry worldwide are paid for by Americans, for example.[56] Moreover, we pay – perhaps two to three times as much as countries such as Great Britain – for the complexity, marketing costs and insurance overhead that result from a market-oriented system.[57] Added to this high administrative cost is the "cost shifting" to insured people of unpaid bills from people moving in and out of coverage and not being able to afford care even when they are insured. In short, we might be able to lose our number one status as having the most expensive health care in the world if we adopted a more rational, efficient, and quality-oriented health system.

Discussion and Policy Implications

The problems in our health system should not overshadow its elements that are excellent. Some of the same studies that compare us to our peer nations found that the U.S. has the best rates of Pap tests and mammograms for women, and that the odds of breast cancer survivorship are 14 percent higher here than in the United Kingdom. We have some of the world's best specialists, a training system that attracts people from all over the world, and facilities that translate medical knowledge into virtual miracles. And we are pioneering systems of delivering care to people with chronic conditions who live in rural areas, offering small-town residents access to the best possible care. Reform plans should preserve the best features of our delivery system, but be bold in taking on its aspects that are weak and failing.

We need to act quickly to insure all Americans; this could be done through the group insurance options that exist now. We should lower costs through common-sense policies like group purchasing and fair pricing. And we should change how we finance health care, so that bad luck or bad health doesn't mean financial catastrophe for a family or small business. This will not be easy. The general policy challenges of change are compounded by entrenched special interests, ideological warfare, and fears that the cure is worse than the sickness. But I strongly believe that the American public, providers and payers will demand change, and leadership will emerge to enact it. To pave the way for this change, the distracting and damaging myths about the health system must be dispelled.

More is at stake than our nation's health. Our global leadership depends, in part, on our ability to address these health system problems. How we care for our poor and our sick, how we allocate the cost of basic services like education and health care, and how we promote ideas, opportunity and productivity all are reflected in our health system, or lack thereof. I believe that affordable, available health care is not a luxury but a basic foundation in a working democracy. Moreover, it has become central to a global and competitive economy in the 21st century. This nation has proven it can ride the crest of change, adapting from local to global neighborhoods and the industrial to the information revolution. Yet, as the new century begins, we must take on this fundamental challenge of securing our economic, personal, and public health through enacting a policy that improves and expands coverage for all.

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