Testimony of

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Mr. Chairman, Sen. Corker, Distinguished Members of the Committee:

My name is Michael Tanner. For the past 16 years I have been in charge of health care research for the Cato Institute in Washington, DC. Before that I served as legislative director for the Georgia Public Policy Foundation and as legislative director for health & welfare with the American Legislative Exchange Council. In all, I have spent more than 20 years studying the American health care system and am the author of five books on health care reform, most recently *Healthy Competition: What's Holding Back American Health Care and How to Free It.*

As part of my research, I have investigated health care systems in other countries, with particular attention to cost within those systems and the quality of care provided. The results of that research is detailed in my Cato Institute study "The Grass Isn't Always Greener: A Look at National Health care Systems Around the World," which I have attached to this testimony. The study looks at a number of specific countries, but it is possible to draw some broader general conclusions.

First, looking at the United States, there is no doubt that the United States spends far more on health care than any other country, whether measured as a percentage of GDP or by expenditure per capita. The United States now spends close to 16 percent of GDP on health care, nearly 6.1 percent more than the average for other industrialized countries.[1] Overall health care costs are rising

[1] "OECD Health Data 2007: Statistics and Indicators for 30 Countries." Organization for Economic Cooperation and Development, July 2007.

faster than GDP growth and now total more than $1.8 trillion, more than Americans spend on housing, food, national defense, or automobiles.[2]

Health care spending is not necessarily bad. To a large degree, America spends money on health care because it is a wealthy nation and chooses to do so. Economists consider health care a "normal good," meaning that spending is positively correlated with income. As incomes rise, people want more of that good. Because we are a wealthy nation, we can and do demand more health care.[3]

But because of the way health care costs are distributed, they have become an increasing burden on consumers and businesses alike. On average, health insurance now costs $4,479 for an individual and $12,106 for a family. Health insurance premiums rose by a little more than 6 percent in 2007, faster on average than wages.[4]

Moreover, government health care programs, particularly Medicare and Medicaid, are piling up enormous burdens of debt for future generations. Medicare's unfunded liabilities now top $50 trillion.[5] Unchecked, Medicaid spending will increase fourfold as a percentage of federal outlays over the next century.[6]

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[2] C. Borger, et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs Web Exclusive* W61: February 22, 2006.

[3] Uwe Reinhardt of Princeton University, for example, estimates that nearly half of the difference in spending between the U.S. and other industrial nations is due to America's higher GDP. Uwe Reinhardt, Peter Hussey, and Gerald Anderson, "U.S. Health Care Spending in an International Context," *Health Affairs* 23 (May/June 2004): 11-12.

[4] "Employer Health Benefits Annual Survey," Kaiser Family Foundation, September 11, 2007.

[5] *2007 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal supplemental Medical Insurance Trust Funds* (Washington: Government Printing Office, 2007).

[6] Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on The Breaks," Cato Institute Policy Analysis no. 597, July 19, 2007.

But, while the US does not do a very good job of controlling costs, we actually do fair well on many measures of quality. I am aware, of course, that not every survey recognizes this. For instance, there is the famous World Health Organization study that ranks the U.S. health care system as 37th in the world in terms of health quality.

However, this study bases its conclusions on such highly subjective measures as "fairness" and criteria that are not strictly related to a country's health care system, such as "tobacco control." For example, the WHO report penalizes the United States for not having a sufficiently progressive tax system, not providing all citizens with health insurance, and a general paucity of social welfare programs. Indeed, much of the U.S.' poor performance is due to receiving a ranking of 54th in the category of "fairness." The U.S. is actually penalized for adopting Health Savings Accounts and because patients pay too large an amount out-of-pocket, according to the WHO. [7] Such judgments clearly reflect a particular political point of view, rather than a neutral measure of health care quality. On the other hand, the WHO report ranks the U.S. number one in the world in responsiveness to patients' needs in choice of provider, dignity, autonomy, timely care, and confidentiality.[8]

There are even difficulties in using more neutral categories of comparison. Nearly all such cross-country rankings use life expectancy as a measure. In reality though, life expectancy is a poor measure of a health care system. Life

[7] Edward Kelley and Jeremy Hurst, "Health Care Quality Indicators Project: Initial Indicators Report," OECD Health Working Papers no. 22, March 2006.
[8] Edward Kelley and Jeremy Hurst, "Health Care Quality Indicators Project: Initial Indicators Report," OECD Health working Papers no. 22, March 2006.

expectancies are affected by exogenous factors such as violent crime, poverty, obesity, tobacco and drug use, and other issues unrelated to health care. As the OECD explains, "It is difficult to estimate the relative contribution of the numerous non-medical and medical factors that might affect variations in life expectancy across countries and over time."[9] Consider the nearly three-year disparity in life expectancy between Utah (78.7 years) and Nevada (75.9 years), despite the fact that the two states have essentially the same health care systems.[10] In fact, a study by Robert Ohsfeldt, John Schneider for the American Enterprise Institute found that those exogenous factors are so distorting that if you correct for homicides and accidents, the U.S. rises to the top of the list for life expectancy.[11]

Similarly, infant mortality, a common measure in cross-country comparisons, is highly problematic. In the United States, very low birth-weight infants have a much greater chance of being brought to term with the latest medical technologies. Some of those low birth-weight babies die soon after birth, which boosts our infant mortality rate, but in many other Western countries, those high-risk, low birth-weight infants are not included when infant mortality is calculated.[12] In addition, many countries use abortion to eliminate problem pregnancies. For example, Michael Moore cites low infant mortality rates in

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[9] "Health at a Glance: OECD Indicators, 2005," Paris, OECD Publishing, 2005.
[10] U.S. Census Bureau, 2000 Census.
[11] Robert L. Ohsfeldt, John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington AEI Press, 2006).
[12] In Austria and Germany, fetal weight must be at least 500 grams (1 pound) to count as a live birth; in other parts of Europe, such as Switzerland, the fetus must be at least 30 centimeters (12 inches) long. In Belgium and France, births at less than 26 weeks of pregnancy are registered as lifeless. And some countries don't reliably register babies who die within the first 24 hours of birth. For a full discussion of the issue, see Miranda Mugford, "A Comparison of Reported Differences in Definitions of Vital Events and Statistics," *World Health Statistics Quarterly* 36 (1983), cited in Nicholas Eberstadt, *The Tyranny of Numbers: Measurements & Misrule* (Washington: American Enterprise Institute press, 1995), p. 50. Some, but not all, countries are beginning to standardize figures and future data may be more reliable.

Cuba, yet that country has one of the world's highest abortion rates, meaning that many babies with health problems that could lead to early deaths are never brought to term.[13]

On the other hand, when you compare the outcome for specific diseases, the United States clearly outperforms the rest of the world. Whether the disease is cancer, pneumonia, heart disease, or AIDS, the chances of a patient surviving are far higher in the U.S. than in other countries. For example, according to a study published in the British medical journal *The Lancet*, the U.S. is at the top of the charts when it comes to surviving cancer. Among men, roughly 62.9 percent of those diagnosed with cancer will survive for at least five years. The news is even better for women, the five year survival rate is 66.3 percent, two thirds. The next best countries are Iceland for men (61.8 percent) and Sweden (60.3 percent for women). Most countries with national health care fare far worse. For example, in Italy, 59.7 percent of men and 49.8 of women survive five years. In Spain, just 59 percent of men and 49.5 percent of women do. And in Great Britain a dismal 44.8 percent of men and only a slightly better 52.7 percent of women live for five years after diagnosis.[14]

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[13] Anthony DePalma, "SiCKO, Castro, and the 120 Year Club," *New York Times*, May 27, 2007.

[14] Arduino Verdecchia et al., "Recent Cancer Survival in Europe: a 2000-02 period analysis of EUROCARE-4 data," *The Lancet* Oncology, Available online August 21, 2007, http://www.thelancet.com/journals/lanonc/article/PIIS1470204507702450/abstract; Nicole Martin, "UK Cancer Survival Rate Lowest in Europe, *Daily Telegraph*, August 24, 2007. Of course it can be argued that these figures are skewed by aggressive US testing and diagnostic procedures. In the U.S., we catch many cancers that would go undetected in other countries. These cancers are small or slow growing and would not kill the person suffering from it. That it is diagnosed in the US, but not other countries, makes our survival rate look higher. Jonathan Cohn, "What Jacques Chirac Could Teach Us about Health Care," *New Republic*, April 10, 2007. That is a theory worth considering and it is likely that increased screening has an impact on the figures for slow growing cancers such as prostate cancer (the source of much controversy since Rudy Giuliani raised the issue in his campaign). "Rudy Wrong on Cancer Survival Chances," *Washington Post*, October 31, 2007; David Gratzer, "Rudy Is Right in Data Duel about Cancer," *Investors Business Daily*, November 6, 2007.

It is notable that when former Italian Prime Minister Silvio Berlusconi needed heart surgery last year, he didn't go to France, Canada, Cuba, or even an Italian hospital—he went to the Cleveland Clinic in Ohio.[15] Likewise, Canadian MP Belinda Stronach had surgery for her breast cancer at a California hospital.[16] Berlusconi and Stronach were following in the footsteps of tens of thousands of patients from around the world who come to the United States for treatment every year. One U.S. hospital alone, the Mayo Clinic, treats roughly 7,200 foreigners every year.[17] Johns Hopkins University Medical Center treats more than 6,000; the Cleveland Clinic more than 5,000. One out of every three

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As, Robert Ohsfeldt and John Schneider concede in their book, *The Business of Health* "[Many] cancer survival rate estimates…do not adjust for cancer stage at diagnosis. This could result in survivor time bias – those with cancers detected at an earlier stage would exhibit longer post diagnosis survival times, even for cancers that are essentially untreatable." Robert Ohsfeldt and John Schneider, *The Business of Health* (Washington: American Enterprise Institute, 2007), pp. 23-24. However, survivor time bias is not as big an issue for cancers that have faster metastasizing times or strike younger patients.

As Ohsfeldt and Schneider go on to note,

> Survivor time bias, however, should not be a significant concern for cancers that respond well to treatment if detected early. For such cancers, early detection makes a substantive contribution to survival time – the longer survival time associated with early detection thus is not a spurious effect of early detection. An example is thyroid cancer. In the United States, virtually all females with thyroid cancer survive for at least five years. The lower survival rates for thyroid cancer in European countries suggest some underperformance in either early detection or post diagnosis management in these countries. In contrast, the differences in survivor rates are less pronounced for cancers that are more difficult to treat, such as lung cancers.

Thus, it is significant that the U.S. advantage holds for other cancers, too, including breast cancer, colon cancer, and thyroid cancer among others. Moreover, there are many benefits to early detection and treatment beyond survival rates. Even for prostate cancer, early treatment can have a significant effect on the quality of life. And it could be that the U.S. simply has more cases of prostate cancer than other countries (diet could play a significant role, for example. Kyung Song, "Study Links Diet to Prostate Cancer," *Seattle Times*, October 11, 2007).

Finally, it should at least be mentioned that one of the most common arguments for socialized medicine is that it would increase screening and preventive care. Indeed, John Edwards actually wants to make testing mandatory for all Americans. "Edwards Backs Mandatory Preventive Care," Associated Press, September 2, 2007.

[15] "World Briefing: Berlusconi has Heart Surgery in US," *New York Times*, December 19, 2006.

[16] "Stronach Went to US for Cancer Treatments: Report," CTV, September 14, 2007; available at http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20070914/belinda_Stronach_070914/20070914

[17] Steve Findlay, "U.S. Hospitals Attracting Patients from abroad," *USA Today*, July 22, 1997.

Canadian physicians has sent a patient to the U.S. for treatment each year,[18] and those patients along with the Canadian government spend more than $1 billion annually on health care in this country.[19]

Moreover, the United States drives much of the innovation and research on health care worldwide. Eighteen of the last 25 winners of the Nobel Prize in Medicine are either U.S. citizens or work here.[20] U.S. companies have developed half of all new major medicines introduced worldwide over the past 20 years.[21] In fact, Americans played a key role in 80 percent of the most important medical advances of the past 30 years.[22] And, dvanced medical technology is far more available in the United States than in nearly any other country.[23]

The same is true for prescription drugs. For example, 44 percent of Americans who could benefit from taking statins, a lipid lowering medication that reduces cholesterol and protects against heart disease, take the drug. That number seems low until compared with the 26 percent of Germans, 23 percent of Britons, and 17 percent of Italians who could both benefit from the drug and receive it.[24] Similarly, 60 percent of Americans taking antipsychotic medication for the treatment of schizophrenia or other mental illnesses are taking the most

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[18] The two principal reasons for sending a patient abroad were the lack of availability of services in Canada (40 percent) and the length of the wait for certain treatments (19 percent),"Robert J. Blendon et al., "Physician's Perspectives on Caring for Patients in the United States, Canada, and West Germany." *New England Journal of Medicine*, 328, (April 8, 1993).

[19] John Goodman, "Moore's SiCKO Could Put Lives at Risk," *The Michael Moore Chronicles*, National Center for Policy Analysis, 2007.

[20] "Nobel Prize in Physiology or Medicine Winners 2007–1901," The Nobel Prize Internet Archive, http://almaz.com/nobel/medicine/medicine.html.

[21] Pharmaceutical Manufacturers Association, "Facts about the U.S. Pharmaceutical Industry," 2002.

[22] *Economic Report of the President* (Washington: Government Printing Office, 2004), p. 192.

[23] Gerard Anderson et al., "It's the Prices Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): 99.

[24] Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations," 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," June 2004.

recent generation of drugs, which have fewer side-effects. But just 20 percent of Spanish patients and 10 percent of Germans receive the most recent drugs.[25]

This is not to diminish the very serious problems facing the US health care system or the need for health care reform. problems with the U.S. system. Too many Americans lack health insurance and/or are unable to afford the best care. More must be done to lower health care costs and increase access to care. Both patients and providers need better and more useful information. The system is riddled with waste, and quality of care is uneven. Government health care programs like Medicare and Medicaid threaten future generations with an enormous burden of debt and taxes.

In reforming our health care system, it may indeed be possible to learn from the experiences of other countries, to see how they are able control costs so much better than us, and to examine what impact those cost controls have on the quality of care.

Of course, there is no single model for national health care systems in other countries. Indeed, the differences from country to country are so great that it is almost misleading to refer simply to "national health care" or "universal coverage" as if there were a collective model for how other countries deal with health care and health insurance. Each country's system is the product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to

[25] Oliver Schoffski, "Diffusion of Medicines in Europe," paper prepared for the European Federation of Pharmaceutical Industries and Associations," 2002, cited in Daniel Kessler, "The Effects of Pharmaceutical Price Controls on the Cost and Quality of Medical Care: A Review of the Empirical Literature," June 2004.

the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between.

Some countries have a true single-payer system, prohibiting private insurance and even restricting the ability of patients to spend their own money on health care. Others are multi-payer systems, with private competing insurers and varying degrees of government subsidy and regulation. Some countries base their systems around employment, while others have completely divorced work and insurance. Some require consumers to share a significant part of health care costs through either high deductibles or high co-payments. Others subsidize virtual first-dollar coverage. Some allow unfettered choice of physicians. Others allow a choice of primary care physicians but require referrals for specialists. Still others restrict even the choice of primary care doctors.

It is also important to realize that no country's system is directly importable to the U.S. Americans are unlikely to accept the rationing or restrictions on care and technology that many countries use to control costs. Nor are U.S. physicians likely to accept a cut in income to the levels seen in countries like France or Germany. The politics, economics, and national cultures of other countries often vary significantly from that of the U.S. Their citizens are far more likely to have faith in government actions and to be suspicious of free markets. And polling suggests that citizens of many countries put social solidarity and equality ahead of quality and choice when it comes to health policy.[26] American attitudes are quite different. As pollster Bill McInturff notes, "Never, in my years

[26] Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006); Helen Disney, et al., *Impatient for Change: European Attitudes to Healthcare* Reform (London: Stockholm Network, 2004),

of work, have I found someone who said, 'I will reduce the quality of the health care I get, so that all Americans can get something.'"[27]

Even so, it is possible to draw some important lessons from the experience of other countries:

- Universal health insurance does not mean universal access to health care. In practice, many countries promise universal coverage, but ration care or have extremely long waiting lists for treatment. Nor does a national health care system necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most leave at least a small remnant (1-2 percent of the population) uncovered. While this is certainly wider coverage than the United States provides, it shows the difficulty of achieving either truly universal coverage or universal access to care.

- Rising health care spending is not a uniquely American phenomenon. While other countries spend considerably less than the U.S. on health care both as a percentage of GDP and per capita, it is often because they begin with a lower base of expenditures. But their costs are still rising, leading to budget deficits, tax increases, and/or benefit cuts. In 2004, the last year for which data is available, the average annual increase for per capita

[27] Robin Toner, "Unveiling Health Care 2.0, Again," *New York Times*, September 16, 2007.

health spending in the countries discussed in this study was 5.55 percent, only slightly lower than the United States' 6.21 percent.[28] As the *Wall Street Journal* notes, "Europeans…face steeper medical bills in the future in their cash-strapped governments."[29] In short, there is no free lunch.

- Those countries that have single-payer systems or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, restrictions on the choice of physician, and other barriers to care. Those countries with national health care systems that work better, such as France, the Netherlands, and Switzerland, are successful to the degree that they incorporate market mechanisms such as competition, cost-consciousness, market prices, and consumer choice, and eschew centralized government control.

- While no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national health care systems is to move away from centralized government control and to introduce *more* market oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public

[28] OECD Health Data 2007: Statistics and Indicators for 30 countries, OECD, Oct. 2007
[29] Quoted in Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 109.

> primacy is being reassessed."[30] Alan Jacobs of Harvard points out that while there are significant differences in goals, content, and strategies, there is a general convergence toward market practices in health care among European nations.[31] Thus, even as the U.S. debates adopting a government-run system, countries with those systems are debating how to make their systems look more like the U.S.

Looking at other countries and their experiences, then, can provide guidance to Americans as we debate how to reform our health care system. National health care is not a monolithic idea, nor is it always as disastrous as its U.S. critics would sometimes portray. *Some* national health care systems do *some* things well.

Yet, neither are those systems without serious problems. In most cases, national health care systems have successfully expanded insurance coverage to the vast majority, if not quite all, of the population. But they have not solved the universal and seemingly irresistible problem of rising health care costs. In many cases, attempts to control costs through governmental fiat have led to problems with access to care, either delays in receiving care or outright rationing.

In wrestling with this dilemma, many countries are loosening government controls and injecting market mechanisms, particularly cost-sharing by patients,

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[30] Richard Saltman and Josep Figueras, "Analyzing the Evidence on European Health Care Reforms," *Health Affairs*, March-April 1998.

[31] Cited in Daniel Callahan and Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006), p. 91.

market pricing of goods and services, and increased competition among insurers and providers. As Pat Cox, former president of the European Parliament, put it in a report to the European Commission, "we should start to explore the power of the market as a way of achieving much better value for money."[32]

Moreover, the growth of the government share of health care spending, which had increased steadily from the end of World War II until the mid-1980s, has stopped, and in many countries the private share has begun to increase, in some cases substantially. There is even evidence of a growing shift from public to private provision of health care.[33] If the trend in the U.S. over the last several years has been toward more of a European-style system, the trend in Europe is toward a system that looks more like the U.S.

Therefore, if there is a lesson which U.S. policymakers can take from national health care systems around the world, it is not to follow the road to government-run national health care, but to increase consumer incentives and control. The U.S. can increase coverage and access to care, improve quality, and control costs without importing the problems of national health care. In doing so, we should learn from the successes—*and the failures*—of systems in other countries.

Thank you and I would be happy to answer any questions.

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[32] "'Cox Report' on Financing Sustainable Healthcare in Europe Presented to European Commission today," Press Release, February 13, 2006.

[33] Hans Maarse, "The Privatization of Health Care in Europe: An Eight Country Analysis," *Journal of Health Politics, Policy, and Law* 31 (2006): 981-1014.