

Chapter Seven

Costs

MYTH NO. 7: COUNTRIES WITH SINGLE-PAYER NATIONAL HEALTH CARE SYSTEMS HAVE BEEN MORE SUCCESSFUL THAN THE UNITED STATES IN CONTROLLING HEALTH CARE COSTS

The United States spends more on health care than any other country in the world, both in dollars per person and as a percentage of GDP. Does this mean that our predominantly private health care system is less able to control spending than are developed countries with national health insurance? Not necessarily.

As we shall see, international comparisons of health care spending are difficult, not least because of differences in the measuring techniques used by other countries.¹ First, however, we should note that the United States is wealthier than other countries. Almost without exception, international comparisons show that wealthier countries spend a larger proportion of their GDP on health care.² In his classic 1977 and 1981 studies, health economist Joseph Newhouse found that 90 percent of the variation in health care spending among developed countries is based on income alone.³ This should give pause to anyone who believes that the United States will significantly lower health care spending by adopting the system or institutions of some other country. As we noted in the introduction, as people have more income, they spend more on health care, whether their spending takes place through the market, the political system or quasipublic institutions.

Some believe that countries with national single-payer health insurance have a coercive “advantage” the United States does not—they can more easily deny access to care. Governments, for example, can and do limit health

care dollars and force hospitals and doctors to ration services. However, such power is not unlimited. Politicians who abuse it risk being replaced by their competitors. In the political systems of other countries, just as in the United States, the pressure to spend more on health care is unrelenting.

THE UNITED STATES VERSUS OTHER DEVELOPED COUNTRIES

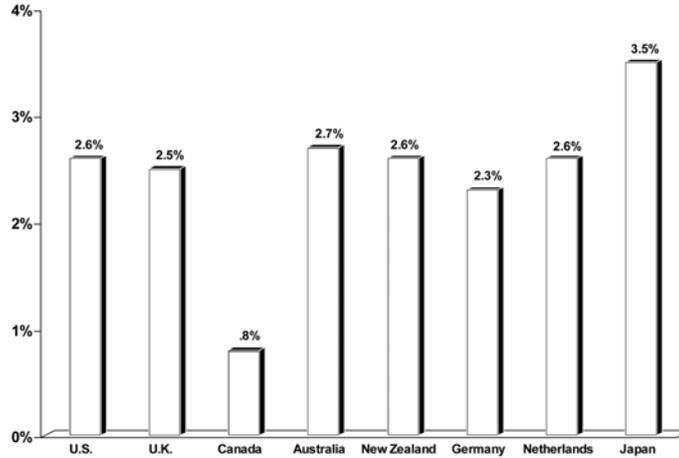
Most international statistics on health care spending are produced by the OECD. However, OECD statistics are not always useful because different countries use different methods to report costs.⁴ No effective international guidelines exist, and some countries include services that others do not.⁵ For instance, the OECD definition of health care expenditures includes nursing home care. But while Germany includes nursing home care as part of total health expenditures, Britain does not.⁶ Some countries count hospital beds simply by counting metal frames with mattresses, whether or not they are in use. In others, a “bed” is counted only if it is staffed and operational.⁷

Although the percentage of the population admitted as inpatients in the United States (11.8) is below the OECD average of 15.4 percent, the U.S. figures exclude procedures performed in outpatient facilities, while OECD figures most likely include these surgeries.⁸ In addition, payments made in the “informal health sector” (under-the-table payments, common in many countries) are generally missed in official estimates.⁹

Figure 7.1 shows the result of an attempt to develop more accurate health care spending measurements among OECD countries. The study calculated the average annual increase in the percentage of per capita spending on health care by OECD countries for the period 1960 to 1998. As the figure shows, the countries of the OECD have been no more successful than the United States in controlling costs and many have been far less successful. During the 1990s, health care spending in all but three of fifteen OECD countries studied grew at about the same rate as in the United States—or higher. The real rate of expenditures on hospital and physician services actually decreased in the United States in the 1990s (2.5 percent and 1.0 percent, respectively), well below the OECD median for both categories.¹⁰

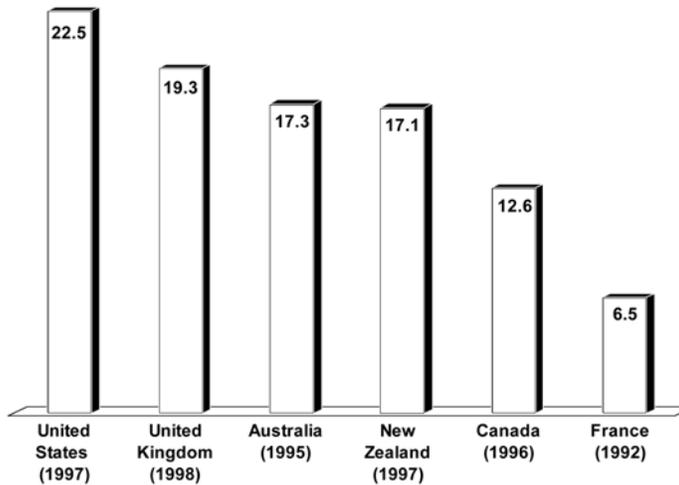
These results are surprising considering that the United States has far less rationing of care and offers greater access to medical technology. Furthermore, the United States confronts a wider range of health problems than most other OECD countries. For example, the incidence of AIDS is almost ten times more prevalent in the United States than in Canada, and obesity is a greater problem here than in other developed countries (see figure 7.2).¹¹ These factors, of course, put greater demands on the U.S. health care system.

FIGURE 7-1
Average Annual Real Growth in
Per Capita Health Spending
1960-1998



Source: Gerard F. Anderson et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960-1998," *Health Affairs*, May/June 2000.

FIGURE 7-2
Percent of the Population Age 15
and Older That Is Obese



Source: Gerard F. Anderson and Peter S. Hussey, "Multinational Comparisons of Health Systems Data," Commonwealth Fund, October 2000.

THE UNITED STATES VERSUS CANADA

During the 1990s, Canada was able to limit the real rate of growth in its health care spending to 1.7 percent per year. By contrast, the rate of spending growth in the United States health care system was equal to the OECD median of 3.0 percent per year.¹² However, as we document elsewhere in this book, Canada limited spending increases by cutting funding for services in ways that caused people to suffer.

- The Canadian federal government reduced block grants to provinces for health care as a percentage of GDP in 1986 and again in 1989; funding to the provinces was frozen at 1989–1990 levels through 1995, and further cuts were made in the second half of the 1990s.¹³
- Provincial governments, in turn, reduced funding available to hospitals (their global budgets), began limiting total expenditures for physicians' fees, severely limited the purchase of new technology, and removed some services from coverage by provincial insurance plans.¹⁴
- Many smaller hospitals were closed—fifty in Saskatchewan alone—and the number of hospital beds available nationwide was reduced from 6.6 per thousand population in 1987 to 4.1 in 1995.¹⁵

By most accounts, these reductions in the availability of medical services had more to do with budgetary shortfalls than lack of medical need. A recent report for the Canadian federal government argued that the Canadian health care system was under funded and in need of an additional C\$5 billion annually.¹⁶ Satisfaction with the Canadian health care system fell throughout the 1990s as a result. As we have seen, when medical resources are allocated based on limited global budgets, patients often go without needed care.

In 2000, the United States spent 13.0 percent of its GDP, or US \$4,631 per person, on health care. By contrast, Canada spent 9.1 percent of its GDP, or US \$2,535 per person.¹⁷ Here again, the spending figures are almost certainly incomplete. In both Canada and the United States, the costs of administering government health care spending are largely hidden. In addition, there are larger, systemic differences between the two countries:¹⁸

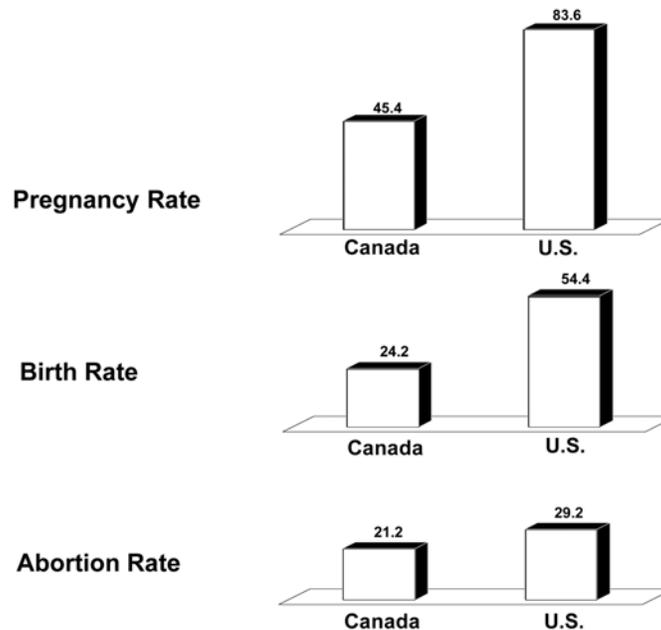
- Canadian figures do not include the capital cost of building and equipment to the extent that the U.S. figures do because Canadian facilities are paid for by the government; hence, the cost of capital is subsumed within the Canadian government's debt.
- The United States spends far more on research and development (R&D) than Canada. The U.S. spending results in technological innovations that benefit Canada and the rest of the world.

- The U.S. population is slightly older, and older people inevitably consume more health care.

According to one study, correcting for these differences between the two countries cuts in half the gap in the fraction of GDP spent on health care.¹⁹

In addition to AIDS and obesity, the United States has other demands on its health care system that Canada does not. For example, the U.S. male homicide rate is three times that of Canada.²⁰ The United States also has health care costs related to war injuries, including those of Vietnam veterans. And as figure 7.3 illustrates, teenage girls, who are more likely to have premature babies and other complications stemming from pregnancy, become pregnant almost twice as often in the United States as in Canada and give birth nearly two and one-half times as often.²¹

FIGURE 7-3
Pregnancy, Childbearing and
Abortions among Girls Ages 15-19
 (per 1,000)



Source: Susheela Singh and Jacqueline E. Darroch, "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries," Alan Guttmacher Institute, *Family Planning Perspectives*, January/February 2000.

NOTES

1. For a discussion of the problems associated with international comparisons of health care spending, see Adrian Towse and Jon Sussex, "'Getting UK Health Care Expenditure Up to the European Union Mean'—What Does That Mean?" *British Medical Journal* (March 4, 2000): 640–42; and Panos Kanavos and Elias Mossialos, "The Methodology of International Comparisons of Health Care Expenditures: Any Lessons for Health Policy?" London School of Economics and Political Science, LSE Health, Discussion Paper No. 3, April 1996, available at www.lse.ac.uk/Depts/lsehsc/papers/Discussion_Papers/dp3.pdf.
2. Pedro P. Barros, "The Black Box of Health Care Expenditure Growth Determinants," *Health Economics* 7, no. 6 (September 1, 1998): 533–44. Of two countries with the same GDP, the country with the faster-growing economy will likely have the higher expenditure. See R. Mark Wilson, "Medical Care Expenditures and GDP Growth in OECD Nations," *American Association of Behavioral and Social Sciences Journal* 2 (Fall 1999): 159–71.
3. Joseph Newhouse, "Medical Care Expenditure: A Cross-National Survey," *Journal of Human Resources* 12 (1977): 115–25; and Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost-Sharing in Health Insurance," *New England Journal of Medicine* (December 17, 1981).
4. Kanavos and Mossialos, "The Methodology of International Comparisons."
5. "OECD Health Systems: Facts and Trends 1960–1991," Organization for Economic Cooperation and Development, 1993.
6. Towse and Sussex, "Getting UK Health Care Expenditure Up."
7. Martin Hensher, Nigel Edwards and Rachel Stokes, "The Hospital of the Future: International Trends in the Provision and Utilization of Hospital Care," *British Medical Journal* (September 25, 1999): 845–48.
8. Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different From Other Countries," *Health Affairs* 22, no. 3 (May/June 2003): 97, Exhibit 5.
9. Mark V. Pauly, "U.S. Health Care Costs: The Untold True Story," *Health Affairs* 12, no. 3 (Fall 1993): 152–59; and Kanavos and Mossialos, "The Methodology of International Comparisons."
10. Gerard F. Anderson et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," *Health Affairs* (May/June 2000): 150–57.
11. Gerald F. Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends In Industrialized Countries," *Health Affairs* 8, no. 3 (1999).
12. Uwe Reinhardt, Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs* 21, no. 3, May/June 2002.
13. Gwen Gray, "Access to Medical Care Under Strain: New Pressures in Canada Amend Australia," *Journal of Health Politics, Policy and Law* 23, no. 6 (December 1998): 905–47.
14. Gray, "Access to Medical Care."

15. The number of acute care beds per thousand stood at 3.3 in 1999. See Anderson et al., "It's the Prices, Stupid." Canada's acting director of health insurance said the government was aiming to bring the ration down to two beds per thousand. See Suzanne Rene Possehl, "Northern Plights," *Hospitals & Health Networks* 71, no. 17 (September 5, 1997): 56–60.
16. David Spurgeon, "Canadians Need to Spend C\$5bn More a Year on Health Care," *British Medical Journal* 325, no. 7372 (November 9, 2002).
17. Spurgeon, "Canadians Need to Spend."
18. Jacques Krasny and Ian R. Ferrier, "A Closer Look at Health Care in Canada," *Health Affairs* (Summer 1991): 152–58. For a critique of this approach see Daniel R. Waldo and Sally T. Sonnefeld, "U.S./Canadian Health Spending: Methods and Assumptions," *Health Affairs* (Summer 1991): 159–164.
19. Waldo and Sonnefeld, "U.S./Canadian Health Spending."
20. Don B. Kates, "Guns and Public Health: Epidemic of Violence or Pandemic of Propaganda?" *Tennessee Law Review* 61 (1994): 513–96.
21. Susheela Singh and Jacqueline E. Darroch, "Adolescent Pregnancy and Child-bearing: Levels and Trends in Developing Countries," Alan Guttmacher Institute, *Family Planning Perspectives* 32, no. 1 (January/February 2000).

