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Routing

The Grass Is Not Always Greener *A Look at National Health Care Systems Around the World*

by Michael Tanner

Executive Summary

Critics of the U.S. health care system frequently point to other countries as models for reform. They point out that many countries spend far less on health care than the United States yet seem to enjoy better health outcomes. The United States should follow the lead of those countries, the critics say, and adopt a government-run, national health care system.

However, a closer look shows that nearly all health care systems worldwide are wrestling with problems of rising costs and lack of access to care. There is no single international model for national health care, of course. Countries vary dramatically in the degree of central control, regulation, and cost sharing they impose, and in the role of private insurance. Still, overall trends from national health care systems around the world suggest the following:

- Health insurance does not mean universal access to health care. In practice, many countries promise universal coverage but ration care or have long waiting lists for treatment.
- Rising health care costs are not a uniquely American phenomenon. Although other countries spend considerably less than the United States on health care, both as a per-

centage of GDP and per capita, costs are rising almost everywhere, leading to budget deficits, tax increases, and benefit reductions.

- In countries weighted heavily toward government control, people are most likely to face waiting lists, rationing, restrictions on physician choice, and other obstacles to care.
- Countries with more effective national health care systems are successful to the degree that they incorporate market mechanisms such as competition, cost sharing, market prices, and consumer choice, and eschew centralized government control.

Although no country with a national health care system is contemplating abandoning universal coverage, the broad and growing trend is to move away from centralized government control and to introduce more market-oriented features.

The answer then to America's health care problems lies not in heading down the road to national health care but in learning from the experiences of other countries, which demonstrate the failure of centralized command and control and the benefits of increasing consumer incentives and choice.

Michael Tanner is director of health and welfare studies at the Cato Institute and coauthor of Healthy Competition: What's Holding Back Health Care and How to Free It (second edition, 2007).

This excerpt omits references and several country profiles. For full document, see: <http://www.cato.org/pubs/pas/pa-613.pdf>

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Aside from Switzerland, the Netherlands has perhaps the most market-oriented national health care system in Europe.

ment in the public health sector must be approved at the ministry level. All hospital administrators and other health officials are appointed on the basis of political affiliation with the governing party, often with little regard for relevant training or other qualifications.²⁰⁴

Not surprisingly, Greece has far less modern health care technology than the United States. The United States has more than twice as many MRI units per million people and 20 percent more CT scanners.²⁰⁵ Much of the state-of-the-art equipment that does exist is clustered in the country's small number of private clinics and hospitals. Indeed, the vast majority of high technology biomedical tests are performed by the private sector.²⁰⁶

One study summed up the problems with the Greek health care system this way:

The Greek health system does not yet offer universal coverage and has fragmented funding and delivery. Funding is regressive, with a reliance on informal payments, and there are inequities in access, supply and quality of services. Inefficiencies arise from an over reliance on relatively expensive inputs, as evidenced by the oversupply of specialists and undersupply of nurses. Resource allocation mechanisms are historical and political with no relation to performance or output; therefore providers have little incentive to improve productivity.²⁰⁷

That would appear to be a fairly accurate summary.

Netherlands

Aside from Switzerland, the Netherlands has perhaps the most market-oriented national health care system in Europe. That was the case even before 2006, when a series of reforms introduced even more market mechanisms.

The old pre-2006 Dutch system resembled Germany's. Dutch workers with incomes below €32,600 were required to enroll in one of 30 government-controlled "sickness funds."

Those with higher incomes had the option of enrolling in the funds if they wished, or opting out of the government system and purchasing private insurance. Sickness funds were financed through a payroll tax and a flat-rate, per-capita premium.²⁰⁸

The funds provided a uniform package of benefits including physician and hospital care, specialist care, diagnostic tests, prescription drugs, and dental care for children.²⁰⁹ While consumers could switch funds annually, there was little competition between funds and few consumers actually switched.

The new Dutch system operates on the theory of managed competition like Switzerland (see below). Both the social health insurance program and the alternative private health insurance option were replaced by a requirement that all Dutch citizens purchase a basic health insurance plan from one of 41 private insurance companies. Although a fine may be imposed for failure to comply, there is no comprehensive system for identifying citizens who do not meet the mandate. An estimated 1.5 to 2 percent of the population is currently uninsured.²¹⁰

The required plan, which covers minimum benefits set by the government, includes general practitioner and specialist care, hospital stays, some dental care, prenatal care, some medicines, and travel expenses. In one interesting innovation, most of the required benefits are specified in terms of "functions of care" rather than by provider category. Thus, "rehabilitation care" is required, but no particular type of rehabilitation provider is mandated.²¹¹ This may mean that the benefits package will be less susceptible to manipulation by provider interest groups, but it is much too early to tell.

The Health Ministry sets premiums, which average around €100 per month for an individual. Insurance companies can offer varying deductibles, ranging from €150 to €1,000 per year, allowing for a small level of price competition. Policies can also offer rebates of up to €225 if a policyholder uses no health services in a given year beyond seeing a primary care physician.²¹² About 90 percent of the popula-

tion also buys supplemental insurance covering services over and above the required standard benefits package.²¹³

Employers generally pay half of insurance premiums, with individual workers picking up the other half.²¹⁴ Individual premiums are tax deductible.²¹⁵ Subsidies, or care allowances, that help low- and middle-income workers purchase the basic insurance plan are extensive and reach well into the middle class. Currently, 5 million Dutch citizens qualify for some level of subsidy on a sliding scale based on income.²¹⁶ Those subsidies are financed through a tax on salaried workers. Because of the high levels of subsidy, the Dutch government remains a large source of health spending, one area of significant difference with the Swiss system.²¹⁷

Insurers negotiate quality, quantity, and price of services with providers. Notably, many insurers require providers to document the quality of the care they provide, frequently relying on evidence-based guidelines and performance metrics.²¹⁸

Some insurers provide care directly, using their own staffs and their own facilities, such as primary care centers and pharmacies. Other insurers contract with a network of providers similar to U.S. preferred provider organizations (PPOs). Patients can go out of network but will receive only partial reimbursement. Most insurers require a referral from a primary care provider before a patient can see a specialist.²¹⁹ Pharmaceutical prices are capped nationwide at the average price of medicines in a therapeutic class. Individuals may choose more expensive drugs but must pay the difference out of pocket.²²⁰

The new system has been in place for only two years, which is not enough time to permit a thorough evaluation. However, preliminary indications suggest that it is an improvement over the pre-2006 system.²²¹

Dutch consumers appear to have embraced the reforms. Consumer organizations are participating in negotiations with providers, insurers, and lawmakers. The system is becoming more transparent, with far greater information available regarding both price and quality. Consumers seem willing to make

decisions and change insurers on the basis of price and quality.

Price competition under the new system has increased significantly and at least 20 percent of Dutch consumers have switched insurers.²²² When the system was initiated, the Dutch government predicted premiums would cost €1,106 on average. However, competition has forced the average premium down to €1,028, 097.6 percent below the prediction.²²³ Overall, the new system is estimated to have increased the purchasing power of Dutch households by as much as 1.5 percent.²²⁴ However, not everyone has been a winner. The community rating requirement has resulted in steep increases in premiums for younger workers who were more heavily subsidized under the old system.²²⁵

Under the old system, waiting lists were widespread—for example, more than three months for a hip replacement and two months for a prostatectomy or hysterectomy.²²⁶ One study estimated that at least 100 heart patients died each year while on waiting lists.²²⁷ Early evidence suggests that some improvement has come as a result of the 2006 reforms.²²⁸

Hospitals are beginning to compete by expanding services such as neurosurgery and radiation therapy.²²⁹ Although some experts have expressed concern that smaller hospitals offering these services may not have sufficient utilization rates to ensure quality and efficacy, the expanded availability of services will likely increase access to care and reduce queues.²³⁰

The new system may even be having a positive impact on health care costs. Since the new system took effect, health care costs have been growing at an annual rate of just 3 percent, compared to more than 4.5 percent in the year before the reforms.²³¹

The jury is still out, and the Dutch system still falls well short of a true free market, but the Netherlands appears to have taken a big step in the right direction.

Great Britain

Almost no one disputes that Britain's National Health Service faces severe prob-

As many as 750,000 Britons are currently awaiting admission to NHS hospitals.

the Swiss market, leading to the over provision of care to the healthy and the under provision of care to the sick.²⁸⁰ In addition, the prohibition on risk management discourages the development of new and innovative products. Peter Zweifel of the University of Zurich, a member of the Swiss Competitive Committee which oversees insurance regulation, believes that a return to some degree of risk-rating is essential to the long-term success of the Swiss system.²⁸¹ As Zweifel puts it, “Let competition work its magic. Let those who are bad risks get the message that they need to become better risks, if possible. If not possible, [they would] still get a subsidy which [keeps their costs] down to little more than 8–10 percent of taxable income.”²⁸²

Third, the cartel structure for negotiating reimbursement schedules can create a number of distortions. Effectively monopsony purchasers, the cartels have enormous leverage when it comes to negotiations. Not surprisingly, physicians have tended to set up practice in cantons with the highest levels of reimbursement, leading to shortages in other areas. Reimbursement rates have reportedly created wasteful incentives—for example, hospitals shifting patients from outpatient to inpatient care.²⁸³ And the combination of increased demand and low reimbursement has led to the first signs of queues for the most complex surgeries.²⁸⁴

In addition, the negotiations freeze in place a pricing structure that inhibits the development of innovative approaches that do not tie payments to specific benefits. This includes both managed care approaches and health services integration.²⁸⁵

Finally, Switzerland has some of Europe’s strongest regulation of nonphysician health care professionals.²⁸⁶ As a result, patients are often forced to use more expensive providers where a less expensive professional would do.

All of the above combine to undermine the consumer-driven nature of Switzerland’s health system. Despite these problems, the Swiss system provides a useful lesson for the United States about the value of consumer-directed health care. In particular, we can see

that when the cost of insurance becomes more transparent, consumers shift their purchasing preferences toward true insurance (spreading catastrophic risk), rather than purchasing prepayment for routine, low-cost services. That gives consumers an overall incentive to make cost-versus-value decisions when purchasing health care, resulting in reduced costs while maintaining individual choice and quality care.

Germany

Germany ranked 25th in the WHO ratings.²⁸⁷ Despite that low ranking, however, the country is worth examining because it is frequently cited as a model by advocates of national health care.

National health insurance in Germany is part of a social insurance system that dates back to Bismarck. All German citizens with incomes under €46,300 (roughly \$60,000) are required to enroll in one of approximately 250 statutory “sickness funds.” Those with higher incomes may enroll in the funds if they wish, or may opt out of the government system and purchase private insurance.²⁸⁸ About three-quarters of workers with incomes above the statutory limit choose to remain in the sickness funds, which currently cover approximately 90 percent of the population. Overall, insurance coverage is nearly universal. However, the number of uninsured has been rising, roughly tripling in the last 10 years to 300,000 people.²⁸⁹ About 9 percent of the population purchases supplemental insurance to cover items that are not included in the standard benefits package.²⁹⁰

Sickness funds are financed through a payroll tax split equally between the employer and employee. The size of the tax varies depending on which fund the worker has chosen, but averages around 15 percent of wages.²⁹¹ Sickness funds are supposed to be solvent and self-supporting, but in reality the system ran a €7 billion deficit in 2006.²⁹² The German government has proposed a 1 percent increase in the payroll tax, split evenly between employer and

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employee, starting next year.²⁹³ In addition, general tax revenues finance capital costs for acute care hospitals and many rehabilitative services, especially for retirees.

Benefits are extensive, covering physicians, hospital and chronic care, diagnostic tests, preventive care, prescription drugs, and part of dental care. In addition to the medical benefits, sickness funds provide sick pay to those who cannot work due to illness, ranging from 70 to 90 percent of the patient's last gross salary, for up to 78 weeks.²⁹⁴

The central government and state governments split the regulation of the health care system. The central government establishes the national global budget for health care spending, defines any new medical procedures to be included in benefit packages, and sets reimbursement rates for physicians. Some of this is accomplished through legislation, while the rest is handled through negotiations between the National Association of Sickness Funds and the National Association of Physicians. At the state level, state associations of sickness funds and physicians negotiate overall health budgets, reimbursement contracts for physicians, procedures for monitoring physicians, and reference standards for prescription drugs.²⁹⁵ The bargaining power in these negotiations clearly lies with the sickness funds backed by the government, allowing them to effectively impose fee schedules and other restrictions on providers. The purchasing power of a German physician's wages is now about 20 percent that of a U.S. physician.²⁹⁶ This has led to physician strikes as recently as 2005.²⁹⁷

Although Germany spends less on health care than the United States, both as a percentage of GDP and per capita, expenditures have been rising at an alarming rate in recent years. Friedrich Breyer, an economist from Konstanz University, estimates that health care spending could reach 30 percent of GDP by 2020 unless significant changes are made.²⁹⁸

The German government has responded by beginning to cut back on benefits. In 2004, sickness funds stopped covering eyeglasses, lifestyle medications, and all over-the-counter

drugs. Copayments were imposed for the first time, such that Germans now pay €10 per quarter to see a general practitioner, €10 per day of hospital stay, €10 per prescription, and for certain specialty services.²⁹⁹ The highest copayments are 10 percent for prescription drugs. Overall, Germans pay out of pocket for about 13 percent of total health care spending, only slightly less than Americans.³⁰⁰ Preliminary evidence suggests that the introduction of cost sharing has slightly reduced utilization and spending.³⁰¹

In 2006, Chancellor Angela Merkel proposed a sweeping set of health care reforms that included creating a centralized health fund, shifting financing in part from payroll taxes to general revenues, trimming benefits, imposing greater cost sharing, and making the system more transparent. She was forced to abandon the package in the face of public and political opposition.³⁰²

The degree of health care rationing in Germany is the subject of considerable debate. Unlike many OECD countries, the German government does not compile data on waiting lists.³⁰³ One frequently cited study suggests that Germans are no more likely than Americans to wait more than four weeks to see a specialist.³⁰⁴ The WHO says, "Waiting lists and explicit rationing decisions are virtually unknown."³⁰⁵

However, at least one study concludes that rationing is occurring for the elderly and those with terminal illness, and concludes that "the question remains as to whether lives at advanced ages could be saved if age rationing were discontinued and maximum medical treatment were to be applied to everyone, irrespective of their age."³⁰⁶ In addition, a survey of German hospitals reported that "waiting times were prolonged" due to both a lack of capacity and hospital target budgets that make the treatment of sickness fund patients with serious conditions financially unattractive.³⁰⁷

Also, Germans have less access to modern medical technology than Americans. The United States has four times as many MRI units per million people and twice as many CT scanners.³⁰⁸ The situation would undoubt-

edly be worse without the existence of the small private insurance sector. Although small as a proportion of total health spending, private insurance puts competitive pressure on sickness funds, pushing them to expand their quality and services. At one time, CT scanners were even rarer in the public system, available only under exceptional circumstances and after long waits, yet relatively common in the private sector. Competition forced the public sector to add more CT scanners.³⁰⁹

Some analysts blame price restrictions and reimbursement rates for increasing bureaucratic interference in how German physicians practice medicine. Physicians trying to work within the maze of reimbursement caps and budget restrictions have no financial incentive to provide more than the minimally necessary care. That has led to questions of quality assurance, and the government has responded with ever greater micromanagement of practice standards. The result has been a huge increase in red tape for physicians and a general loss of innovation.³¹⁰

Germans seem aware of the need to reform their health care system. In a 2004 poll, 76 percent of Germans thought health care reform was “urgent,” while an additional 14 percent thought it was “desirable.” However, Germans are split nearly down the middle about what that reform should be. Roughly 47 percent would like to see an increase in private health care spending, whereas 49 percent would not. Similarly, 45 percent of Germans believe that more patient choice would improve health care quality, whereas 50 percent do not. The reluctance to fully embrace market reforms undoubtedly stems from a long-standing German belief in social solidarity. By a margin of 81 to 18 percent, Germans believe that equal access to the same quality of care for everyone is more important than their own access to the best possible care.³¹¹

Costs and demographics will eventually force changes in the German system. However, given the failure of Chancellor

Merkel’s reforms, change is unlikely in the near future.

A Few Thoughts on Canada

Canada is another country that did not make the top 20 health care systems in the WHO rankings (it finished 30th), and few serious advocates of universal health care look to it as a model. As Jonathan Cohn puts it, “Nobody in the United States seriously proposes recreating the British and Canadian system here—in part because, as critics charge . . . they really do have waiting lines.”³¹² However, since the press still frequently cites it as an example, it is worth briefly examining.

Although Canada is frequently referred to as having a “national health system,” the system is actually decentralized with considerable responsibility devolved to Canada’s 10 provinces and 2 territories. It is financed jointly by the provinces and the federal government, similar to the U.S. Medicaid program. In order to qualify for federal funds, each provincial program must meet five criteria: 1) universality—available to all provincial residents on uniform terms and conditions; 2) comprehensiveness—covering all medically necessary hospital and physician services; 3) portability—allowing residents to remain covered when moving from province to province; 4) accessibility—having no financial barriers to access such as deductibles or copayments; and 5) public administration—administered by a nonprofit authority accountable to the provincial government.

Federal financing comes from general tax revenue. The federal government provides a block grant to each province which amounts to around 16 percent of health care spending. However, most funding comes from provincial taxes, primarily personal and corporate income taxes. Some provinces also use funds from other financial sources like sales taxes and lottery proceeds. And some (British Columbia, Alberta, and Ontario) charge premiums, although health services cannot be denied because of inability to pay. The health

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care system is an enormous part of the Canadian welfare state. On the provincial level, the health care system amounts to between one-third and one-half of all social welfare spending.³¹³

Provinces must provide certain benefits, including primary care doctors, specialists, hospitals, and dental surgery. Other benefits, such as routine dental care, physiotherapy, and prescription drugs, are optional. Some provinces offer substantial coverage for these services, some cover them only partially, and some do not cover them at all. Except for emergencies, treatment by specialists or hospital admission requires a referral from a primary care physician.

Provider reimbursement is set by each province, and some provinces restrict overall physician income. In general, however, reimbursement is on a fee-for-service basis. Hospitals are paid a specific pre-set amount to cover all noncapital costs. Capital expenditures must be approved on a case-by-case basis.

An increasing number of Canadians also carry private insurance, most often provided through their employer. Originally this insurance was designed to cover those few services not covered by the national health care system. At one time, all provinces prohibited private insurance from covering any service or procedure provided under the government program. But in 2005, the Canadian Supreme Court struck down Quebec's prohibition on private insurance contracting.³¹⁴ Litigation to permit private contracting is now pending in several other provinces.

In addition to the public hospitals covered by the government, many private clinics now operate, offering specialized services. Although private clinics are legally barred from providing services covered by the Canada Health Act, many do offer such services in a black market. The biggest advantage of private clinics is that they typically offer services with reduced wait times compared to the public health care system. Obtaining an MRI scan in a hospital could require a wait of months, whereas it could be obtained much faster in a private clinic.

Waiting lists are a major problem under the Canadian system. No accurate government data exists, but provincial reports do show at least moderate waiting lists. The best information may come from a survey of Canadian physicians by the Fraser Institute, which suggests that as many as 800,000 Canadians are waiting for treatment at any given time. According to this survey, treatment time from initial referral by a GP through consultation with a specialist, to final treatment, across all specialties and all procedures (emergency, nonurgent, and elective), averaged 17.7 weeks in 2005.³¹⁵ And that doesn't include waiting to see the GP in the first place.

Defenders of national health care have attempted to discount these waiting lists, suggesting that the waits are shorter than commonly portrayed or that most of those on the waiting list are seeking elective surgery. A look at specialties with especially long waits shows that the longest waits are for procedures such as hip or knee replacement and cataract surgery, which could arguably be considered elective. However, fields that could have significant impact on a patient's health, such as neurosurgery, also have significant waiting times.³¹⁶ In such cases, the delays could be life threatening. A study in the *Canadian Medical Association Journal* found that at least 50 patients in Ontario alone have died while on the waiting list for cardiac catheterization.³¹⁷ Data from the Joint Canada-United States Survey of Health (a project of Statistics Canada and the National Center for Health Statistics) revealed that "thirty-three percent of Canadians who say they have an unmet medical need reported being in pain that limits their daily activities."³¹⁸ In a 2005 decision striking down part of Quebec's universal care law, Canadian Supreme Court Chief Justice Beverly McLachlin wrote that it was undisputed that many Canadians waiting for treatment suffer chronic pain and that "patients die while on the waiting list."³¹⁹

Clearly there is limited access to modern medical technology in Canada. The United States has five times as many MRI units per million people and three times as many CT

scanners.³²⁰ Indeed, there are more CT scanners in the city of Seattle than in the entire province of British Columbia.³²¹

Physicians are also in short supply. Canada has roughly 2.1 practicing physicians per 1,000 people, far less than the OECD average. Worse, the number of physicians per 1,000 people has not grown at all since 1990. And while the number of nurses per 1,000 people remains near the OECD average, that number has been declining since 1990.³²²

In addition, although national health care systems are frequently touted as doing a better job of providing preventive care, U.S. patients are actually more likely than Canadians to receive preventive care for chronic or serious health conditions. In particular, Americans are more likely to get screened for common cancers, including cancers of the breast, cervix, prostate, and colon.³²³

Canada has been relatively effective at controlling spending. The country spends about 9 percent of GDP on health care, a percentage that has risen only slightly over the last decade. Relative to average OECD expenditures, Canadian health expenditures have declined by 4 percent since 1997.³²⁴ That cost control, however, has clearly come at the expense of access to care.

Canadians' dissatisfaction with the problems in their system has been growing for some time. One survey showed that some 59 percent of Canadians believe that their system requires "fundamental changes," and another 18 percent believe the system needs to be scrapped and totally rebuilt.³²⁵ Still, Canadians are reluctant to embrace market reforms that are associated with the U.S. health care system—a system that Canadians disdainfully reject. As one observer put it:

Anxiety about Americanization and the constantly reinforced strain of national pride in Canadian health care coexist[s] with considerable uneasiness about the actual state of that care. It is as if, when Canadians look south across the border they swell with pride, but when they look within they shrink back, seeing

many problems and feeling uncertainty about the future.

Canadians may jealously guard their system and resist "Americanizing" it, but even advocates of universal health care are coming to recognize that it does not provide a valid model for U.S. health care reform.

Conclusion

The U.S. health care system clearly has problems. Costs are rising and are distributed in a way that makes it difficult for some people to afford the care they want or need. Moreover, although the number of uninsured Americans is often exaggerated, far too many Americans go without health insurance. And while the U.S. provides the world's highest quality health care, that quality is uneven, and too often Americans don't receive the standard of care that they should. But the experiences of other countries with national health care systems show that the answer to these problems lies with more pro-market reform, not more government control.

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 the terms "national health care" or "universal coverage" can be misleading—as if one collective model shows 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 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 sys-

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tems around employment, while others have completely divorced work from insurance. Some require consumers to share a significant portion of health care costs through either high deductibles or high copayments. Others subsidize virtually 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.

In fact, about the only system one cannot find is the type of system described by Michael Moore, Physicians for a National Health Program, and other national health care advocates—a system that provides unlimited care with no premiums, deductibles, or copayments, from the physician of one’s choice. For example, in *SiCKO*, Moore lambastes American insurers for denying coverage for rare and experimental treatments.³²⁷ And, during the New Hampshire primary, John Edwards ran television advertisements highlighting the tragic death of a teenage girl whose liver transplant was rejected by her father’s insurer.³²⁸ These stories play effectively on the emotions and drive a desire for change. Yet one searches in vain for a national health care system anywhere that regularly pays for experimental and untested procedures.

Likewise, advocates for national health care tap into the anger many patients (and doctors) feel for the gatekeepers and prior approval required under American managed care. But many if not most foreign systems require similar gatekeepers. Moreover, copayments and other forms of cost sharing are commonplace.

It is also important to realize that no country’s system would translate directly to the United States. 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 those of the United States. 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.³²⁹ American attitudes are quite different. As pollster Bill McInturff notes, “Never, in my years 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.’”³³⁰

Even so, some important lessons can be drawn from the experiences 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. Although 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. Other countries spend considerably less than the United States on health care, both as a percentage of GDP and per capita, often because they begin with a lower base of expenditures. Nonetheless, 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 health spending in the countries discussed in this study was 5.55 percent, only slightly lower than the United States’ 6.21 percent.³³¹ As the *Wall Street Journal* notes, “Europeans . . . face steeper medical bills in the future in their cash-strapped governments.”³³² 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.

- Dissatisfaction and discontent with a nation's health care system seems to be universal. Undoubtedly, Americans are unhappy with the current state of our health care system. According to the most recent Commonwealth Fund survey, an astounding 82 percent of Americans believe that our system either requires fundamental change or needs to be completely rebuilt.³³³ Not surprisingly, polls suggest health care reform is the top domestic policy issue in the upcoming presidential election.³³⁴ Yet, that same Commonwealth Fund study shows large majorities in every country, ranging from 58 percent in the Netherlands to 78 percent in Germany calling for fundamental reform or complete rebuilding of their health care systems.³³⁵ Earlier polling by the Stockholm Network found similar levels of unhappiness.³³⁶ Not as bad as in the United States, perhaps, but certainly no ringing endorsement of their systems.
- Although 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 introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organization put it, "The presumption of public primacy is being reassessed."³³⁷ Alan Jacobs of Harvard points out that despite significant differences in goals, content, and strategies, European nations are general-

ly converging toward market practices in health care.³³⁸ Thus, even as Americans debate adopting a government-run system, countries with those systems are debating how to make their systems look more like that of the United States.

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 as disastrous as U.S. critics sometimes portray. Some national health care systems do *some* things well.

Yet, those systems do have 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 intractable 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, 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."³³⁹

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. Some evidence shows a growing shift from public to private provision of health care.³⁴⁰ If the trend in the United States over the last several years has been toward a more European-style system, the trend in Europe is toward a system that looks more like America's.

Therefore, if U.S. policymakers can take one

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lesson 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 United States 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.

Notes

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10. Jagadeesh Gokhale, "Medicaid's Soaring Costs: Time to Step on the Brakes," Cato Institute Policy Analysis no. 597, July 19, 2007.
11. Carmen DeNavas-Walt et al., "Income, Poverty and Health Insurance in the United States: 2005," *Current Population Reports* (Washington: U.S. Census Bureau, 2006). This number should be approached with a great deal of caution, however. A study for the Department of Health and Human Services suggests that the Current Population Survey "appears to overstate the uninsured substantially compared to other surveys." Cathy Callahan and James Mays, "Working Paper: Estimating the Number of Individuals in the United States without Health Insurance," Actuarial Research Service, prepared for the Department of Health and Human Services (Washington: U.S. Department of Health and Human Services, 2005), p. 22. Other studies put the actual number of uninsured at 21-31 million. Congressional Budget Office, "How Many People Lack Health Insurance and for How Long?" (Washington: Congressional Budget Office, 2003). Moreover, all those estimates include people who could obtain coverage. For example, as many as one-third of Americans without health insurance are eligible for existing government programs such as Medicaid or the State Children's Health Insurance Program but have failed to sign up for the program. BlueCross BlueShield Association, "The Uninsured in America," January 2005, www.coverageforall.org/pdf/BC-BS_Uninsured-America.pdf. Roughly another third live in households with annual incomes above \$50,000, suggesting that many could reasonably afford to purchase insurance if they chose to do so. Devon Herrick, "Crisis of the Uninsured: 2007," National Center for Policy Analysis Brief Analysis no. 595, September 28, 2007.
12. "Overview of the Uninsured in the United States: An Analysis of the 2005 Current Population Survey" (Washington: U.S. Department of Health and Human Services, 2005).
13. This is not to say that *universal* coverage should be the goal of health care reform, and certainly not the primary goal. Universal insurance coverage does not necessarily translate into access to care. And, while some evidence indicates that uninsured Americans have somewhat worse health outcomes than insured Americans, the evidence of a direct link between health insurance and health is weak. Nor is expanding insurance