Chapter 8
Health Care

Draft 2.0 February 2008

There is perhaps no domain of economic activity that has generated more controversy in the United States than health care. In the advanced capitalist world, the United States is the only country within which the market plays a substantial role in the delivery of health care services; all other countries have one form or another of universal, publicly supported health care. In the United States there are many people who believe that private health care inherently offers people more choice and higher quality than publicly provided health care, and that market competition is the best way to control costs. Others argue that this is an illusion, that the peculiar character of health care as a service means that market competition will have all sorts of negative effects and that only a more publicly organized system of care will provide high quality care for all.

This chapter will explore these issues. We will begin in the first section by discussion the special qualities of health care, why this is so different from most other things produced for a market. We will then describe the character of the system of health care in the United States at the beginning of the 21st century. This will be followed by alternative ways of organizing healthcare delivery, focusing one two examples: the Veterans Administration in the US (direct government provision) and the Canadian health care system (universal government provided insurance). The chapter will conclude with a discussion of why it has proven so difficult to transform the American system.

I. THE SPECIFICITY OF THE MARKET IN HEALTH CARE

The production and distribution of medical services is a very complex social phenomenon, very different from almost anything else produced for a market. Of course, many goods and services have distinctive qualities, but generally these do not call into question the very possibility of delivering the service in a satisfactory manner through market mechanisms. In the case of health care, these properties pose acute problems for a market economy. We will focus briefly on six issues.

1. *Extraordinary value of the service*.

People in general value their health very highly, especially when there are life-threatening health prblems. When people think about choices among other forms of consumption they generally find it fairly easy to figure out the trade-offs: If I buy this more expensive car how will this affect my budget for new clothing or vacations? In the case of health, people are willing to pay a great deal for cures. If the price goes up and a person can pay for it, they will do so. This is especially the case when their lives or the lives of people they love are at stake: how much income would you give up to save your life or the life of your child? It is thus not surprising that in the United States in medical expenses are the leading cause of consumer bankruptcy.

2. *Ethical issues in distribution of health care.*

Almost everyone believes that people should not be denied basic medical care because they cannot afford it. Virtually everyone feels that this should be the case for children, since they are not responsible for their poverty. Should children of rich people have access to higher quality care, with better doctors and more comprehensive, advanced treatments then poor children? Should a poor child have to wait in a crowded hospital emergency while a rich child goes to a pleasant urgent care facility? Most people would say that there is something unfair in such situations, even if they are reluctant to do anything about. Most people also feel that when it is necessary for certain kinds of treatments – like heart transplants – to be rationed, they should not be rationed by price and ability to pay. Should hearts and kidneys be auctioned off to the highest bidder? Most people recoil at such a market solution to the problem of distributing life-saving organs and believe instead that these should be distributed on the basis of medical need and prospects for benefiting from the treatment. **[Get opinion poll data on attitudes towards provision of health care]**

When it comes to the distribution of health care services to adults, there is less universal agreement among Americans that healthcare is a basic "human right" and that inequalities in access to healthcare are unfair**.[opinion poll data?]** If some adults go bankrupt due to healthcare costs, then this may be regrettable, but – libertarian defenders of markets would say – it is not the responsibility of the state to cover these costs. Still, most people feel that at least basic health care (even if not all treatments), should be accessible to everyone. Healthcare goes along with food and shelter as consumption goods that are close to a "human right" and thus there is a general consensus for having some mechanism for paying for medical care for people who cannot afford it. This, of course, leaves open the best way of accomplishing this. There are many alternatives: charity from doctors or the public; government direct provision for people below a certain income level in the forms of hospitals and clinics for the poor; government direct provision of healthcare for everyone; government insurance for which only the poor are eligible; universal government insurance for everyone. The fact is that health care has to be rationed one way or another, and the ethical problem is how this should be done -- by ability to pay or ability to wait.

Another issue in the ethical distribution of healthcare concerns the priorities for research on new medications and treatments for diseases. From an ethical point of view, the amount of research effort and funds devoted to any given health problem should depend in significant ways on the seriousness of the disease and the number of people whose lives would be helped by prevention and treatment. In a market-based system, however, research and development will be directed towards the profitability of the treatment once developed, and this depends to a significant sense of the wealth of the people who get the disease. The result is that far more research goes into diseases and health conditions of people in rich countries than in poor countries. The most notorious example is the low level of research on malaria which kills tens of millions of people a year compared to research on heart disease. **[get data on this diseases of the rich vs poor problem – research spending on different conditions]**

3. *Information costs*

Most consumers of health care find it extremely costly, if not impossible, to acquire the necessary information to make informed decisions as consumers. How do you really get high quality information on the relative competence of different doctors or clinics or hospitals? There are public ratings of hospitals, but these are very hard to interpret and often quite misleading. A given doctor may exude self-confidence with a warm and engaging personal style, and yet be much less competent than a much less personally appealing doctor. How can most people really figure out who is better? And what about alternative treatments? To be sure, there is lots of information on the web about alternative treatments for any given disease, but there is also lots of bad and misleading information. How can an ordinary person sort this all out? And think how much harder it is to sort out good from bad information in the context of the worry and anxiety that accompanies a serious illness. For all of these reasons people almost always rely on experts, especially on their doctors, to give them information about their health conditions and what to do about them. And while it is desirable for patients to be active participants in making choices about their healthcare and to learn about illnesses and treatments, realistically for most people this will play a secondary role to listening to the advice of their physicians.

There are, of course, information costs to really learning about the quality of other goods and services that are important to people. There is a notorious information problem of buying used cars in which the salesman says that they were only driven on weekends by little old ladies. It is difficult to get reliable information on financial advisors, as reflected in the extraordinary scandal involving Bernie Madoff's ponzi scheme. It is in the nature of markets that actors in exchanges have incentives to hide information when this is to their advantage. But the information problems people face in making choices about health care are particularly salient because the stakes are so high. This is why everywhere, even in the market-dominated healthcare system of the United States, health care services are heavily regulated.

4. *The market for Health vs the market for Treatment*

What consumers want is *health* not the consumption of medical treatments. From the consumers' point of view, prevention is much more important that treatment, but from the point of view of profit-maximizing producers of healthcare, treatment is much more lucrative than prevention. The folk saying is "an once of prevention is worth a pound of cure", but if you are selling things you would rather have people buy a pound of cure than an ounce of prevention. This means that in a market-oriented system dominated by profit-maximizing investors, there will be a significant underproduction of preventive measures and a strong emphasis on expanding the market for expensive treatments.

A good example of this mismatch between the priorities of consumers (health) and the priorities of sellers (treatment) was the crisis in availability of flu vaccines in 2007. Flu shots are an example of preventive medicine: you take a shot to prevent an illness, not to treat an illness. Drug manufacturers do not make much money off of the flu vaccine, so only a few facilities are devoted to producing it. When, in 2007, one of these facilities had to be shut down because of contamination, the result was a tremendous world-wide shortage in flu vaccine. More generally, profit-maximizing firms are unlikely to devote a lot of resources to disseminating health-

promoting knowledge and encouraging healthy lifestyles, for less money is to be made in these domains than in the treatment of illness.

5. Supply creates demand in healthcare

In most markets, the consumer's demand for a good or service is what generates the supply: producers see what people want and then increase production (supply) to satisfy these desires (demands). In healthcare services the causal relation between supply and demand often works in the opposite direction: there is a tendency for the existence of a medical technology to generate a demand for its use in medicine. For example, when a group of doctors or a hospital purchase an expensive technology such as a CAT-Scan, then they need to order treatments of patients in order to pay for the investment. This generates a strong pressure to increase the use of the technology. This does not mean, it should be said, that the invention and diffusion of CAT-Scan machines does not constitute an advance in medical treatment. But when the purchase and use of such technologies is governed by market principles, in the aggregate there will be a tendency for unnecessary treatments and tests to occur because of the incentive in using them.

6. *Competition between providers generates over-investment.*

In a competitive market for healthcare services, every hospital wants to have the latest, most advanced technologies since this will improve their ability to recruit patients. This means, for example, that every hospital wants to have a CAT-Scan or the facilities needed for open-heart surgery. Instead of figuring out the optimal level of investment in these advanced, expensive technologies relative to other kinds of medical facilities for a particular geographical region, all of the hospitals acquire the expensive technologies in their competition for patients. Instead of competition lowering costs and generating efficiency, it raises costs by generating massive duplication and waste.

Taken together, these six factors mean that the delivery of healthcare services is very different from the market for shoes or cars or entertainment. Different countries have responded to this set of issues in different ways, but among the family of countries with developed economies, only the United States relies significantly on market mechanisms in the healthcare sector. In the next section we will see exactly how this works.

II. THE SYSTEM IN THE UNITED STATES

The Healthcare sector is one of the most complex economic sectors in the United States. Even though in the United States the market plays a much bigger role in the delivery of healthcare than in any other economically developed country, it would be a mistake to think of the American healthcare system as a free market system. Rather, the US system should be regarded as a kind of incoherent patchwork of different ways of organizing healthcare services that has developed in a haphazard way over many decades in which the state is heavily involved in healthcare along with nonprofit organizations, groups of doctors and capitalist firms operating within markets. In what follows we will lay out the basic components of this system and some of its consequences.

How healthcare is provided

In describing how healthcare is provided a distinction needs to be made between the *organizational form through which the service is produced* and the mechanism through which *people gain access to the service.* The main organizational forms in the United States include private doctor's offices organized as individual practices or group practice; nonprofit clinics and hospitals; for-profit hospitals run by capitalist corporations; Health Maintenance Organizations (HMOs), which include both primary care physicians and hospitals; and government-run clinics and hospitals, organized by cities, counties, states and the federal government. Access to these services is controlled through a variety of different processes involving private payment, various kinds of insurance, and government rules of personal eligibility:

1. *Direct private payment for medical services.* There was a time when the main way people got access to medical services was simply to pay for it out of pocket on a fee-for-service basis. This is the purest market-based form of delivery of health services: the service is offered on a market and when you need it, you buy it. Because in the case of serious illness these expenses can far exceed the ability to pay of everyone except the very wealthy, most people prefer to have some kind of health insurance rather than to rely on good luck and their ability to pay.

2. *Employer-provided insurance*. Sometimes employer-provided insurance takes the form of a general health insurance policy which enables the insured person to see any doctor or go to any hospital, but more often employer-provided insurance is connected to what are called Health Maintenance Organizations (HMOs). These are usually large organizations that include hospitals, clinics, doctors, and a range of other health related services. When an employer provides HMO-insurance, the employee has access to the health care providers within the HMO but cannot use the insurance to pay for health care by other doctors or hospitals without the permission of the HMO. Generally this kind of insurance comes with various forms of "co-payment" in which the insured person pays a relatively small out-of-pocket fee for a given service. Roughly X% of the population is covered by employer-provided insurance.

3. *Individually-purchased health insurance*. Small employers rarely offer health insurance as a fringe benefit, and increasingly larger employers are not offering this benefit. In many firms, part time workers are not eligible for health insurance. Self-employed people and unemployed people also do not have access to employer insurance. In all of these cases, in order to get health insurance, people have to turn to the private health insurance market. This can be very expensive, generally in the $5,000-10,000 range for a single person, and often with very high co-payments and large deductibles. In many cases it is simply impossible to buy private insurance: insurance companies have the right to refuse to insure someone on the basis of "pre-existing medical conditions." Often they do this even if the condition is relatively minor.

4. *Government-provided insurance.* There are two principal government insurance programs paid for through taxation in the United States: Medicare provides fairly comprehensive health insurance for the elderly, and Medicaid provides health insurance for

the very poor. Recently government provided health insurance for children has been extended to families whose household income is above the poverty line. Because Medicaid is administered by the States, the quality of the service and the level of income that is used to qualify vary enormously across the states. **In Mississippi Medicaid is only available if you earn below XXXX whereas in New York the level is $YYYY [get figures for the states that are at the extremes of the thresholds.]**

5. *Direct Government-provided healthcare.* Access to Government-run healthcare services is generally governed by strong eligibility criteria. The most important of these services are linked to the military: military hospitals for active duty soldiers, and the Veterans Administration hospital system for military veterans. The VA hospitals constitute a form of socialized medicine: the state does not simply provide insurance for people to go to private doctors; it directly organizes the service itself. As we will see at the end of the chapter, this is accomplished in a relatively cost-effective way without sacrificing quality.

6. *Pro-bono services provided by doctors and hospitals.* The final way that people get access to healthcare services is through the charity of doctors and hospitals providing free healthcare to people who do not have insurance and cannot afford to pay. In principle, no one is refused admission to an emergency room or denied medical care for life threatening conditions. Care is supposed to be provided without first screening patients for their ability to pay. The result is that in many instances the costs of this care has to be absorbed by hospitals and doctors, which ultimately means higher insurance premiums and out-of-pocket expenses for everyone else.

Figure 8.X [Figure with distribution of healthcare spending into the above categories – or something close to that] shows the basic distribution of health care spending across these various ways of paying for health care. As is clear from the figure, the government already plays a quite substantial role in funding healthcare in the United States, but it does so in a way that leaves plenty of space for market forces. This, as we will see below, has substantial consequences on healthcare costs, access to healthcare, and health itself.

Arguments in defense of this system

In every other developed capitalist economy in the world, people have decided that it is bad idea to allow for a large role for markets in determining access to medical care. Every other country has some kind of universal system organized by the government and paid by taxes.

Two kinds of arguments in favor of competitive markets in healthcare have dominated the discussion in the US. The first is simply the general pro-market argument applied to healthcare: the market allows freedom and choice; if the government provides universal healthcare insurance it will ration healthcare services resulting in long waiting times for doctor's appointments and necessary surgery, and reduce the ability of individuals to choose their own doctors and treatments. Bureaucrats in Washington, conservatives insist, will make these decisions for you.

The second argument involves a special kind of issue called the "moral hazard problem." A moral hazard is a situation in which there is no incentive to worry about costs since someone else is paying the bill. Insurance sometimes creates a moral hazard by enabling people to engage in

riskier behavior. The moral hazard in Healthcare occurs because, it is argued, if you have insurance, you will tend to overuse medical services since you do not have to pay each time you go to the doctor. In private insurance this problem is mitigated because the insurance companies will be worried about such overuse and will impose co-payments and other controls to counter it. But in government insurance, these incentives will disappear. If you have medical care paid for by the government, therefore, this will lead to a massive over-use of the medical care system since no one will have an incentive to make responsible choices: people will consume more medical care than they need, doctors will order more tests than are necessary. Because both doctors and patients face no direct costs for doing so, they will overspend, imposing costs on others – taxpayers in this case – because the government assumes all of the risks for paying for health care.

The proposed solution to this moral hazard problem in health care is a good dose of market competition with individuals paying more of medical costs and healthcare providers competing with each other to reduce costs. *Markets impose responsible behavior on people by making them bear the costs of their choices.* This should lower usage of medical services which in turn will result in lower spending on medical care. This is why the main proposal for health-care reform by strong pro-market conservatives is the idea of health savings accounts: people can put money into these accounts which will be exempt from taxes and then use these accounts to pay for medical bills. This solution implies that in a sense we have too much insurance now rather than too little.

Both of these arguments in favor of market competition in health care are flawed. The first argument incorrectly assumes that a system of government payment for healthcare requires strong government control over the autonomy of doctors and the choices of patients. As we will see in the discussion of the Canadian system at the end of this chapter, this does not have to be the case: the Government can pay the bills and negotiate prices and yet allow as much freedom of choice as in a market. Furthermore, in the United States healthcare system as currently organized, choice is heavily circumscribed for most people: employer insurances often requires employees to sign up with a specific HMO, and within that HMO they are assigned doctors and cannot go outside of the HMO without permission. People often have to wait a very long time for appointments to see specialists. Most fundamentally, the existence of a market does not guarantee freedom of choice and short waiting times unless you have the resources required of that market.

The second argument – that universal insurance guaranteed by the government would generate massive moral hazard problems – is greatly exaggerated as an issue in medical care. The problem in healthcare systems is that people tend not to go to the doctor until they are very sick, thus ultimately costing the system more, rather than going to the doctor too frequently. Most people do not want to "overconsume" medical services regardless of who is paying. When they face high deductibles, co-payments and other direct expenses that reduce the "moral hazard" they may indeed wait longer to see a doctor, but in the end this often makes their health condition worse and more expensive to treat.

Still, there is a moral hazard problem in healthcare, for example of doctors ordering unnecessary tests since an insured patient will not directly have to pay for this. However, it is

probably impossible to eliminate such problems so long as insurance plays an important role in healthcare, which will certainly be the case regardless of whether the insurance is provided by the government or by private insurance companies.

Consequences of the healthcare system

The fact the United States has such a complex, hybrid structure of healthcare services is not in and of itself a problem. Indeed, one might think that each of the elements in this system might counteract the flaws in the others. A pure state-based system might be plagued by government inefficiencies and bureaucratic rigidity, which market competition might alleviate. A pure market-based system might generate unacceptable gaps and inequalities in access to healthcare, which the government system could alleviate. So, it *could* be the case that the complexity of the multi-pronged approach to providing healthcare in the US makes it better than other less pluralistic approaches.

This does not seem to be the case. For starters, Americans spend the most on healthcare of any country in the world, both in absolute dollars and as a percentage of national income. **In 200X Americans spent well over $3000/capita a year on healthcare, which comes to over 16% of the gross national product. Compare this with other economically advanced countries (see Figure 8.X): Our closest rivals are France and Canada, which spend about 10% of their GNP on healthcare; in Sweden the figure is only 8.6%, while in Japan only 7.2%. [get updated figures].**

Proponents of market competition in health care argue that competition should force healthcare providers to reduce costs to attract customers, but this simply has not happened. This is actually not so surprising, for a variety of reasons. First, as already noted, because of the peculiar character of healthcare, competition can raise costs as hospitals compete with each other by buying expensive equipment which they then want to use to recover costs. Both the overuse of expensive technologies and the duplication of facilities raise the aggregate cost of healthcare services. Contrary to what defenders of the free market argue, for-profit hospitals are *not* more efficient than nonprofit hospitals. They may be more profitable, but this is mainly because they are more selective in who they treat, since they refuse to treat uninsured poor people. Second, the complexity of the system, particularly in terms of the enormous variety of insurance plans, each with specific rules and procedures, increases administrative and paperwork costs of medicine tremendously. It has been estimated that **administrative costs in the United States count for roughly 12% of the total cost of medical care covered by insurance, in contrast 2-6% of the cost of government provided health care in the US, and only about 1% of health care costs in the government financed system in Canada. (see figure 8.X – 2003 data available in powerpoint).** Third, the highly fragmented system of financing health care in the United States make it very difficult for providers to negotiate lower prices for medicines with the large pharmaceutical companies. When finally the U.S. Congress agreed to include prescription drugs in Medicare coverage for the elderly, they explicitly blocked the government from negotiating lower prices. The result is that drug costs in the US are significantly higher than in other countries where government organized health care is able to control such costs.

Now it is not completely obvious that spending X% of American national income on healthcare is too much. After all, the United States is a very rich country and people certainly value health very highly, so perhaps what the comparison with other countries in Figure 8.X reveals is that other countries are spending too little, not that the U.S. is spending too much. A key issue, then, is what do Americans get from this very high level of spending?

Unfortunately, in many respects the American healthcare system does not compare favorably with other countries in terms of what it actually delivers. First, consider access. Every other developed capitalist country guarantees universal healthcare coverage to all of its citizens. We are the only country without some form of universal healthcare. **In 2008 50 million US citizens** had no insurance at all and had to rely on personal funds or charity for their healthcare. Access to health care was especially problematic for the near-poor, people who were not sufficiently poor to qualify for Medicaid, but even Medicaid only covered about 40% of the poor in 200X, down from 65% in mid-1970s, because of various kinds of restrictions. **[See Figure 8.X for insurance coverage by economic status. The figure I have is for 2001 – try to get this for 2007 or 2008]**

It is not surprising that so many people lack insurance in a system in which public insurance is only available for the elderly and the very poor and private insurance companies are free to deny people coverage. Private insurance companies, after all, are profit-maximizing businesses. If you are in the business of insuring people against medical risks, your ideal customer is a healthy young person who is unlikely to use the insurance. Above all you would like to avoid insuring anyone with a known, serious, health problem. What this means is that people currently on employer-provided health insurance who develop cancer or have a heart attack or some other serious illness and then lose their job, generally find it impossible to buy insurance on the private market.

What about the quality of American medical care and, above all, its impact on actual health outcomes? There may be problems with health insurance coverage, but the quality of care could still be so good as to more than compensate for the problems in insurance. And, after all, most of the uninsured do get some kind of healthcare when they have an emergency. So, perhaps in spite of the problems of access and high aggregate cost, the quality of health care in the United States could be relatively good compared to other comparable countries.

The first thing to say here is that the best hospitals and doctors in the United States do indeed provide excellent medical care. Indeed, this is one of the reasons why wealthy people from around the world often come to the leading American hospitals for treatment. Such facilities are undoubtedly among the best in the world with cutting edge technologies and highly trained doctors. Nevertheless, in evaluating the system as a whole the central issue is not the quality of the very best facilities, but the extent to which the system delivers adequate medical care for the society as a whole. While it is a complex matter to link the characteristics of the healthcare system to health outcomes since so many other things also affect health, nevertheless the available data suggest that health outcomes in the United States also do not compare favorably with most other countries. Table 1 compares the United States with other comparable countries on two important indicators of health outcomes: life expectancy and infant mortality. On both of these measures, the United States fares worse than other wealthy countries. **[Previously I got data for this from the *OECD Health Data, 2004,* publication – need more recent data].** In

the case of infant mortality for black children in inner cities, the rates in the United States are sometimes even higher than in many third world countries. **[The statement is often made – we need a graph showing it…]**

One final consequence of the strong presence of markets within the American healthcare system is the preoccupation with medical treatment of disease rather than public health and preventive medicine. Three examples illustrate this problem.

- The United States is the only country that does not provide universal, free vaccinations of children. When an attempt was made to provide federal funding for universal **vaccination of children in 200X**, this was seen as very controversial and ultimately failed to pass congress.
- The United States does not provide free prenatal care for pregnant women in spite of the fact that research indicates that $1 of prenatal care ultimately reduces medical costs for post-natal care by $3. A market-logic of health care provision does not encourage prenatal care since, when people have to pay for their own medical care (either outright or through co-payments), most people only go to the doctor when something hurts or seems to be going wrong. The only way to make pre-natal care widely used is for it to be free, and this means that it must be paid by taxpayers.
- In the United States there are relatively weak occupational safety and health (OSH) regulations and enforcement. OSH may not at first glance seem like an issue in the healthcare system, but in fact it is a critical dimension of public health, since accidents and illnesses generated within work are a major form preventable health problems. From an economic point of view, accidents and work-related illnesses are examples of a negative externality for a capitalist firm. It costs employers something to protect the health of their employees, and if they can displace this cost onto their employees, then this will lower their costs of production and raise profits. Dangerous and unhealthy practices within work can only be blocked by systematic state regulation. In the United States, because of the strong belief in the virtue of self-regulating markets and the general erosion of government regulation OSH regulations are weak, with standards that are generally much lower than other comparable countries, and with weak enforcement of the regulations that do exist. Since the early 1980s, health and safety inspections have declined steadily to the point that by the 2000s there were only enough inspectors to visit every workplace once in 50 years. **[some comparative data on industrial accidents could be useful]**

As a result of these various problems – high cost of medical care, inequalities in access, insecurity of insurance coverage, weak preventative care – there is a great deal of dissatisfaction in the United States about the health care system among both consumers and doctors. Very high levels of dissatisfaction with the system: among doctors, among consumers. While it is difficult to compare across countries the level of satisfaction of people with their institutions, since satisfaction and dissatisfaction depend on people's expectations, nevertheless, it seems that the level of satisfaction with their healthcare system is much lower in the United States than in other

in other countries. As Figure 8.X indicates, out of ten developed countries, satisfaction with medical system is lowest in the US, highest in Canada.

It is one thing for people to feel dissatisfied with the status quo and another thing to propose a workable alternative that will actually improve the overall performance of the system. In the next section we will examine two models for a more efficient and equitable healthcare system: the United States Veterans Administration hospitals and the Canadian Single-Payer healthcare system.

III. ALTERNATIVES

U.S. Veterans Administration hospital and health system

The Veteran's Health Administration (VHA) is a system of direct healthcare provided to U.S. military veterans established after WWII. These are hospitals run by the federal government in which the doctors are simply employees of the government. It is not fee-for-service medicine paid for by private insurance. It is a direct government system. As recently as the 1980s, the VHA health system was a mess: the hospitals were deteriorating, morale was low, efficiency was down, quality was uneven. Given the general turn to privatization, there was a lot of pressure to scrap the VHA altogether and give veterans vouchers which they could use to buy health care of the free market. This is more or less what Medicare is – the system for the elderly. The elderly select their health care on the open market and pay for it through the medicare public insurance system. The dismantling of government run hospitals for Veterans would have seemed the natural thing to do.

Instead, what happened was a major internal reorganization of the VHA – with new technology, new procedures for quality control, new systems of cost containment. How do things look today? In 2003, when the prestigious *New England Journal of Medicine* published a study that compared veterans health facilities on 11 measures of quality with fee-for-service Medicare. On all 11 measures, the quality of care in veterans facilities proved to be "significantly better." The National Committee for Quality Assurance – an organization that provides information of health care quality for business – today ranks health-care plans on 17 different performance measures. These include how well the plans manage high blood pressure or how precisely they adhere to standard protocols of evidence-based medicine such as prescribing beta blockers for patients recovering from a heart attack. Winning NCQA's seal of approval is the gold standard in the health-care industry. The winner in 2005 was not Johns Hopkins or the Mayo Clinic or Massachusetts General. In every single category, the VHA system outperforms the highest rated non-VHA hospitals.

Contrary to popular myths, when it comes to health care, it is a government bureaucracy that is setting the standard for maintaining best practices while reducing costs, and it is the private sector that is lagging in quality. There are many reasons for this. First, the scale of the VHA generates large economies of scale in purchasing all sorts of inputs into production. This is especially important in their purchase of drugs at a reduced cost by negotiating significant discounts from large pharmaceutical companies. Second, the VHA has much lower administrative overhead costs than any other health system in the United States. This is also, partially, because of economies of scale – one system of paperwork for a very large organization.

But it is also because the VHA does not have to deal with a wide variety of different insurance programs. Third, in the VHA there are very strong incentives for preventive medicine because of the life-time link between the VHA and the patient and also an ease in medical record keeping and health monitoring because of this life-time connection. Private health companies do not have incentives for doing this. Here is an example from a report by Philippe Longman: "Suppose a private managed-care plan follows the VHA example and invests in a computer program to identify diabetics and keep track of whether they are getting appropriate follow-up care. The costs are all upfront, but the benefits may take 20 years to materialize. And by then, unlike in the VHA system, the patient will likely have moved on to some new health-care plan. As the chief financial officer of one health plan told Casalino: "Why should I spend our money to save money for our competitors?" More generally Longman writes, "investing in any technology that ultimately serves to reduce hospital admissions, like an electronic medical record system that enables more effective disease management and reduces medical errors, is likely to take money straight from the bottom line."

The Canadian Healthcare System:

Until the early 1970s, the Canadian healthcare system was very much like that in the United States. Most healthcare was provided on a fee-for-service basis paid for by various forms of private insurance, often connected to employment. There was no national program and no universal guarantee of healthcare. In 1971 there was the Enactment of the Canadian National Health Insurance System, now commonly referred to as a "single-payer" system.

The system involves a close working partnership between the Canadian Federal Government and the Provincial Governments. The plans are actually run at the Provincial level with substantial subsidies from the Federal Government. The Federal government provides grants covering about 40% of total costs to Provinces on condition that they have a healthcare program which satisfies the following core conditions:

- It is universal, available to all citizens.
- It is comprehensive, covering all necessary medical services.
- It is portable in the sense that it recognizes the healthcare systems of other provinces and will provide care to any Canadian citizen in the province.[check the details of this provision: does this mean that the Ottawa program pays for a Quebecois in Ottawa, or that it will pay for an Ottawa citizen who gets treatment in Quebec?]
- It is fully accessible to all – there are no special limits and no supplementary charges.
- It is publicly administered and does not allow doctors or hospitals who receive payment from the government program to also receive funds from private insurance or other private forms of payments. This government organization is the only payer, thus the name "single payer". This single payer negotiates fees and total budgets for hospitals, clinics and doctors. Healthcare providers can choose, if they prefer, to operate outside of the single-payer system and accept private paying patients, but if they do so then they cannot receive any funds from the government system.

Within this system the actual provision of healthcare services can be organized in a wide variety of ways. Individual doctors can open up offices as solo practitioners. Doctors can form group practices of various sorts. Grassroots organizations can create community clinics. Hospitals can be run by churches, nonprofit organizations, by local governments. Individual patients chose their doctors or groups. The national government does not itself directly run these services. What it does is pay the bills on an agreed upon fee schedule that is negotiated annually.

How does this system work in practice? First, it must be said that there is rationing on the basis of medical need in Canada and sometimes this means that there longer waits than would occur for some people in the U.S. There is less diffusion and duplication of CAT-scans, for example, in Canada. They are located in fewer hospitals, whereas in the United States competition for patients has the result that most hospitals acquire such technologies. Even though the overall satisfaction with the Canadian system is very high, these longer waits for some procedures does lead to complaints, and sometimes wealthy Canadians come to the US in order to get quicker service. It could be argued, therefore, that the rationing that comes with the single-payer system does mean a lower "quality" healthcare system *for some people*, since individuals are unable to buy better care or quicker service in the system.

This rationing, however, does not mean that these waiting times have adverse effects on real health outcomes. Indeed, there are situations in which the existence of a waiting list can actually improve health outcomes since it forces doctors to be more concerned about placing those in greatest need at the top of the list, and this can have the result of reducing unnecessary surgery. In the United States heart surgeons have considerable incentives to perform coronary by-pass surgeries, and a certain proportion of these are medically unnecessary. If there was a waiting list, the more ambiguous cases would be placed lower on the list and alternative therapies would be tried. Some of these, in the end, would not need surgery. In any case, there is no evidence that the modest delays that are sometimes caused in the Canadian system adversely affect health outcomes.

A second consequence of the Canadian single-payer system is that Canada has much more uniform medical services across regions and across classes. There is very little difference in the quality of medical care received by the rich and the poor.

Third, in Canada the availability of health insurance does not enter into employment decisions. In the United States people are very concerned about health benefits with jobs. Many people are reluctant to leave a job they dislike in order to get new training or to look for a better job because of fear of being without insurance. Health insurance costs are also a major problem for many employers for home this significantly raises their costs of production. These rigidities are absent in Canada.

Fourth, the administrative costs for medical care are much much lower in Canada than in the US. In the mid-1980s total administrative costs came to $95/capita in the US, while less than $20 per capita in Canada. Since then the disparity has grown even more. **[track down time series data on administrative costs].**

Fifth, the paperwork hassles for patients are also enormously less than in the U.S. In the United States, even if you have good insurance, there is an enormous amount of paperwork

involved in getting sick, especially for long complex illnesses involving different doctors, hospitals and clinics. This complexity is increased when people create "health savings accounts" which they use to cover deductibles and co-payments. To use these accounts patients have to keep track of all expenses, get proper documentation and submit complicated forms to the appropriate agencies. In Canada, patients face none of these headaches. They go to a doctor, get treated, and that's it. The doctor submits the bill to the single-payer system and gets paid according to the negotiated fee structure.

All of this creates a great irony: Canadians have socialized universal insurance, but doctors are less hassled by the state and by bureaucracy than in the United States. Government programs actually result in a leader and simpler bureaucracy than more market oriented programs! And what is more, individual consumers of health care actually have greater freedom of choice in Canada than in the US. People are not forced to join a specific health plan which only pays for specific doctors, but can choose any doctor that has available slots in his or her clinic.

IV. OBSTACLES TO TRANSFORMATION

Given the remarkable improvement in the quality of health care and cost containment in the Veterans Administration hospital system in recent decades, and given the superior performance on so many grounds of the Canadian single-payer system, it becomes a real puzzle why it has proven so very difficult to create some system of universal national insurance in the United States. One common answer to this question is American individualism and the cultural opposition to government programs in the United States, and the generally conservative policy preferences of average Americans. While public opinion undoubtedly plays some role in obstructing universal healthcare, a more important factor is the power of organized forces who have a stake in the existing institutional structure. Three interest groups are especially important: organized physicians, the insurance industry, and pharmaceutical corporations.

The American Medical Association, the professional association of doctors, has been militantly opposed to anything that smacks of "socialized medicine". In 1989 AMA committed $2.5 million to tell Americans the "facts" about the Canadian system, emphasizing the complaints that are voiced about the system and ignoring the very high level of overall satisfaction with the system of both patients and doctors. During the early 1990s the AMA raised the specter of Big Government making health decisions for all Americans, depriving them freedom of choice.

While the AMA is strongly hostile to state run universal health programs, ordinary doctors are more receptive. Opinion poll data of doctors indicate that somewhat over 60% of American doctors support some form of national health insurance, but also, curiously, a large majority of U.S. doctors think that most US doctors oppose national health insurance. [Get the citation for this poll and actual numbers]. What this reflects is the fact that doctors beliefs about the opinions of other doctors are shaped by the AMA, and since the AMA so stridently opposed national health insurance, most doctors believe that this is the dominant view among doctors. In fact, the AMA's opposition is rooted in interests and preferences of the elite strata of doctors, but because of their visibility and power they are able to define the "public opinion of doctors" as a whole.

The other powerful sources of opposition to national health insurance are the private insurance companies and large pharmaceuticals. As a spokesman for Health Insurance Association of America stated: “We’d be out of business; it’s a life and death struggle.” Pharmaceutical companies are among the most profitable corporations because of their ability to charge high prices on patented drugs. They successfully blocked the idea of negotiated lower prices for the medicare drug plan passed in 200X. In Canada the Single-payer system has forced drug companies to charge lower prices, and the VHA in the United States has also been able to negotiate lower prices than the open market. The pharmaceutical companies oppose any unified national system for paying for healthcare because of the threat this would pose to their ability to demand such prices.

So long as these private interests are able to dominate the public debate over healthcare and influence the policy options that politicians are prepared to put on the table, the prospects for a universal health care system capable of controlling costs and providing good quality care for all are dim.