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# U.S. Health Care and Real Health in Comparative Perspective: Lessons from Abroad

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# U.S. Health Care and Real Health in Comparative Perspective: Lessons from Abroad*

Harold L. Wilensky

## Abstract

Among the 19 rich democracies I have studied for the past 40 years, the United States is odd-man-out in its health-care spending, organization, and results. The Obama administration might therefore find lessons from abroad helpful as it moves toward national health insurance. In the past hundred years, with the exception of the U.S., the currently rich democracies have all converged in the broad outlines of health care. They all developed central control of budgets with financing from compulsory individual and employer contributions and/or government revenues. All have permitted the insured to supplement government services with additional care, privately purchased. All, including the United States, have rationed health care. All have experienced a growth in doctor density and the ratio of specialists to primary-care personnel. All evidence a trend toward public funding. Our deviance consists of no national health insurance, a huge private sector, a very high ratio of specialists to primary-care physicians and nurses, and a uniquely expensive (non)system with a poor cost-benefit ratio. The cure: increase the public share to more than 65% from its present level of 45%. In regards to funding the transition cost and the permanent cost of guaranteed universal coverage: no rich democracy has funded national health insurance without relying on mass taxes, especially payroll and consumption taxes. Whatever we do to begin, broad-based taxes will be the outcome. Three explanations of "why no national health insurance in the U.S.?" are examined.

**KEYWORDS:** healthcare reform, national health insurance, Obama Administration, American exceptionalism

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For a great many policies and in system structure and outputs, the United States has plenty of company, most especially the United Kingdom, Canada, Australia, New Zealand, Ireland, and sometimes Switzerland. For instance, they share patterns of weak strength of political parties and fast erosion of party loyalty in the electorate, a relatively fragmented and decentralized political economy, vulnerability to the ascendance of mass media in politics and culture, a taste for means-testing in welfare-state administration, and high poverty rates. But when it comes to health care, the US is indeed unique:

- No national health insurance. The US is deviant in its continued reliance on medical care individually purchased, collectively bargained, or voluntarily provided by employers and in the large number of its people with no insurance coverage (now about 47 million) or clearly inadequate coverage (an accelerating number, surely not less than tens of millions).
- Big private sector. The private share of total health care spending in the U.S. in 1990 was about three-fifths, accounted for by such commercial vendors as insurance companies, drug companies, hospital chains, HMOs, and employers. That greatly exceeds the next highest private share—just under a third in Austria, Switzerland, and Australia, and typically less than a quarter elsewhere. Today the U.S. remains uniquely privatized with a 55 percent private share.
- A very high ratio of specialists to primary-care physicians (general practitioners, family doctors, pediatricians), nurses, and midwives.
- A uniquely expensive (non)system with a poor cost-benefit ratio. The total cost of US health care today is over 16% of GDP. No other rich democracy comes close to that figure. Yet the US remains below average on a wide range of health indicators, sometimes at the very bottom among rich democracies.[1]

The American case is a lesson for those medical economists and politicians who advocate privatizing of pensions, medical care, and other welfare-state programs. The odd private/public mix of the US gives private actors strong incentives to play two games: cost shifting and risk selection. If the government

[1] In constructing a real health index as part of our analysis of system outputs (Wilensky 2002, Ch. 16), I asked, "What health indicators could we expect to be affected by intervention of the medical community, indicators that could also be measured cross-nationally in all 19 countries?" I rejected numerous indicators for which knowledge about the effect of medical care is limited or dubious and cross-national comparability is insufficient (e.g., mental illness, peptic ulcers, or multiple sclerosis). I ended up with five dimensions of real health that are themselves intercorrelated: infant mortality rate per 1,000 live births; life expectancy at age one for males; the same for females; circulatory disease deaths per 100,000 aged 65-74; and deaths from pregnancy and childbirth complications per 100,000 females aged 25-34. Countries were ranked on each health indicator using natural cutting points for a four-point scale (0-3) and they were equally weighted. The summary scores ranged from Japan's 13.5 to the United State's 2.5.

tries to control the costs of service provided by vendors who serve patients in Medicare (mainly the aged) and Medicaid (means-tested for the poor and long-term disabled) or the privately controlled plans, the dominant actors—insurance companies, employers, HMOs, hospital chains—will shift costs to the public sector by restricting coverage and charging patients more. Commercial providers also save money by risk selection: they skim off the younger, healthier, cheaper patients and dump older, sicker, costlier patients onto the public sector. These games escalate costs while they reduce coverage.

With the cost-cutting, privatizing fervor of the past 25 or so years, we hear such slogans as "Stop throwing government money at the problem," "We need market competition among the providers," "True competition has not yet been tried," "Tell people to take responsibility for their own health, make them cost-conscious so they choose less-costly care." The evidence (Wilensky 2002, Ch. 16) shows first that the market model of health care borders on the absurd. Second, and most important, it shows that spending per capita through the public sector improves a broad range of health indicators and moves the system toward prevention. (On the public share and per capita government spending see Table 1 below).

The concept of the market applied to health care is taken seriously in the media and public discourse only because medical economists dominate the debate about health care reform, especially in the US, UK, and New Zealand, three countries with poor health performance. The guiding concepts of these economists include willing buyers and willing sellers contracting for services in a more-or-less competitive market where the buyer (patient) compares alternative sellers (doctors); is adequately if not fully informed about the nature of the product, its price, and its quality; and makes a rational choice. The seller as he views his competition must provide either higher quality or lower price or both, or he will go out of business. The system as a whole will thus tend toward a match between price and quality and a nice equilibrium between demand and supply. Further, under market discipline, as the price-conscious buyer constrains his appetite for service and the seller is constrained to be more efficient, cost containment will be the happy result.

Many medical economists know that when applied to health care, these ideas must be modified. Thus they speak of imperfect competition, managed competition, and market failures. As every observer of the institutions providing care knows, the health-care "market" is wildly different from the market in economic theory. The buyer at the peak of expense may not even be conscious, let alone adequately informed; if conscious, he is anxious, maybe in pain, full of fear, and ignorant of the purchases before him. His demand for the service is sometimes urgent, even desperate. Whether the private share of spending is high as in the United States or low as everywhere else, the typical patient is not even

**TABLE 1 Types of political economy, public share of health spending 1960-2005, and real health 2000-2005**

| Types of Political Economy[e] | Public share of total healthcare spending (%)[a] | | | | | Govt. health per capita[b] | Real Health Index 2005[c] | |
|---|---|---|---|---|---|---|---|---|
| | 1960 | 1980 | 2000 | 2005 | Avg. 00-05 | | | |
| Left Corporatist | | | | | | | | |
| Sweden | 73 | 93 | 85 | 82 | 84 | $2,490 | 11.5 | (4) |
| Norway | 78 | 85 | 83 | 84 | 83 | $3,784 | 9.5 | (7) |
| Finland | 54 | 79 | 75 | 78 | 76 | $1,764 | 7.0 | (12) |
| Denmark | 89 | 88 | 82 | 84 | 83 | $2,254 | 5.5 | (15) |
| Avg. | 73 | 86 | 79 | 79 | 79 | $2,573 | | |
| Left-Catholic Corp. | | | | | | | | |
| Netherlands | 33 | 69 | 63 | 65 | 64 | $2,093 | 6.5 | (14) |
| Belgium | 62 | 83 | 72 | 71 | 72 | $1,972 | 7.0 | (12) |
| Austria | 69 | 69 | 76 | 77 | 76 | $2,360 | 9.0 | (9) |
| Avg. | 66[d] | 74 | 70 | 71 | 70 | $2,142 | | |
| Catholic Corporatist | | | | | | | | |
| Italy | 83 | 81 | 73 | 77 | 75 | $1,606 | 11.0 | (5) |
| Germany | 66 | 79 | 80 | 77 | 78 | $2,341 | 7.0 | (12) |
| Avg. | 75 | 80 | 76 | 77 | 77 | $1,974 | | |
| Corporatist w/o Labor | | | | | | | | |
| France | 62 | 80 | 78 | 80 | 79 | $2,340 | 10.0 | (6) |
| Japan | 60 | 71 | 81 | 83 | 82 | $2,351 | 13.5 | (1) |
| Switzerland | 61 | 68 | 56 | 59 | 58 | $2,682 | 12.5 | (2) |
| Avg. | 61 | 73 | 72 | 74 | 73 | $2,458 | | |
| Least Corporatist | | | | | | | | |
| United States | 23 | 41 | 44 | 45 | 45 | $2,429 | 2.5 | (19) |
| United Kingdom | 85 | 89 | 81 | 87 | 84 | $2,043 | 4.5 | (17) |
| New Zealand | 81 | 88 | 79 | 77 | 78 | $1,342 | 5.5 | (15) |
| Australia | 48 | 63 | 67 | 67 | 67 | $1,646 | 12.0 | (3) |
| Canada | 43 | 76 | 70 | 70 | 70 | $1,952 | 9.5 | (7) |
| Ireland | 76 | 82 | 74 | 80 | 76 | $2,173 | 4.0 | (18) |
| Avg. | 59 | 73 | 69 | 71 | 70 | $1,931 | | |

[a] Source, OECD stat (2008).

[b] Average of 2000 and 2005. Source: OECD.stat (2008)

[c] See footnote "a" to table 2

[d] Excluding the Netherlands as a deviant case.

[e] From Wilensky, 2002, ch. 2. The first 3 types are all big social spenders, the bottom two are lean spenders, except for France. "Corporatist" = more-or-less centralized bargaining among labor, management, government, professions, and political parties. Or "consensual democracies." Or "negotiated political economies." "Least corporatist" = Most fragmented and decentralized political economies. The types are generated by combining the cumulative power of broad based political parties (e.g. Left and Catholic) since 1919 with national bargaining arrangements.

spending his own money, and no one in the system can accurately gauge the unit cost. The seller-provider, in turn, is a licensed professional monopolist who creates demand by authoritative statements of what the purchaser should want, and the buyer-patient has neither the competence nor the wish to second-guess the monopolist.

It is clear from Table 1 that from 1960 to 2005, all countries except Switzerland moved toward an ever-larger public share of total healthcare spending. By 2005, all countries except the US reached a public share of at least 65% (the U.S. was at 45%) and all but three of eighteen exceeded 70% in public share (those three exceptions being Switzerland 59%, Netherlands 64%, and Australia 67%). The lesson: to avoid the fate of the US and overcome the pathologies of cost-shifting and risk-selection and the concomitant total cost of over 16% of GDP, a country must spend something like 65-70% of the total through the public sector.

Much of current debate singles out the alleged inefficiencies—"waste, fraud, and abuse"—of Medicare.[2] Again we have assertions that are, to be kind, short on the relevant comparative data. Figure 1 directly compares Medicare and private insurance spending increases for comparable benefits in recent decades (Hacker 2008). From 1983 to 2006, the spending per enrollee of private plans has grown much faster than spending per enrollee of Medicare. This comes to 7.6% vs. 5.9% annual average, adding up to a 22% difference. The gap is even bigger in recent years, adding up to a full 37% edge for Medicare in cost savings.

One reason for the greater efficacy of Medicare over private insurance for the same service is the extraordinary administrative costs of the private sector, including profits, advertising, sales staff, an apparatus to determine how to limit coverage, avoid sick and older patients, and to craft inflated billing—not to mention lobbyists in Washington and elsewhere. Estimates of the cost of private health-care administration range from 16% to 20% of each medical care dollar;

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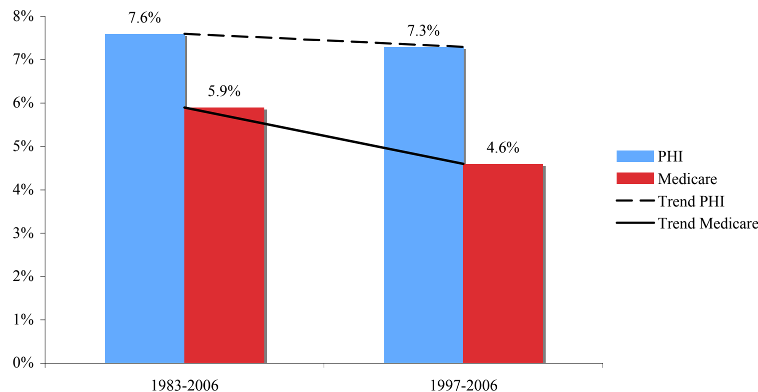
[2] In June of 2009, President Obama pressed his staff and key Senators to read a *New Yorker* article along this line (Gawande 2009). Drawing on a study by two Dartmouth economists, Dr. Gawande of Harvard claims in this attack on Medicare costs that the private/public distinction makes no difference, that the root of the troubles is instead excessive medical tests and procedures—too many doctors enriching themselves. He ignores commercial sector games—risk selection and cost shifting—and other pathologies of a dominant private sector. He is impressed with regional and local variation in costs, e.g. McAllen, Texas vs. Rochester, Minnesota. The President's Budget Director, the sophisticated Peter Orszag, similarly claims that "nearly 30% of Medicare costs could be saved without negatively affecting outcomes." But these studies seldom control adequately for type of patient and patient risks (e.g. McAllen has very high rates of obesity and alcoholism) and they never carefully compare public costs with private. However, they accurately invoke over-specialization as a factor explaining our uniquely high total cost. If you have more surgeons, you will have more surgery. Specialists everywhere take pride in their craft, and it is a good thing they do. The problem instead is how the system is financed, the commercialization of a medical-industrial complex, resulting in the extreme ratio of specialists to primary care physicians.

some estimates are higher (Wilensky, 2002, pp. 611-614). Public sector administration is much lower in Medicare (about 3% overhead) and the VA.

**Figure 1**




Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures, Table 13, 2008, Cf. Hacker 2008.

There is substantial convergence in health performance, with the poorest performers catching up with the top performers, and a lesser convergence in spending. And there is substantial convergence in the financing and organization of medical care. If we compare 1980 (not included here) and 2005, public education spending became useless as a predictor of good health because of the convergence in universal secondary education and to a lesser extent post-secondary education. Similarly, GDP per capita became ever weaker as a predictor of good health, as a result of some convergence in affluence among the rich democracies, with the least rich catching up. More important, the threshold of good health has been reached by almost all of the rich democracies, beyond which only the sharp contrasts in life styles and the organization and delivery of healthcare counted. Again, however, governmental health spending combined with corporatist bargaining structures and affluence still count at the extremes. Of nine countries with relatively good to excellent health performance, circa 2005, seven are consensual democracies; only two (Italy and Australia) are lean public spenders per capita. Of five countries with poor to fair health performance only one, Denmark, is corporatist; four are medium to low spenders (Denmark, UK,

**TABLE 2 Interaction of government health spending per capita (2000 and 2005), corporatism, and affluence fosters good health performance (circa 2005). Public spending and affluence each enhances health performance. Corporatism alone has little effect.**

| | Nine Countries with good to excellent health performance | | | | | Five countries with average health performance | | | | | Five countries with poor to fair health performance | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Health Index[a] | | Health per cap.[b] | GDP per cap.[c] | | Health Index | | Health per cap. | GDP per cap. | | Health Index | | Health per cap. | GDP per cap. |
| Big health spenders ($2340 and over per cap.) | Japan* | 13.5 | (1) | $2,351 | $34,112 | Germany** | 7.0 | (12) | $2,341 | $28,901 | US | 2.5 | (19) | $2,429 | $38,401 |
| | Switzerland* | 12.5 | (2) | $2,682 | $43,356 | | | | | | | | | | |
| | Sweden** | 11.5 | (4) | $2,490 | $34,154 | | | | | | | | | | |
| | France* | 10.0 | (6) | $2,340 | $28,380 | | | | | | | | | | |
| | Norway** | 9.5 | (7) | $3,784 | $51,525 | | | | | | | | | | |
| | Austria** | 9.0 | (9) | $2,360 | $30,916 | | | | | | | | | | |
| | cell avg. | 11.0 | | $2,668 | $37,074 | | | | | | | | | | |
| Medium health spenders ($1764 to $2254) | Canada | 9.5 | (7) | $1,952 | $28,973 | Finland** | 7.0 | (12) | $1,764 | $31,171 | Denmark** | 5.5 | (15) | $2,254 | $39,358 |
| | | | | | | Belgium** | 7.0 | (12) | $1,972 | $29,579 | UK | 4.5 | (17) | $2,043 | $31,380 |
| | | | | | | Netherlands** | 6.5 | (14) | $2,093 | $32,326 | Ireland | 4.0 | (18) | $2,173 | $38,425 |
| | | | | | | cell avg. | 6.8 | | $1,943 | $31,025 | cell avg. | 4.7 | | $2,157 | $36,388 |
| Lean health spenders ($1646 and below) | Australia | 12.0 | (3) | $1,646 | $28,146 | Israel | 7.0 | (12) | $1,062 | $25,930 | N. Zealand | 5.5 | (15) | $1,342 | $20,003 |
| | Italy** | 11.0 | (5) | $1,606 | $25,448 | | | | | | | | | | |
| | cell avg. | 11.5 | | $1,626 | $26,797 | | | | | | | | | | |

** Corporatist. Germany a marginal case. * Corporatist without labor. Switzerland perhaps marginal.

[a] Combines infant mortality, life expectancy at one for males, the same for females, circulatory disease deaths, and pregnancy and childbirth deaths, equally weighted; circa 2005.

[b] Total government health expenditure per capita, average of 2000 and 2005 using U.S. dollar exchange rates. Source: OECD.stat.

[c] Average of 2000-2006 GDP per capita in dollars (OECD, 2008). Data for Israel from World Bank (2008).

Ireland, New Zealand). For reasons already discussed, the USA moved from below average in 1980 (rank 11) down to poorest performer in 2005 (rank 19).[3]

### What Other Countries Do: A Case of Convergence[4]

In the past hundred years, the currently rich democracies have converged in the broad outlines of health care. Except for the US, they all developed universal and comprehensive coverage for medical care, based on principles of social right and shared risk. They all developed central control of budgets with financing from compulsory individual and employer contributions and/or government revenues. All have permitted the insured to supplement government services with additional care, privately purchased. All, including the United States, have rationed health care: the US by income, others by medical need. All have experienced a growth in doctor density and the ratio of specialists to primary-care personnel. All evidence a trend toward public funding.

Centralized state funding, by itself, expands access to care and to some extent reduces national mortality rates and improves health. In a natural process, state funding eventually leads to increased control over prices and personnel via direct employment, capitation payments, and/or government bargaining with providers. This combination yields better national health performance because it reduces inequalities in access to care by class and region, increases the volume of services available, while limiting the degree of specialization and the concomitant duplication and lavish use of expensive high-tech machines and procedures. In general, the assertion of the public interest over the interests of insurance companies, pharmaceutical firms, hospitals, physicians and other providers results in a gradual reallocation of budgets toward primary care and preventive community care. There is some evidence that centralized control of funding, prices, and personnel under state auspices compared to the alternatives yields greater social efficiency—an improved tradeoff between mortality reduction and cost escalation—as well as a better balance between equality of access and levels of health (both improve) and innovation (a mixed effect). The effect on innovation is to speed up the adoption and diffusion of vaccines and effective screening programs while slowing down the use of expensive high-tech medical

[3] Eliminating three deviant cases (Italy, Australia, and the United States), this is confirmed by a moderate zero-order correlation (0.45) between per capita public spending and our real health index.

[4] Among the best comparative studies of the organization, delivery, and real health effect of health-care systems are Hollingsworth, Hage, and Hanneman, 1990; Hollingsworth, Hanneman, and Hage 1992; Evans and Stoddard 1994; Heidenheimer, Heclo, and Adams 1990; Mechanic and Rochefort 1996; and OECD country studies, various years.

practice—again, basing the latter on medical need rather than ability to pay. (Hollingsworth, Hage, and Hanneman 1990)

The American case highlights the role of the ratio of specialists to primary care physicians, nurses, and midwives as a source of both costs and real health performance. As the density of physicians everywhere climbed with economic growth, the proportion of all physicians who are specialists also climbed—in recent decades at an accelerating rate. By 1970, the proportion of specialists had risen from a trivial figure at the turn of the century to 34 percent in Britain, 42 percent in France, 56 percent in Sweden, and 77 percent in the United States (Hollingsworth, Hanneman, and Hage 1992, 14 and Table 1). Recent figures show that the specialist share of all doctors in Canada and Germany is a bit less than half, while the United States, despite recent efforts to increase GPs, maintains its heavy specialist lead.

In the absence of state control, a more privatized, commercialized system accelerates the trend toward increasing medical specialization and cost. A high proportion of specialists with little constraint on their high-tech services has several effects: it speeds the diffusion of innovation, especially very expensive technologies; it means more expensive services in hospitals and more staff; it reduces age-sex standardized mortality rates but at ever-increasing cost (Ibid., 30-31). Thus, a high ratio of specialists reduces social efficiency. In fact, both the trend toward doctor density and a rising ratio of specialists boost medical expenditures more than they reduce mortality (Hollingsworth, Hage, and Hanneman, 1990, 150-151, 180-181). In other words, there is a diminishing return from increases in this most-expensive, labor-intensive service.

## Why No National Health Insurance in the US?

How did we get ourselves into this mess? Two explanations are persuasive and one has little merit. First is the history of public policy choices since WWII. Second, and most important, is the fragmented and decentralized structure and operation of our government. The weak explanation invokes our alleged love of free enterprise and the market, our hatred for government, and a culture of individualism. Let's look at each.

### *The Legacy of Past Choices*

Since World War II, American public policy has given priority to increasing the supply of specialized, technologically-intensive health care; widening access took a back seat. Among the measures: the Hospital Construction Act (Hill-Burton) of 1946, and the financing of hospital-based care, bio-medical research, technological innovation, and training of specialists. This locked the US into a

payment system—procedure-based, fee-for-service— that discouraged primary care, preventive care, and low-tech solutions (Jacobs 1995, 144-146). The resulting institutionalization of expensive care made it more difficult to reverse course and embrace universal coverage, quite apart from the well-known political-system barriers. In contrast, all other modern democracies began with equality of access as their primary goal, which forced them to concentrate hospital care in fewer places, multiply and disperse primary-care clinics, increase the supply of GPs or family practitioners, and discourage over-specialization. Where they established universal coverage but still centered their care in hospitals, as in Sweden and Germany, their costs did rise beyond the norm (see Table 1) but they were in a position to consolidate the high-tech care and ration it more fairly according to medical need rather than income.

The findings on physician types and density as they shape mortality are consistent with the argument that GPs, compared to specialists, disseminate a broader array of bio-medical knowledge throughout society. Specialists may "keep up" better and be a bit more open to scientific evidence and innovation, but they speak to a narrower range of issues and treat only part of the organic whole. Continuity of primary care in which the whole patient can be assessed and managed apparently has a greater effect in reducing population mortality than the uncoordinated care of specialists, however dramatic the latter's impact on the smaller number of intensive-care patients.

If an abundance of GPs, say about 50 percent, can favorably shape health outcomes, what about an abundance of nurses, nurse-practitioners, and midwives? Relating our real health index (see footnote 1) to data on the number of nurses and midwives per 10,000 population in 18 rich democracies in 1980, we see that a high nurse-midwife density is associated with good to excellent health performance (Wilensky 2002, Table 16.2). Of the seven countries ranked highest in health outputs in 1980, five have the highest density of nurses and midwives. And of the 11 countries ranked average to poor in health performance that year, only two (Australia and the United Kingdom) are high in this staff category.[5]

The very low cost and the lowest specialist share of the United Kingdom suggest caution. The UK exceeds every other country in its GP to specialist ratio. If it also ranks so high in the nurse ratio, we might infer that the specialist/hospital sector is underfunded and understaffed as is the whole system. And it has been below average in health performance and remained so in 2000-2005. Perhaps Britain's NHS represents the extreme beyond which the benign effects of GPs and nurses diminish.

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[5] A multiple regression study of prefecture reductions in infant mortality in Japan (whose rate of improvement was the best of our 19 countries, 1960-1980) found that public health nurses per 100,000 population was the only significant medical intervention that is strongly correlated with reduced infant mortality (Morio 1985).

In sum: although data on preventive care are generally limited to fewer than our 19 countries, my analysis suggests that a balance between specialization and primary care, perhaps 50/50, results in wider diffusion of bio-medical knowledge, more continuity of treatment, better diagnosis of "the whole patient," and more time and money for prevention. Further, if primary-care physicians and their assistants serve as guides to specialists and their activities are coordinated, better cost control is likely. Clinics that combine specialists and generalists where they interact freely— and are not hostages to insurance companies and other managers preoccupied with cost cutting—may be ideal for this balance (Mechanic 1992, p. 1723). Sweden and Norway approximate this picture. So do the few HMOs in the U.S. that have a decent cost-benefit ratio, rare as they are. Kaiser Northern California, including Oakland, is low-cost, high-performance, with very high patient satisfaction. It is organized so primary care physicians act as guides to specialists and referrals are easy—down the hall or across the street. Pay is collective—salaries based on market rates for group practice in the area plus a 5 or 10% bonus for performance (patient outcomes and satisfaction)—hours are regular (most female physicians work part-time), and the support staff is unionized.

There is some evidence that all of the above improves a nation's health performance. In contrast, systems with a sharp separation between hospital-based specialists and GPs, such as Britain's and New Zealand's, are below average in real health performance (Table 1). Finally, the case of the UK suggests that a willingness to pay more than 7 percent of GDP and a specialist ratio higher than 25 percent is necessary for good health performance.

### *A Word about the Interdependence of Public Policies*

Countries that have reallocated their spending toward family physicians and physician assistants, including public health nurses, and have constrained the overuse of high-cost technology and specialist services, also tend to spend increasing amounts on health-related social policies that reduce the population at risk. They have reduced large inequalities in access and in levels of health. They have invested in public health. They have combined this with programs of subsidized housing, home care for the aged, poverty prevention, and health education in clinics and schools. They have developed family policies accenting prenatal and infant care, parental leave, and child care at every level of child development (Wilensky 2002, ch. 7). They have crafted policies and programs that reduce teenage pregnancy and drug abuse (ch. 8). They have been effective in cleaning up the air and water (ch. 15). In short, the effectiveness of preventive medicine is greatly increased where it is integrated with broader health-relevant

programs for the most vulnerable populations at risk and where cost pressures do not subvert the physician's clinical time and practice.

The United States is deviant in almost all of these measures. Although lifestyle risk factors (e.g. smoking, poor diet, drugs and alcohol abuse, firearms, sexual behavior, and auto accidents) account for about half of premature deaths in the US in 1990, the country spends less than an estimated 10 percent of its health-care dollars on disease prevention and helping people to adopt healthy habits (Bodenhorn and Kemper 1997, iii, 2). That includes all funding for personal preventive health and community health services. Whether 10 percent is high or low in comparative perspective is not known, because no good comparable definition or data are available. But there is reason to believe that the preventive percentage is relatively low and, more important, that the money the United States devotes to prevention is less effective than it is in many European countries, especially for younger populations (evidence reviewed in Wilensky 2002, pp. 593-595).

### *Electoral Systems and the Structure and Operation of Government*

Beyond the legacy of the past, the second major source of U.S. failure to achieve national health insurance is a reminder of what you learned in Political Science 101. It is worth repeating because it is basic to any understanding of our lag in many social and labor policies. The uniquely extreme commercialization of the medical-industrial complex with its high administrative costs, a private sector that greatly exceeds that of every other country, a chaos of private and public regulation, a very high ratio of specialists to primary-care physicians, a shortage of nurses, and much higher use of expensive technologies account for the poor cost-benefit ratio; they make change difficult. The most important political barrier to the adoption of national health insurance is the dominance of the insurance companies. All other countries have contained their power and confined their reach.

In view of these structural barriers, it is understandable that the center-left and even parts of the center-right who favor national health insurance have shied away from it. Reform efforts from Teddy Roosevelt through Truman to Clinton have failed. FDR’s two-to-one to four-to-one margin in the US Senate when he signed New Deal social legislation did not bring national health insurance. Lyndon Johnson, with his big margin, had to settle for Medicare for the aged and Medicaid for the poor and long-term disabled.

The political barriers that account for these failures can best be understood if we compare Canada and the USA. They are similar in so many ways, yet Canada was able to achieve national health insurance at less cost and better outcomes while the U.S. remained odd man out. First the similarities: Both

countries share origins in the British empire but lack a feudal past. Both have a decentralized federalism with continual battles over "states (provincial) rights," alternating major party control of government, a "majoritarian" electoral system with the rule of first-past-the-post winner take all, and fairly rapid erosion of political parties in the electorate. Both are well below average in their social spending. There is even a parallel in the regionalism of the two countries: from President Johnson-on federal largesse has flowed disproportionately to the South and Southwest just as federal funds in Canada went disproportionately to Quebec (militants derisively call this "fedéralisme de portefeuille" as they win attention and cash by threatening to secede). Finally, and most important, before Canada adopted comprehensive reform in the early 1970s, their medical systems were much alike and their health-care spending as a percentage of GDP was nearly the same (about 7.5%); both countries paid physicians by fee-for-service and physicians' training and outlook were alike (Kudrle and Marmor, 1981, p. 104). Even the political coalitions strongly opposed to national health insurance were similar.

Despite these notable similarities, several small structural differences in this one policy area added up to a near-insurmountable obstacle for U.S. efforts to achieve national health insurance. My comparison of the two countries points to five structural differences.

- More paralyzing federalism: There is no greater division of powers, no weaker central government, no more fragmented and decentralized federalism than that of the US. The dogma of local self-government is enshrined in its constitution and laws; a federal system divides powers among central government and 50 sovereign states, which in turn, divide powers among thousands of counties, townships, municipalities, and other local units. To survive and deal with real problems that do not fit these arbitrary boundaries, the modern metropolis is therefore forced to create a staggering number of special district governments—school districts, water districts, fire districts, sanitation districts, park and port districts, rapid transit authorities—each concentrating on a limited area-wide task; each competing for budget, tax base, or subsidy; all adding to the maze of overlapping and duplicating units. If there is a constitutional explanation of why the United States finds it so difficult to come to grips with urban problems or to develop national social, labor, and industrial policies, it is here, in the tyranny of the locality, made possible by extreme federalism and the separation of powers. (Wilensky 1965, xviii-xix.)
- Weaker demonstration effects. You can have progressive legislation in Minnesota and Wisconsin, including healthcare reform—and nothing will happen nationally. In Canada, if Saskatchewan or one of the more

progressive provinces lights the way, their demonstration effects can spread.

- An electoral system more unfavorable to a left third party. Parties in Quebec and the NDP elsewhere hold many seats and can dominate in important provinces. Electoral laws in the U.S. block such parties.
- Unique rules of the US Senate. First is the use and abuse of the filibuster, used by Republicans under Clinton more than in the entire history of the country. Also prominent is the privilege of a single senator to delay an appointment or a bill by putting a hold on it. (For a longer list see Mann and Ornstein, 2006.) And of course rural and small-town overrepresentation explains much.
- Weaker party discipline. Entrepreneurial senators can go their own way. Even with recent increase in party discipline among Congressional Democrats—Republicans have long marched in lock step—there are numerous deviations from the Democratic party line.

These are modest differences between Canada and USA that make a difference. Added up they explain why we failed to achieve national health insurance, while Canada, starting from the same place, similar in so many ways, ended up with national health insurance and good health performance.

## American Values, Beliefs, Public Opinion, and All That

The third explanation for our medical care mess is American values, beliefs, public opinion, or mass sentiments about the proper role of government. Scholars and pundits often assert that the citizens of "statist" Europe are "collectivist", while their counterparts in the U.S. are "individualist." In fact, the citizens of all rich democracies are quite similar in their ambivalence and confusion when confronted with abstract ideological statements about public spending and taxing. More important and even stronger are the similarities in issue-specific public opinion. (Evidence reviewed in Wilensky 2002, 369-374, 391-395.)

Two major patterns from this large body of surveys stand out. First, there is nothing uniquely American about mass attitudes toward the proper role of government. Modern voters, including vast majorities in the US, are ambivalent and contradictory in their values and beliefs. They are simultaneously individualistic and collectivistic, Social Darwinist (every man for himself) and humanistic (pro-welfare state), laissez-faire and statist, meritocratic and populist, believers in both individual liberty and community as well as equality of opportunity and (to a lesser extent) equality of results. True, if we ask abstract questions like "Do you think government should see that everyone has a job and a good standard of living? " or "Government should let each person get ahead on his own?", the balance of these antimonies will reflect the actual taxing, spending,

and social policies of the government. Sweden, a big spender, has an edge over Britain in support for affirmative government; Britain, a middle-rank spender, over Canada and the United States, two lean spenders. But the differences are not large and the pro-government intervention preference is a clear majority among all rich democracies.

The great ambivalence of mass publics permits politicians to play it either way. If they are hostile to expansive social and labor policies they can work the tax-welfare backlash; if they are friendly, they can mobilize majority sentiments. When you read pollsters' claims that Americans have shifted to the Republican agenda or have become "moderate" because they are individualistic and want a less active government or have embraced new values, remember that it is typically media-filtered "information" that is fed back to pollsters as public opinion. My favorite example comes from a focus-group survey on the proper role of government done at the height of the balanced budget debate of 1994-95. One older citizen on Social Security who was a heavy user of Medicare explained that "I want the government off my back. . . . I don't want the government messing around with my Medicare."

The second pattern of results goes beyond abstract ideology to issue-specific opinion about taxes, spending, and particular policies comprising the welfare state. Here there is no confusion and little ambivalence. The structure of public opinion has remained remarkably stable since World War II both in the US and in affluent democracies with sharply contrasting cultures and politics. Briefly, modern voters everywhere love guaranteed pensions and disability insurance and are only a shade less enamored of national health insurance. Next most popular and becoming more so are family policies and active labor-market policies (ALMP); both draw majority support. When we go beyond these most expensive and popular policies we find that the mass of citizens in all these countries have serious reservations about passive unemployment compensation and are downright hostile to means-tested public assistance: they think the benefits too often go to the undeserving.

In mass attitudes toward specific programs, Sweden and the United States are actually brothers (sisters?) under the skin. Again, nowhere do we uncover a mass defection from the core programs of the welfare state. Because the rank order of enthusiasm about specific programs is so similar across these 19 countries, we cannot explain large national differences in the success of tax-welfare backlash movements and parties in a few—US, UK, Denmark, and Switzerland—by invoking a similar structure of public opinion in all. A uniform and stable structure of opinion does not tell us why sustained tax-welfare backlash

appears in only four or five of our 19 democracies.[6] It is instead types of political economy and their contrasting patterns of politics and public policy that explain national differences.

## A Final Note on Cost-Savings and Finance

Even if Congress does not chew up these measures, savings from limiting tax deductions for dependent and charitable contributions, from specific efficiencies such as evidence-based practice, information technology, Medicaid rebates for brand-name drugs, strengthening Medicare pay for hospital performance incentives, competitive bidding to reduce Medicaid or Medicare payments—none of this will substantially reduce costs unless the public share of total health-care expenditures reaches 65-70%. This is the level where the bargaining power of the government and its assertion of the public interest sharply reduces cost shifting and risk selection, plus the other pathologies of US health care. And that is why the current House bill with its robust public option modeled on Medicare is essential for even a modest beginning.

What about funding? In the U.S., funding expansion of guaranteed coverage through increased income taxes on the rich or taxing health benefits or the dubious revenue from a cap-and-trade energy system will be fatal for health care reform unless these measures are viewed as a very small start. No country has funded national health insurance without mass taxes. My analysis of tax revolts shows what all the rich democracies discovered long ago: consumption taxes (VAT) and payroll taxes, even if not earmarked for universal health care, have never provoked a sustained tax revolt. In contrast, increases in the two most painfully visible taxes—income taxes and property taxes on households—often whip up mass hysteria, California style. And they yield too little for the transition costs facing us before the long-term savings kick in.

How could one possibly sell this? Begin by repeating every day in every way a three-word sound bite: "Medicare for Everyone." If President Obama had used that approach, he would not now be hostage to Senator Baucus and the "Blue

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[6] By "tax-welfare backlash" I mean strong social-political movements and/or parties that emphasize anti-tax, anti-social spending, anti-bureaucratic ideological themes and achieve electoral success for substantial periods. I coded our 19 countries on this idea (Wilensky 1981, and 2002, ch. 10). Highest scores are unrelated to the level of taxing and spending; they went to Denmark, a big spender (Glistrup and the Progress Party); US, a lean spender (Reagan to Bush II and the Republicans); UK, a middle-rank spender (Enoch Powell, Margaret Thatcher and the Tories); and Switzerland, a lean spender (from Schwartzenbach to Blocher). The country backlash rankings from the time when such candidates achieved success until now are remarkably steady as is their electoral base—middle-mass voters (people with only secondary school certificates or a year or two of post-secondary vocational education but no baccalaureate, i.e., the merged "upper-working class" and "lower-middle class").

Dog Democrats." Even the most cautious incrementalist can begin with this. Together with Social Security, Medicare is the most popular, successful, and widely understood social policy in our postwar history (except for the recent confusing drug benefit, a step toward privatization). Phased in gradually – starting with a robust public option modeled on Medicare -- it will end with national health insurance and meanwhile make it easier for Democrats to face the electorate in 2010 and 2012.

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