U.S. HEALTH CARE – WHAT'S REALLY THE PROBLEM?
– POINT / COUNTERPOINT

Stephen L. Bakke – August 4, 2009

This is one of several topics which lead into my attempt at identifying reasonable and viable elements of health care reform – "soon to be completed". My suggestions will recognize the compelling need for reform, accept those aspects which virtually all citizens agree must change, and provide an alternative to the undesirable, and ever less popular, government imposed system.

The following is largely based on a portion of my April 2009 report on health care and is intended to be a reference of competing arguments. The next report will deal with addressing more common criticisms, and will recognize some of the positives.

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Background

One of the biggest problems in health care reform is that parties to the debate have different viewpoints of what really needs fixing. There can be no successful reform without determining what's really wrong, and reaching agreement about what should be done. The information below is intended to present some of the issues being debated and a few of the arguments on both sides.

Points and Counterpoints

World Health Organization (WHO) Study

A few years ago, the WHO published a study of medical care around the world with specific comparisons to the U.S. The study included information on 191 nations and in the rankings the U.S. finished 37th, behind nations like Morocco, Cyprus, and Costa Rica. Finishing first and second were France and Italy. Michael Moore makes much of this in his movie "Sicko". The New York Times declared "the disturbing truth … that … the

United States is a laggard not a leader in providing good medical care". To evaluate the issue, we at least need to take a look at some of the claims and contrary arguments.

- *Point:* The WHO evaluated the quality of health care based on life expectancy.

  Counterpoint: Critics say that there are many things that cause premature death that have nothing to do with medical care. For example, the U.S. has proportionately more fatal transportation accidents than other countries, and our homicide rate is far greater than the U.K., France, or Canada. If the affect of homicide is factored in, the U.S. life expectancy is higher than each of the countries listed. Going one step farther, when "fatal injury" rates are adjusted for, U.S. life expectancy is higher than in almost every other industrialized nation, and is the highest of the wealthy nations listed in the TCF section which follows.

- *Point:* The WHO judged the quality of health care on the "fairness" of distribution of services.

  Counterpoint: The critics would say that there was inadequate measurement of actual quality of health care. Some have demonstrated that using WHO's criterion, a country with high-quality care overall, but with some "unequal distribution" would rank below a country with lower quality average care but with equal distribution of the what is available.

- *Point:* The number of people with medical insurance automatically improved or reduced the overall ranking for quality of health care.

  Counterpoint: Critics of this report state that many of America's "uninsured" are there by choice, ignorance, or because they are in the country illegally. This topic is taken up later in the ***Insurance*** section.

- *Point:* For all its problems, the WHO study gives the U.S. credit for quality of care and innovation by ranking them near the top for this category.

  Counterpoint: Some explain that the reason for this ranking is that development of life-saving drugs is included as a measurement. The other lower rankings are due to using subjective criterion which reward systems closer to socialized medicine.

The Commonwealth Fund (TCF) "Weighs In"

The recent TCF study looked just at wealthier nations – Australia, Canada, Germany, New Zealand, the United Kingdom and the U.S. In the TCF study, the U.S. ranked last or next to last on all but one criterion. So is that the final verdict? Let's take a closer look

- *Point:* The study states that despite having the most costly health system in the world the U.S. consistently underperforms.

Counterpoint: Critics point out that one of the most important reasons for the low ranking was that the U.S. was the only country in the study without universal health insurance, thereby distorting the results. Also, while there are U.S. government programs that do guarantee basic medical care to the uninsured, no credit is given for that fact. Often the uninsured don't seek available programs. We have a different problem than access – rather, it's ignorance of the system.

- *Point:* All important performance factors were considered in the study.

  Counterpoint: Critics point out that the evaluation didn't consider that the U.S. is the center of medical innovation. When internists ranked the world's top 10 recent medical innovations, eight were developed from American innovations.

- *Point:* The U.S. scores at or near the bottom in most "quality" measurements.

  Counterpoint: It has been demonstrated that good ratings in the following categories or sub-categories could ONLY be achieved if a universal health plan was in place – i.e. lack of such a plan AUTOMATICALLY receives a low rating without regard to actual statistics: care management, coordinated care, patient-centered care, access, and equity. Critics convincingly point out biases and problems with other criteria including the fact that results were based on subjective telephone interviews with patients and doctors, not an objective study of data from records or about outcomes.

- *Point:* The British National Health Service properly is one of those systems held up as a highly rated system in almost all respects compared to the U.S.

  Counterpoint: Critics are quick to point out that the U.K.'s National Health Service recently made a promise to reduce wait times for hospital care to four months. More than 70,000 Brits have become "health tourists" by traveling long distances to other countries for major operations. It was recently reported that 750,000 Brits are awaiting hospital admission. Britain's National Health Services has tried to achieve an 18 week maximum wait from general practitioner to treatment, including all diagnostic tests.

- *Point:* Michael Moore's movie confirmed what was stipulated in the TCF study.

  Counterpoint: Many consider Michael Moore's movie as anything but objective. He accepts TCF assertions and then "reaches" for support. He praises Canada's system, but doesn't point out it ranked only 5th overall, ahead of only the U.S. and was evaluated by TCF as being worse than the U.S. in many ways.

- *Point:* The study's shortcomings are mitigated by the fact that the same telephone interview questions were asked of patients and physicians in all of the countries.

Counterpoint: While its uniformity was commendable, critics point out that there was no attempt to make real objective measurements of outcomes, practices, etc. The fact that it was a telephone interview measuring impressions only is a weakness not a strength. It's an accumulation of "impressions", largely from patients. The report does nothing more than reveal which nation does the worst job of satisfying the subjective preferences of the people who conducted this study. Expectations do tend to be higher in the U.S., and not taking this into account biases the study against the U.S. health care system.

The real "rub" here is that the survey would automatically permit a country with a universal system to be rated higher than one with higher overall quality care but no universal coverage. The U.S. fails the survey simply and only because a high rating is dependent on a system's proximity to socialized medicine.

There will be more on this study in my next report.

Michael Moore, "Sicko", and Cuba

"Sicko" is a 2007 documentary film by American filmmaker Michael Moore (MM). The film is represented as an investigation of the American health care system. The film compares the for-profit, non-universal U.S. system with the non-profit universal systems of Canada, Cuba, France and the U.K. While it opened to positive reviews, it also generated criticism and controversy. Critics say the positive reaction generally came from those who heard what they wanted to hear. But it now is generally agreed by all that this project was anything but an objective gathering of data. It was, quite clearly, a project which set out to create film footage which would put the U.S. system in a bad light – a preconceived agenda by the filmmaker. Some objective critics of our U.S. health care system now consider the film as having done their cause considerable damage. After careful scrutiny of the filming process and the film's representations, it's clear the movie isn't a credible and accurate documentary after all.

- *Point:* MM contends in the movie that "…if there's one thing they do right in Cuba, it's health care. There's very little debate about that." He took a group of 9/11 rescue workers to Cuba and asked Cuban officials to "give us the same exact care they give their fellow Cuban citizens. No more, no less. And that's what they did." He states that there is really no argument about this.

  Counterpoint: There is considerable argument available. In actuality they were sent to a special clinic that is specifically used for important citizens, tourists, and dignitaries – not at all representative of typical care. Cuban born Dr. Jose Carro, who interviews Cuban doctors who have moved to the U.S., contends that MM's movie lies. Dr. Darsi Ferrer, a human-rights advocate in Cuba, told John Stossel at ABC News that Americans should not believe the claims being made. He describes the Cuban people as "crazy with desperation" because of poor quality care. ABC News reported that, unlike "Moore's hospital", most hospitals in Cuba

are dilapidated. And when Fidel Castro became ill in 2006, a Doctor from Spain was brought in to care for him.

- *Point:* MM claims Cubans live longer than Americans.

  Counterpoint: It's true that a U.N. report claims that, but the U.N. didn't gather that data. Dr. Carro contends that "The United Nations simply reports whatever the government in Cuba reports, so we have no objective way to know what the real statistics are". It's very doubtful that this is even close to the truth.

- *Point:* Cuba has low infant mortality.

  Counterpoint: Once again, this is what the Cuban government reports. Doctors report that Cuban obstetricians tend to abort a fetus when they think there might be a problem. Dr. Julio Alfonso reported to John Stossel of ABC News that they used to do 70 to 80 abortions a day (presumably at his medical facility). There is another report from former Cuban doctors that is disturbing – Cuban doctors don't count an infant as ever having lived if he or she dies within a few hours of birth.

- *Point:* MM claims in a representation to ABC that "All the independent health organizations in the world, and even our own CIA, believe that the Cubans have a pretty good health system. And they do, in fact live longer than we do."

  Counterpoint: The CIA disagrees with this – their position is the opposite, and this is clearly stated in their "Fact Book": U.S. citizens live approximately a year longer than Cuban citizens.

- *Point:* It didn't take Mr. Moore long to discover the very favorable aspects about Cuba's health care system. The information had been there all along and the movie merely raised the visibility of the Cuban successes.

  Counterpoint: Long before Mr. Moore's 2007 movie, in the mid 1990s, anthropologist Dr. Katherine Hirschfeld became interested in Cuba after reading laudatory books and articles describing Castro's achievements in health and medicine. She found that the research was not credible and few, if any, of the authors actually spent time in Cuba. She even was hospitalized in a Cuban hospital with no working phone and never saw a doctor during her hospitalization. She completed her research, and published a book several years later.

More About the Canadian Health Care System

Many claims have been made by Michael Moore and others as to the superiority of the Canadian system. Critics acknowledge the greatness of our close neighbor and ally Canada, but nevertheless a complete and objective evaluation of their health care system must consider its many flaws.

- *Point:* Mr. Moore "dares" supporters of the U.S. system to try to "challenge me on these things" – referring to the higher Canadian rating compared with the U.S.

  Counterpoint: Rationing of health care services does occur in Canada. In 2007, a lady was about to have a multiple delivery. She was discouraged from going to the nearby neonatal units because of crowding. She chose to travel to Montana to have the babies. Dr. David Gratzer, author of "The Cure" reported on ABC that he thought the Canadian system was great until he started treating patients. "The more time I spent in the Canadian system, the more I came across people waiting". He sited examples of people waiting 6 months to see a neurologist for headache diagnosis and treatment. MRIs take a similar time to schedule.

  The Vancouver, B.C. based Fraser Institute's annual publication, "Waiting Your Turn" reports that Canada's median waiting times from a patient's referral by a general practitioner to treatment by a specialist, depending on the procedure, averages from five to 40 weeks. The wait for diagnostics, such as MRI or CT, ranges between four and 28 weeks. The Cato Institute reports that one out of three Canadian physicians send a patient to the U.S. for treatment each year.

- *Point:* Canadians live longer lives because of their superior health care.

  Counterpoint: The life expectancy is slightly higher in Canada, but for a different reason. The comparison would show U.S. citizens living longer if the effect of traffic accidents and violence were factored out.

- *Point:* The Commonwealth Fund Study (TCF) cited above rates Canada higher than the U.S. in "access" to health care services.

  Counterpoint: The fact that the U.S. does not have a universal system automatically lowered the ranking dramatically – without regard to any other objective measurement or available statistics. For example, one thing that wasn't considered is that more than a million Canadians cannot find a regular family doctor – in spite of their universal system. One town actually holds a lottery to determine those who will have access to a family doctor – but their treatment is "free" when it occurs. Canadians stuck on waiting lists sometimes pay "medical travel agents" to come to the U.S. for treatment. And there are many examples of important surgery being classified as "elective". One veterinarian reported he can see a dog or cat the next day for a CT scan, but humans typically wait a month. **Access to a waiting list is not access to health care.**

- *Point:* The Canadian system is incorrectly identified as "socialized medicine". In socialized systems, the doctors work for the state. In Canada, and many countries with universal care, the state reimburses the doctors for the care they provide.

  Counterpoint: Critics would say that's a distinction without a difference. What really distinguishes a socialized system is that the government makes all the

decisions on care and pricing. This is different from a free market for health care, even if an insurance industry is superimposed on top.

- *Point:* Canadian physicians do make considerably less than in the U.S., but there are other, less measurable, more intangible benefits.

  Counterpoint: Critics would call this a "yes/but" argument. While escaping the problem of dealing with insurance companies and other distractions is a positive, there isn't the inherent motivation, focus and other advantages of a typical free market – even with all of the flaws of a free market system.

- *Point:* A recent report intended to defend the Canadian health system, and expunge the myths about it, stated that the claims that Canadian patients have horrendous wait times is partly true and partly false. "It depends on which province you live in, and what's wrong with you".

  Counterpoint: This would be described as a very weak "yes/but" argument – almost an admission of inferiority.

- *Point:* The report referred to in the prior item takes exception to the assertion that you have to wait forever to get a family doctor. But they admit this is the case for a percentage of Canadians. Again it depends on where you live, for the most part.

  Counterpoint: This is another admission disguised as a "yes/but" defense.

- *Point:* The claims that Canada has universal coverage for only the basics, and "you are on your own for anything else" is acknowledged as true by its defenders. It's not really a problem, they claim, because the basic coverage covers so much. Items not covered, according to the defenders, are things such as medical equipment, prescriptions, physical therapy, chiropractic care, dental, vision, private rooms, etc. This information is taken directly from the pro Canadian report referred to above which also points out that "filling the gap between the basics and the extras falls to the country's remaining private health insurers".

  Counterpoint: This is another "yes/but" defense which actually seems to close the definitional gap between the U.S. and Canadian systems – perhaps more than universal health proponents are comfortable with.

- *Point:* Canadian health care services are not rationed.

  Counterpoint: Many expert observers disagree. Claude Castontuay chaired a 1960s Canadian government committee studying health reform and recommended that his home province adopt government administered health care. All citizens would be covered through tax levies. He is considered by many as the architect of the existing Canadian health care system – at least for the province of Quebec. His ideas for Quebec were implemented coast to coast.

Investors' Business Daily, reports that four decades later, as chairman of a government committee reviewing Quebec health care in 2008, he concluded that the system is in "crisis". He states, "We thought we could resolve the systems's problems by rationing services or injecting massive amounts of new money into it". And now he prescribes a radical overhaul: "We are proposing to give a greater role to the private sector so that people can exercise freedom of choice". He wants to contract services back out to the sector which had it originally.

What made him change his mind was a reluctant (probably) acknowledgement that the Canadian system is so overburdened that hundreds of thousands in need of attention wait for care, participate in lotteries for family doctor appointments, travel to the U.S. for certain problems, etc.

Quietly, the provincial governments of Canada have sent patients to the U.S. For example, in the last two years, Ontario has sent at least 164 patients to New York and Michigan for neurosurgery emergencies – defined as "broken necks, burst aneurysms and other types of bleeding in or around the brain".

Critics point out that you simply can't "centrally plan" your way to better care.

Insurance

- *Point:* Insurance is a savior and individuals should get all they can.

  Counterpoint: Some characterize insurance as a necessary evil. Some contend that we should invest in it only for the bigger financial risks. If everyone could do this it would be best for the system. Health insurance has become a payment system, rather than a risk management tool.

  Doctors spend approximately 14% of their revenue on insurance paperwork. We need to have more consumer control over what is paid and how much coverage is obtained. Furthermore, some feel that the current payment system is too invisible and that a better transparent system would be if the consumer paid the bills with reimbursement by the insurance company coming to the consumer. This should also be tied in with tax credits for the consumer.

- *Point:* Insurance is an efficient way to pay for health care.

  Counterpoint: Perhaps it is for major medical and catastrophes, but not what is referred to as "first dollar coverage". Therefore some believe the best way is to combine major/catastrophic coverage with a self insured savings plan for "first dollar coverage". One form of this is a health savings account (HSA). This gives an added benefit because consumers spend directly for this part of their coverage which many believe is a more efficient method to provide wise decisions for amounts less than major medical coverage. But many states right now do not

allow an insurance company to sell you that major medical coverage without all the add-ons that politicians and special interests have come up with.

This philosophy opposes universal systems as being inefficient with poor choices for expenditures the result. Put the individual in charge. Care deteriorates under governmental control. Foolish pursuit of "free care" is the enemy of good care.

- *Point:* Based on census data from 2005, over 46 million people lack health care coverage because it's too expensive. The estimate is now over 47 million people.

  Counterpoint: Skeptics of this data provide the following analysis. Of the total 46 million, approximately 17 million made over $50,000 and simply chose not to obtain coverage – affordable coverage was available to them. The average uninsured American has above average income, and low income people do have access to Medicaid. Almost half of the 46 million were in transition and not part of a long-term uninsured group. They were between jobs and chose not to pay flor the Cobra continuation coverage available to them – again a matter of choice. Of the remaining, about 10 million are not citizens, including illegal immigrants.

  As many as 14 million of the uninsured are fully eligible for government assistance programs like Medicare, Medicaid, and SCHIP. A study in 2008 by the Georgetown University Health Policy Institute shows that 70% of uninsured children are eligible for either Medicaid, Schip, or both. They just aren't enrolled.

  Some estimates conclude that the so-called "crisis" really applies to fewer than 10 million Americans who truly lack long term access to health care coverage. These certainly should be a significant focus of any reform we institute.

- *Point:* People without health insurance have no access to care.

  Counterpoint: Among those with comparable incomes, the uninsured get about the same amount of health care as those with insurance once they seek care. Many of those not receiving care simply aren't seeking it.

- *Point:* Insuring people will eliminate uncompensated care.

  Counterpoint: The largest amounts of uncompensated care are generated by Medicare and Medicaid patients. This occurs because Medicaid and Medicare often pay providers less than cost. Eliminating the uninsured by putting them on Medicaid may actually increase the amount of uncompensated care by eliminating the payments the uninsured make for their own care, increasing utilization and increasing administrative overhead. In the 1990s, Tennessee insured everyone in the state under the TennCare program. The program was supposed to eliminate uncompensated care, but by the late 1990s uncompensated care had increased.

- *Point:* Health insurance is unaffordable for individuals.

Counterpoint: As one example, in Colorado, a 40 year-old woman can choose from a number of comprehensive health insurance policies that cost less than $100 a month. Adding two children costs about $50 to $100 a month more. The most this woman would have to pay for health insurance, regardless of health status, would be $425 a month under Cover Colorado, the state's risk pool, or insurance plan, for the uninsurable. These are rates available as of 2008. Most or all states have programs for making reasonably priced coverage available to all.

- *Point:* Medicare has lower administrative costs than private insurance plans or private care providers. A government report stated that administrative costs for Medicare are 1.5% of total expenditures, while for private health care it is 25%.

  Counterpoint: Recent information suggests that Medicare administrative costs are similar to those in the private sector. Overhead is not completely a waste. For example, it includes case management for patients with chronic conditions, health education expenses, fraud detection and customer service, areas in which Medicare is notoriously weak.

  The government report is misleading and inaccurate. A study by the Council for Affordable Health Insurance (CAHI) found that Medicare administrative costs were 5.2% compared to private sector care that was approximately 8.9%. PriceWaterhouseCoopers found that only 6% of private health care premiums go to administrative costs and a full 86% of premiums go to providing actual medical care. In 2002, the Washington State Office of the Insurance Commissioner determined that administrative expenses for companies filing annual statements with the state averaged 12.6 percent of overall revenues.

  Part of the confusion here is that the government's official estimate didn't account for the hidden costs of Medicare, and hid other costs. For example, the government's report doesn't include things like the salaries of managers and administrators, or the marketing costs associated with advertising new policies like Medicare Part D drug benefits. Private plans must, and do report all such costs. Additionally, Medicare passes off a great deal of its costs to private payers. And the low reimbursement rates of Medicare and Medicaid end up being subsidized by private plans – some estimate this to be as much as a 10% impact. CAHI found that when all of the hidden costs and certain related unfunded liabilities were included, Medicare and Medicaid administrative costs were significantly higher (26.9%) than the private sector (16.2%).

- *Point:* People are better off if their health insurance policies have lower deductibles and pay for routine care.

  Counterpoint: Buying insurance for predictable expenses is the most expensive way to purchase medical care. Lower deductibles come with higher premiums. Someone spending $10,000 on health insurance with a $500 deductible might be

able to buy a policy with a $5,000 deductible for $5,000 a year and save the remaining $5,000 in a tax-free health savings account. The higher deductible makes this plan better if health expenses for the year are less than $5,000.

The anecdotal evidence that I have read and heard about seems to indicate that if one opts for a high-deductible plan, and then due to health issues you pay most or all of the deductible, the total you expend for the year will be a bit less, but in the same magnitude, as if lower deductible insurance had been purchased. The horror stories come from the fact that the amounts saved on the monthly premiums were not set aside in a tax deductible medical savings account, but rather spent.

- *Point:* Insurance company profits increase the cost of care.

  Counterpoint: There is a great deal of evidence showing that for-profit entities minimize costs better than nonprofit entities. Competitive markets generally make price increases difficult. When that happens, the only certain way to generate profits is to cut costs. In some cases, the efficiencies created by the drive to minimize costs allow for-profit firms to provide services that are better and less expensive than their nonprofit competitors, even though the for-profit entities must pay higher taxes and shareholder dividends. There is no evidence that health insurers are making abnormal margins or profits.

- *Point:* Malpractice lawsuits are essential to protecting patients.

  Counterpoint: In fact, many believe it hurts many and generally reduces innovation and availability of care. One famous serious of lawsuits is held out as an example. Many suits claimed C-sections reduced the incidents of cerebral palsy, and large settlements were obtained. Many personal injury lawyers are still litigating these cases. But some research has shown that the increase of the use of C-sections hasn't reduced cerebral palsy. In spite of this, our friend John Edwards has not returned one cent of the $40 to 60 million he earned by bringing these suits. Fear of lawsuits introduces a "better safe than sorry" attitude which some believe leads to unnecessary procedures. Fear of suits also leads to secrecy.

Drugs and Drug Companies

- *Point:* Drug companies are evil and are price "gougers"

  Counterpoint: Given all their "warts" and the many things drug companies do to give us "stomach acid", the business climate in the U.S. has made us the producer of almost 90% of the new drugs coming to market. But there is no doubt, capitalism, like free speech, brings some bad with a whole lot of good.

- *Point:* Drug companies spend more on advertising than on research.

Counterpoint: Wrong. Investigators for network television reported that over 12 times as much is spent on developing new drugs.

- *Point:* Prescription drugs is one of the most important reasons for rising costs.

  Counterpoint: There is evidence that the real price of prescription drugs is actually decreasing, partly due to the increased use of generic drugs. And drug spending is but a small slice of total health care spending – less than 11% of health care expenditures go to prescription drugs. Moreover, drugs actually reduce health-care costs in the long run as newer drugs often obviate the need for expensive surgeries and long hospital stays. According to a recent study published by the National Bureau of Economic Research, each dollar spent on pharmaceutical drugs through Medicare saves the program $2.06. Drugs are effective in controlling chronic diseases, thereby reducing costs.

- *Point:* Drug importation could be an important part of the solution to rising costs.

  Counterpoint: Americans are subsidizing the lower cost of drugs in other countries. How? The U.S. drug manufacturers face government controls in those countries and are able to sell into those controlled markets only because we pay the "full freight" here in the U.S. It doesn't seem right does it? Should they refuse to sell anywhere there are such controls? That attitude reminds me of the old movie title "The Ugly American". Also, some other countries have permitted their local manufacturers to undercut the U.S. patent protection laws by manufacturing generics soon after development in the U.S.

- *Point:* Drug companies shouldn't be allowed to charge high prices for new drugs.

  Counterpoint: The only reason we have many new drugs is because of free market forces. Most experimental drugs fail in clinical trials, driving up the average cost to bring a new drug to consumers to about $1.3 billion. Since Europe and Canada do very little drug R&D, they absorb few of these costs. Investors in the U.S. are willing to make such a risky investment because of the rewards of developing successful drugs. Without the profit motive, investment and innovation would dry up and "miracle cures" from America would vanish. Thank God for U.S. innovation! Success isn't cheap or easy!

Next – More on The Commonwealth Fund (TCF) study and some recognition of the positives in our system.

Sources of Information

The major sources of information used in developing my health care commentaries will be included in my future report on health care reform recommendations. A preliminary, but not complete, list of sources can be found in my April 2009 report on the status of our health care system and reform.