

## American Health Care and American Productivity: An International Comparison

By John R. Graham

One of the great myths about American society is that our lack of a “universal” health plan harms our competitiveness. Even Lee Scott, former CEO of Wal-Mart, a company that has introduced some headline-making innovations in health benefits for its workforce and customers, bemoans the cost of U.S. health care as a burden on the economy: “The soaring cost of health care in America cannot be sustained over the long term by any business that offers health benefits to its employees. And every day that we do not work together to solve this challenge is a day our country becomes less competitive in the global economy,” according to Mr. Scott.<sup>1</sup>

Many other American business leaders and politicians have complained that U.S. health care puts this nation at a competitive disadvantage.<sup>2</sup> The masters of this refrain, of course, are the American automakers. Years before driving themselves into bankruptcy and the unwelcoming arms of their new owners, the American taxpayers, they used to claim that they spent up to \$1,600 per car on health care. This was more than they spent on steel, and a multiple of what they claimed their foreign competitors spent. According to professor Regina Herzlinger of Harvard Business School, these claims are inflated.<sup>3</sup> Nevertheless, there’s little doubt that U.S. automakers fund significantly greater health benefits than their foreign competitors, putting them at a disadvantage.

Case closed? Not at all. We don’t hear Mark Zuckerberg complaining that Facebook’s health care costs are preventing him from competing against foreign social-media businesses. Indeed, while all Americans complain about health costs, and fewer employers are offering health benefits, the argument that our health “system” reduces our competitiveness versus other countries with “universal” health care is actually quite weak.

### Key Points:

- Domestic critics claim that U.S. health care is a drag on productivity, but the United States is the world’s most productive nation.
- American productivity leads to much higher national income than in other countries, suggesting that our high health spending as a share of GDP is not out of line.
- After spending more on health care, the United States has more dollars per person to spend on all *other* goods and services than our neighbors do: about \$4,500 more than Canada, \$5,000 more than Great Britain, \$6,000 more than Germany, and \$8,000 more than France.
- Obamacare, which massively increases government control of Americans’ access to health care, threatens our productivity and general welfare.

Of course, the rigidities and inefficiencies in U.S. health care caused by massive government intrusion create pain for many Americans, and the need to get rid of these obstacles to health ownership is a constant theme of health care studies at PRI. Nevertheless, the percentage of all firms offering health benefits actually increased from 66 percent in 1999 to 69 percent in 2010. Recently, a greater number of smaller firms have begun to offer health benefits.<sup>4</sup>

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The *status quo* is clearly unacceptable in many ways: lack of portability of health benefits, opaque prices for health services, reckless trial lawyers driving up health costs through expensive litigation, and regulation that reduces competition amongst both payers and providers. These are some of the problems for which PRI and others have proposed solutions. Nevertheless, we need to be more skeptical about claims that the current organization of U.S. health care results in such a terrible burden on the nation's welfare. That is why we have challenged "conservative" reforms in the direction of "universal" health care, such as former Governor

Romney's efforts in Massachusetts, which is proving unwieldy as anticipated.<sup>5</sup>

Even a "conservative" reform can play into the hands of those who seek more government power over our health care. For example, the Medicare Modernization Act of 2003 brought us Health Savings Accounts and tried to inject market forces into Medicare by creating a prescription drug benefit, Part D, offered only through private insurers. It also created added incentives for seniors to enroll in Medicare Advantage, where they receive all their benefits through private insurers.

Unfortunately, this made both drug makers and health insurers more dependent on government for their success, instead of patients. Further, as we anticipated years ago, the "free-market" protections in these programs are withering under the attack of those who demand more political control over health care.<sup>6</sup> Under Obamacare, the government will decide whether a patient can take a "blue pill" or a "red pill," according to a statement the president himself made during the debate.<sup>7</sup>

One major goal of those who seek to expand state power over our health choices to reduce the amount spent on health care. One oft-cited metric is that the United States spends far more on health than other countries as a share of Gross Domestic Product (GDP). But this measurement can mislead. For example, advocates of government monopoly health care point out that Canadian and U.S. health spending as a share of GDP was about the same before the Canadian government took over health care, but diverged starting in 1970, soon after the government completed its takeover. This is presented as evidence that the state can control costs better than the private sector.

Advocates ignore that real GDP growth in Canada dramatically outpaced U.S. growth between 1969 and 1987, meaning that the *denominator* of the health spending per GDP ratio grew much faster in Canada, not that the *numerator* grew much slower. In fact, between 1975 and 1987, the period soon after the Canadian state imposed its monopoly, real dollar spending on physicians' services in Canada stabilized at just under the U.S. rate of growth: 4.2 percent versus 4.8 percent annually.<sup>8</sup>

Common sense indicates that richer countries will spend more on health care. Robert L. Ohsfeldt and John R. Schneider estimate that an increase of \$1,000 in GDP per person results in a \$110 increase in health care spending, if the relationship is linear. If this is the case, then something is seriously wrong in American health care, because the United States spends far more than that for each dollar increase in GDP.<sup>9</sup> This model, however, is a poor fit.

It is more likely that nations increase their health spending at a certain *rate* as GDP goes up, not a certain dollar amount. The international evidence fits the latter hypothesis much better: a thousand-dollar increase in GDP

increases health spending by about 8 percent.<sup>10</sup> In this case, health spending really ratchets up as national income increases. For example, if GDP increases from \$30,000 per capita to \$31,000, health spending increases by \$232; but if GDP per capita increases from \$40,000 to \$41,000, health spending increases by \$500. According to Ohsfeldt and Schneider, this model explains 93 percent of variation in health spending internationally—much greater explanatory power than the linear (dollar for dollar) model. Most importantly, the United States is not at all an outlier.

This finding challenges our intuition, however, because it is hard to grasp how much more the U.S. earns than other countries, and how much buying power this gives us. U.S. GDP per capita is far greater than almost any other nations' and this is largely due to American productivity. U.S. GDP per person engaged (employed) in 2008 was \$65,480, followed by Hong Kong at \$58,605 and Ireland at \$55,986. Some of this was due to Americans working longer hours, but mostly it was due to productivity: value produced per hour worked. Most developed countries produce between 60 percent and 90 percent of the value that the U.S. does, per hour worked. For the four countries compared in this analysis, France was the second most productive, with a productivity rate 91 percent of the United States. Germany lagged at 72 percent.<sup>11</sup>

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Table 1 compares the USA with four countries whose health care systems are often held up as admirable options: Canada, Germany, France, and Great Britain. In all these countries, GDP per capita was significantly less than the United States. The U.S. spent significantly more on health care per person than comparable countries. Nevertheless, Americans still have much more money left over *after* paying for health care. Indeed, we have almost one-third more resources than Germany or France—*after* paying for health care—a “bonus” of American productivity.

Although many Americans suffer without the means to pay for their health care, PRI has argued elsewhere that this is largely a consequence of misguided government intrusion. And it's not as though the American welfare state cannot subsidize those truly incapable of financial self-reliance. Medicaid, the joint state-federal program for poor patients has grown relentlessly in the last four decades.<sup>12</sup>

American crusaders for “universal” health care—as opposed to universal choice in health care—emphasize America's uniqueness in lacking this characteristic of the modern welfare state. Given the benefits of America's productivity, perhaps it is a uniqueness we should not rush to abandon.

**Table 1: National Accounts for Five Countries, U.S. dollars, Purchasing Power Parity, 2008**

	U.S.	Canada	Germany	France	Great Britain
GDP	\$46,901	\$38,923	\$36,918	\$34,641	\$37,250
Health Spending	\$7,538	\$4,079	\$3,737	\$3,696	\$3,129
Difference	\$39,363	\$34,844	\$33,181	\$30,945	\$34,121
U.S. “bonus” after health spending as percentage		13%	19%	27%	15%
U.S. “bonus” after health spending in dollars		\$4,519	\$6,182	\$8,418	\$5,242

Source: Organization for Economic Co-operation and Development, StatExtracts (Paris, France, Organization for Economic Co-operation and Development, data extracted November 2010).

# Endnotes

- 1 A. Granito, "Health-care fix will require co-operation, Wal-Mart chief says," *Seattle Times*, February 27, 2006.
- 2 See, e.g., Lee Hudson Teslik, *Healthcare Costs and U.S. Competitiveness*, Backgrounder (New York, NY: Council on Foreign Relations, May 14, 2007).
- 3 Regina Herzlinger, *Who Killed Health Care? America's \$2 Trillion Medical Problem – And the Consumer-Driven Cure* (New York, NY: McGraw-Hill, 2007), pp. 104-105.
- 4 Kaiser Family Foundation & Health Research and Education Trust, *Employer Health Benefits 2010 Annual Survey*, Pub. #8085 (Menlo Park, CA: Henry J. Kaiser Family Foundation, September 2010), pp. 29-32.
- 5 Thomas Cheplick and Joe Emanuel, "Massachusetts Slashes Funding, Rations Care," *Health Care News* (August 8, 2009), available at [http://www.heartland.org/policybot/results/25810/Massachusetts\\_Slashes\\_Funding\\_Rations\\_Care.html](http://www.heartland.org/policybot/results/25810/Massachusetts_Slashes_Funding_Rations_Care.html); John R. Graham, "Eenie, Meenie, Miney, Mandate: Compulsory Private Health Insurance is Not Universal Choice," *Health Policy Prescriptions*, vol. 4, no. 11 (November 2006).
- 6 John R. Graham, "Republican HillaryCare: The Medicare Drug Benefit's Prescription for Perverse Incentives," *Health Policy Prescriptions*, vol. 4, no. 2 (February 2006).
- 7 John R. Graham, "Red Pill, Blue Pill, Better Not, Get Ill," *National Review Online*, July 22, 2009. Available at <http://www.nationalreview.com/critical-condition/48618/red-pill-blue-pill-better-not-get-ill/john-r-graham>.
- 8 Brian S. Ferguson, *Expenditure on Medical Care in Canada: Looking at the Numbers*, AIMS Health Care Reform Background Paper #8 (Halifax, NS: Atlantic Institute for Market Studies, December 2002).
- 9 Robert L. Ohsfeldt and John R. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington, DC: The AEI Press, 2006), p. 7.
- 10 *Ibid.*, p. 8.
- 11 ILO, "Labor Productivity (KILM 18)," *Key Indicators of the Labor Market*, sixth edition (Geneva, Switzerland: International Labor Organization, September 2009). Available at <http://kilm.ilo.org/KILMnetBeta/pdf/kilm18EN-2009.pdf>.
- 12 John R. Graham, "Government Greed, Not Human Need, Drives the Growth of Medicaid," *Health Policy Prescriptions*, vol. 8, no. 8 (August 2010).

