

American Health Care and American Productivity: It's Better Than You Think!

By John R. Graham

- Domestic critics often claim that U.S. health care is a drag on our productivity, but this is far from clear. 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.
- Even after spending more on health care than other countries, the U.S. has more dollars per person to spend on all *other* goods and services than our neighbors do: about \$5,000 more than Canada or Great Britain and about \$8,000 more than France and Germany.
- Policies to impose "guaranteed, universal" health care in the U.S., simply because "every other country in the world has it," ignore the unintended consequences of such policies to American productivity and welfare.

There's a rising chorus in the land that the flaws of American health care are not only bad for our health but harm national competitiveness and overall welfare. Even Lee Scott, 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 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.¹

Many other American business leaders and politicians have complained that U.S. health care puts this nation at a competitive

disadvantage.² American automakers claim to spend up to \$1,600 per car on health care, more than they spend on steel, and a multiple of the \$110 per car they claim Toyota spends. According to professor Regina Herzlinger of Harvard Business School, these claims are inflated.³ 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 Steve Jobs complaining that Apple's health-care costs are so many dollars per iPod. Indeed, though 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.

Of course, the rigidities and inefficiencies 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 at the Pacific Research Institute. The percentage of all firms offering health benefits declined from 69 percent in 1999 to 60 percent in 2007. However, this decline is almost completely accounted for by businesses with fewer than 10 employees.⁴ Indeed, one might even argue that the freedom to contract employment without health benefits is a competitive advantage of American entrepreneurship, in that American companies and workers are free to opt out of the government-regulated health "system" if they have to in order to compete — a freedom denied in other countries.

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

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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 to be as unwieldy as we anticipated.⁵

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, that made both drug makers and health insurers more dependent on the government for their success, instead of patients. Further, as we anticipated almost two years ago, the "free-market" protections in these programs are withering under attack by those who seek more political control over health care.⁶

Congress now demands a reduction in payments to private insurers in order to rope more kids into SCHIP (state government health insurance plans) and impose direct government price-fixing for prescription drugs. Even the piracy of potentially fake medicines from foreign countries would likely be "legalized" (if that's the right term for theft of intellectual property) with the White House and Congress both under Democratic control.

One major goal of those who seek to expand state power over our health choices is to reduce the amount spent on health care. One often-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, real dollar spending on physicians' services in Canada stabilized at just under the U.S. rate of growth between 1975 and 1987, the period soon after the Canadian state imposed its monopoly: 4.2 percent versus 4.8 percent annually.⁷

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 U.S. spends far more than that for each dollar increase in GDP.⁸ However, this model 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.⁹ 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 U.S. is not at all an outlier.

However, this finding challenges our intuition, 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 other nations, and this is largely due to American productivity. U.S. GDP per person employed in 2006 was \$63,885, followed by 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. Only Norway was more productive than the U.S., producing \$37.99 per hour worked versus \$35.63.¹⁰

Table 1 compares the U.S. with four countries whose health-care systems are often held up as admirable options for the U.S.: Canada, Germany, France, and Great Britain. In all these countries, GDP per capita was significantly less than the U.S. The U.S. spent significantly more on health care per person than comparable

Table 1: Per Capita Spending in Five Countries, U.S. Dollars, Purchasing Power Parity, 2005

	U.S.	Canada	Germany	France	Great Britain
GDP	\$41,837	\$33,939	\$30,720	\$30,396	\$32,819
Health Spending	\$6,401	\$3,326	\$3,287	\$3,374	\$2,724
Difference	\$35,436	\$30,613	\$27,433	\$27,022	\$30,095
U.S. "bonus" after health spending as percentage		16%	29%	31%	18%
U.S. "bonus" after health spending in dollars		\$4,823	\$8,003	\$8,413	\$5,340

Source: Organization for Economic Co-operation and Development, *Stats v. 4.4*

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.¹¹

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

John R. Graham is Director of Health Care Studies at the Pacific Research Institute. He can be reached via email at jgraham@pacificresearch.org or 415-955-6104.

Endnotes

- ¹ A. Granito, “Health-care fix will require co-operation, Wal-Mart chief says,” *Seattle Times*, February 27, 2006.
- ² See 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 2007 Annual Survey*, Pub. #7672 (Menlo Park, CA: Henry J. Kaiser Family Foundation, September 2007), p. 32.
- ⁵ See Sally Pipes, *Questionable Cure for A Questionable Crisis: The Massachusetts Health Plan Takes Shape* (San Francisco, CA: Pacific Research Institute, November 2006); and John R. Graham, “Enie, Meenie, Miney, Mandate: Compulsory Private Health Insurance is Not Universal Choice,” *Health Policy Prescriptions*, Vol. 4, Nov. 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 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).
- ⁸ Robert L. Ohsfeldt & John R. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington, DC: The AEI Press, 2006), p. 7.
- 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. 8.
- ¹⁰ ILO, *Key Indicators of the Labor Market*, 5th ed. (Geneva, Switzerland: International Labor Organization, September 2007).
- ¹¹ John R. Graham, “Taming the Medicaid Monster: The President Pushes Progress but States Shirk Solutions,” *Health Policy Prescriptions*, Vol. 4, No. 8 (August 2006).