What Health-Care Crisis?

America's medical care is second to none—and available to all.

by Fred Barnes

Bill and Hillary Clinton have contributed heavily to a national myth. Mrs. Clinton, as boss of the administration task force plotting to overhaul America's health-care system, refers routinely to "the health-care crisis." Her husband uses the same phrase ("Our government will never again be fully solvent until we tackle the health-care crisis," Clinton declared in his State of the Union address on February 17). And he goes one step further. "A lot of Americans don't have health insurance," he told a group of schoolkids February 20 during a nationally televised children's town meeting at the White House. "You know that, don't you? A lot of Americans don't have health care."

The press also trumpets the crisis theme. *Parade*, the popular Sunday supplement, emblazoned its February 28 cover with this headline: "THE GROWING CRISIS IN HEALTH CARE." The result is that the American people, despite their personal experience, now believe there actually is a health-care crisis. Most opinion polls show roughly three-quarters of Americans are satisfied with the availability and quality of the health care they receive. Yet, in most polls, 60 to 70 percent feel the health-care system is failing and needs significant, if not radical, reform.

There is no health-care crisis. It's a myth. If millions of seriously ill Americans were being denied medical care, that *would* be a crisis. But that's not happening. Everyone gets health care in this country—the poor, the uninsured, everyone. No, our health-care system isn't perfect. There isn't enough primary care—regular doctor's visits—for many Americans. Emergency rooms are often swamped. The way hospitals and doctors are financed is sometimes bizarre. Health care may (or may not) be too costly. But it's the best health care system in the world—not arguably the

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best, but the best. Its shortcomings can be remedied by tinkering, or at least by less-than-comprehensive changes. An overhaul of the sort Hillary Clinton envisions is not only unnecessary, it's certain to reduce, not expand, the amount of health care Americans receive (price controls always lead to less of the controlled commodity). Then we really will have a health-care crisis.

You don't have to take my word that there's no crisis now and that health care here is the world's best. There's solid evidence. Let's examine four key aspects of the health care debate: access, false measures of quality health care, true measures, and how America's system compares with those of other industrialized democracies (Canada, Germany, Japan, Great Britain).

Access

Will someone please tell Bill Clinton that having no health insurance is not the same as having no health care? The uninsured get health care, only less of it than the insured. Being uninsured means "one is more likely to use emergency-room care and less likely to use office, clinic, or regular inpatient care," said Richard Darman, President Bush's budget director, in congressional testimony in 1991. "This is not to suggest that this is desirable. It is not." But it *is* high-quality health care.

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Doctors in emergency rooms are specialists. In fact, they have a professional organization, the American College of Emergency Physicians. Its motto is: "Our specialty is devoted to treating everyone in need, no questions asked." Turning away patients isn't an option. Federal law (section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985) requires medical screening of everyone requesting care at a hospital emergency room. If treatment is needed, it must be provided. What this adds up to is "universal access" to health care in America, as one head of a hospital board told me.

It's no secret how much health care the uninsured get. The American Hospital Association estimated in 1991 that hospitals provide $10 billion in uncompensated care annually. Another study found that the 16.6 percent of the non-elderly population who are uninsured—36.3 million people—accounted for 11 percent of the nation's personal health-care expenditures in 1988. They had 37 percent fewer sessions with doctors and 69 percent fewer days in the hospital. There's a reason the uninsured get less health care, beyond the fact most work in low-paying jobs without health insurance. The uninsured tend to be young, thus healthy. According to a new poll by Frederick/Schneiders, 39 percent are 18-29 years of age and another 25 percent are 30-39. By the way, the elderly (65 and up), who require more medical care, are covered. Ninety-nine percent are eligible for Medicare.

To make sure we really have universal access, I checked on how victims of the most recent epidemic, AIDS, are treated. These are the folks doctors are supposed to be leery of dealing with.

What if a penniless AIDS patient shows up at, say, the Whitman-Walker Clinic in Washington, D.C.? That patient, even if indigent, gets treatment. When the time comes (T-cell count below 500), the patient is started on AZT, which costs about $5,000 a year. Later, the patient gets expensive, experimental drugs: DDI, DDC, D-4T. The drugs are paid for mostly by federal funds. There's also doctor care, painkillers, laboratory work. To prevent infections or complications, the patient is treated with prophylaxis.

A friend of mine volunteered to help an indigent, bedridden AIDS patient. He was amazed at the level of care. "It was an endless supply of extremely sophisticated drugs, an elaborate IV system [to feed the patient], and eventually a five-day-a-week home help nurse," my friend said. "Sometimes we had so much medicine, we had to throw it away. There was never a sense we'd be left in the lurch." The patient had no insurance. He lived with a boyfriend, but the boyfriend was not required to pay for any of the care. The federal and city governments—the taxpayers—footed the bill. The American Medical Association says "lifetime medical care" for a single AIDS patient costs $102,000.

False Tests

Judging by the two most common measures of health, life expectancy at birth and the infant mortality rate, health care in the United States is not the best or even among the best. In 1990, life expectancy in America was 72 years for males, 78.8 for women. This put the U.S. behind Canada, France, Germany, Italy, Japan, and Great Britain, among others. On infant mortality, the U.S. fared still worse, ranking nineteenth in 1989 with a rate of 9.7. (The infant mortality rate is the number of deaths of children under one year of age, divided by the number of births in a given year, multiplied by 1,000.) Finland, Spain, Ireland, East Germany, and Italy finished higher.

What's wrong with these measures? Just this: they're a reflection of health, not the health-care system. Life expectancy is determined by much more than the quality of a nation's health care. Social factors affect life expectancy, and this is where the U.S. runs into trouble. "Exacerbated social problems . . . adversely affect U.S. health outcomes," noted three Department of Health and Human Services officials in the fall 1992 issue of *Health Care Financing*

Review. "The 20,000 annual U.S. homicides result in per capita homicide rates 10 times those of Great Britain and 4 times those of Canada. There are 100 assaults reported by U.S. emergency rooms for every homicide. About 25 percent of spinal cord injuries result from assaults." And so on. The incidence of AIDS is even more telling. Through June 1992, there were 230,179 reported AIDS cases here, two-thirds of whom have died. Japan, where life expectancy is four years longer for men than in the U.S. and three years longer for women, has had fewer than 300 AIDS cases. Once social factors have played out, the U.S. ranks at the top in life expectancy. At age 80, when most people are highly dependent on the health-care system, Americans have the longest life expectancy (7.1 years for men, 9.0 for women) in the world.

The infant mortality rate (IMR) is also "reflective of health and socioeconomic status and not just health care," wrote four Urban Institute scholars in the summer 1992 issue of *Health Care Financing Review*. And there are measurement problems. Many countries make no effort to save very-low-birth-weight infants. They aren't recorded as "live born" and aren't counted in infant mortality statistics. In contrast, American hospitals make heroic efforts in neonatal intensive care, saving some infants, losing others, and driving up the IMR. "The more resources a country's health-care system places on saving high-risk newborns, the more likely its registration will report a higher IMR," according to the Urban Institute scholars.

Social factors probably have a bigger impact. A poverty rate twice Canada's and Germany's, a rash of drug-exposed babies, a high incidence of unmarried teenage pregnancy—all lead to low-birth-weight infants and affect the IMR. "Infant mortality rates of babies born to unmarried mothers are about two times higher than the rates of babies born to married mothers," the scholars write. The point is not that America's high IMR is excusable, but that it's grown to abnormal levels in large part because of factors unrelated to the quality of health care.

Not only that. The entire medical system bears the brunt of social and behavioral problems that are far worse in the U.S. than in other industrialized democracies. "We have a large number of people who indulge in high-risk behavior," says Leroy L. Schwartz, M.D., of Health Policy International, a non-profit research group in Princeton, New Jersey. Behavioral problems become health problems: AIDS, drug abuse, assaults and violence, sexually transmitted diseases, etc. "The problem is not the health-care system," says Dr. Schwartz. "The problem is the people. Every year the pool of pathology in this country is getting bigger and bigger. We think we can take care of everything by calling it a health problem." But we can't.

Real Tests

While primary and preventive care are important, the best measure of a health-care system is how well it treats the seriously ill. What if you've got an enlarged prostate? Your chances of survival are better if you're treated here. The U.S. death rate from prostate trouble is one-seventh the rate in Sweden, one-fourth that in Great Britain, one-third that in Germany. Sweden, Great Britain, and Germany may have higher incidences of prostate illness, but not high enough to account for the wide disparity in death rates.

An ulcer of the stomach or intestine? The death rate per 100,000 persons is 2.7 in the U.S., compared to 2.8 in the Netherlands, 3.1 in Canada, 4.9 in Germany, 7.6 in Sweden, and 8 in Great Britain. A hernia or intestinal obstruction? The American death rate is 1.7. It's 2 in Canada, 2.7 in Germany, 3 in the Netherlands, 3.1 in Great Britain, and 3.2 in Sweden. Can these be attributed solely to varying incidences of ulcers and obstructions? Nope.

I could go on, and I will. The overall death rate from cancer is slightly higher in America than in Sweden or Germany, but lower than in Canada, the Netherlands, and Great Britain. But for specific cancers, the U.S. has the lowest death rate: stomach cancer, cervical cancer, uterine cancer. Only Sweden has a lower death rate from breast cancer. The U.S. also has the second lowest death rate from heart attack. No matter what the disease—epilepsy, hypertension, stroke, bronchitis—the U.S. compares well. For a country with a heterogeneous population and large pockets of pathology, this is remarkable. Life expectancy for American males at 65 is 14.7 years, only a tad less than Canada (15), Sweden (14.9), and Switzerland (14.9), more homogeneous countries with fewer social problems. (I'm grateful to Dr. Schwartz for all these figures.)

Another measure that's important is the proliferation of new technology. "Major medical technology has had a profound impact on modern medicine and promises even greater impact in the future," wrote Dale A. Rublee, an expert in cross-national health policy comparisons for the AMA's Center for Health Policy Research, in *Health Affairs*. He compared the availability of six technologies—open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extracorporeal shock wave lithotripsy, and magnetic resonance imaging—in the U.S., Canada, and Germany in 1987. "Canada and Germany were selected because their overall health-care resources are fairly comparable to the United States," Rublee wrote. The U.S. came out ahead in every category, way ahead in several. In MRI's, the U.S. had 3.69 per one million people, Germany 0.94, Canada 0.46. For open-heart surgery, the U.S. had 3.26, Canada 1.23, Germany 0.74. For radiation therapy, the U.S. had 3.97, Germany 3.13, Canada 0.54. Small wonder that, as Rublee put it, "American physicians, with a universe of modern technology at their fingertips, are the envy of the world's physicians."

Rival Systems

Canadian politicians get special health care privileges, moving to the head of waiting lists or getting treatment at the elite National Defence Medical Centre. But that wasn't sufficient for Robert Bourassa, the premier of Quebec. He came to the National Cancer Institute in Bethesda, Maryland, for diagnosis, then returned to the U.S. for surgery, all at his own expense.

The Canadian health-care system has many nice attributes, but speedy treatment isn't one of them. Ian R. Munro, M.D., a Canadian doctor who emigrated to the U.S., wrote in *Reader's Digest* last September of a young boy in Canada who needed open-heart surgery to free the blood flow to his lungs. He was put on a waiting list. He got a surgery date only after news reports embarrassed health officials. After waiting two months, he died four hours before surgery. This was an extreme case, but waiting is common in the Canadian system, in which the government pays all costs, including set fees for private doctors. A study by the Fraser Institute in 1992 found that 250,000 people are awaiting medical care at any given time. "It is not uncommon for patients to wait months or even years for treatments such as cataract operations, hip replacements, tonsillectomies, gallbladder surgery, hysterectomies, heart operations, and major oral surgery," according to Edmund F. Haislmaier, the Heritage Foundation's health-care expert. Canada has other problems: health costs are rising faster than in the U.S., hospital beds and surgical rooms are dwindling, and doctors are fleeing (8,263 were practicing in the U.S. in 1990).

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The Japanese model isn't any better. When Louis Sullivan, M.D., President Bush's secretary of health and human services, visited Japan, he was surprised to find medical care matched that of the U.S.—the U.S. of the 1950s. Japan has universal access and emphasizes primary care at clinics, financed mostly through quasi-public insurance companies. The problem is price controls. "Providers seek to maximize their revenue by seeing more patients," wrote Naoki Ikegami, professor of health at Keio University in Tokyo. "This dilutes the services provided."

Patients receive assembly-line treatment. "In outpatient care, a clinic physician sees an average of 49 patients per day [and] 13 percent see more than 100," Ikegami said. For the elderly, a survey found, the average number of doctor's visits for a six-month period was 17.3 (3.6 here) and the length of visits was 12 minutes (30 in the U.S.). Like Canada's queues, this is an extraordinarily inefficient way to dispense care. Patients return repeatedly to get the same care that in the U.S. is given in a single visit.

Japanese doctors also prescribe and sell drugs. Not surprisingly, they sell plenty. Thirty percent of the country's health expenditures are for drugs (7 percent in the U.S.). In Japan, wrote Ikegami, "no real incentives exist to maintain quality." The one exception is specialists at Japan's teaching hospitals. To avoid queues, patients pay bribes of $1,000 to $3,000 to be admitted to a private room and treated by a senior specialist.

Germany also has strict fees for doctors, with predictable results. Annual doctor's visits per capita are 11.5 (5.3 here), a figure exceeded only by Japan (12.9). In other words, price controls are as inefficient in Germany as in Japan. Hospitals face perverse incentives, too. The government pays a fixed rate per day, regardless of the patient's illness or length of stay. So hospitals pad their billings by keeping patients for unnecessarily long recuperations, which compensates for the losses they incur taking care of critically ill patients.

Then there's Great Britain, home of the National Health Service. Officials take great pride in having reduced the number of patients waiting more than two years for medical attention. In 1986, the number was 90,000; in 1991, 50,000. In April 1992, it was down to 1,600. Sounds great, but there's a catch. The number of patients waiting six months or less grew by 10 percent. The overall drop in waiting lists was only three percent. And this was achieved, a survey by the National Association of Health Authorities and Trusts found, chiefly because of a 13 percent hike in NHS spending in 1991, not increased efficiency. The good news in Great Britain is that private insurance is allowed and 6.6 million Brits have it. Insurance firms encourage beneficiaries to have an operation or other treatment in a private hospital. Sure, the company pays, but it knows that once a patient has experienced care in a private hospital, he'll never go back to the socialized medicine of NHS. And he'll keep buying health insurance. Private hospitals, anxious to fill empty beds, have their own come-on. At Christmas, they offer discount prices for operations.

In truth, the U.S. has little but painful lessons to learn from the health-care experience of other countries. There's practically nothing to emulate. On the contrary, foreign health officials, Germans especially, now look at the incentives in the American medical system as a way to remedy problems in their health care systems. Hillary Clinton and health policy wonks should stop apologizing for our system.

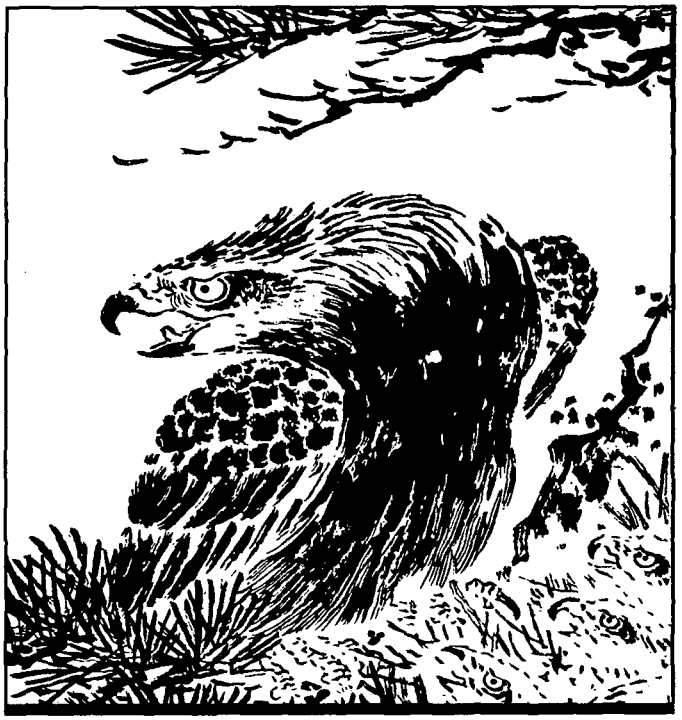
They won't. The existence of a few health care problems, chiefly the lack of proper primary care for several million Americans, allows them to declare a crisis and go on wartime footing. Liberals love this. Hillary's task force meets in private, keeps the names of its members secret, obsesses over leaks, spurns the advice of outsiders (doctors, Republicans). The program that emerges is sure to dwarf the problem. If enacted, it will make the problem worse. This is a common phenomenon in Washington. Some people never learn.

In 1991, an American official addressed Russian health experts in Moscow. He bemoaned that many Americans get care at emergency rooms and occasionally wait six or eight hours. To the American's shock, the Russians erupted in laughter. In Russia, with twice as many doctors per capita as the U.S., a wait of six to eight hours represented unusually fast service. ❐

William McGurn

I Hear Asia Calling

The most populous and industrious part of the world can't face the future without American leadership. Is anyone in Washington listening?



As dawn creeps up on the main gate of Subic Bay Naval Station, 62-year-old Dominga do Lopo is already here waiting, chatting away with a group of friends. A hundred yards down the road, members of a Manila high-school marching band alight from their bus. Dozens of other townfolk, many in their Sunday best, are giving the street vendors brisk business despite the early hour.

They are all here to see a bit of history. Until recently, Subic was home to America's largest base in Asia. Today it looks like a ghost town. Vast expanses of parking lots once jammed with cars lie empty; roadsides are bereft of the usual Marines jogging by; the base McDonald's stands closed and shuttered. In a few short hours the last 500 or so American sailors and Marines will ship out on the USS *Belleau Wood*, ending an American military presence that began almost a century ago and a foreign presence that dates to Magellan. The Manila papers have been treating it as a day of emancipation.

Most of the Filipinos here, however, have more regret than pride. "I am feeling very lonely for the Americans," says Mrs. do Lopo, who spent years as a base worker. The others nod in agreement. Even after months of evacuation, people here just can't believe that the Americans are really going—this time with no promise to return.

The rest of Asia watched with similar anxiety. Although the pullout from Subic threatened no vital American commitments, Asians wonder whether the closing of America's premier base might soon prove a metaphor for a lessening commitment to the region. Not so, says Washington, but it's hard not to notice that the U.S. withdrawal from Subic and scaling down of American forces comes at a time when an increasingly belligerent Peking is shopping for all sorts of new military hardware, North Korea has opted out of the Nuclear Non-Proliferation Treaty, and the Japanese (whose defense budget is the third largest in the world) are talking about revoking, or at least modifying, their pacifist constitution.

Without doubt the disintegration of the USSR has lessened the security threat both to America and its allies in the region. But the shift in Moscow notwithstanding, America's vital interests in Asia have not so much diminished as changed. In sight today is a world characterized by open markets and international institutions such as the General Agreement on Tariffs and Trade and the United Nations. From the Asian perspective, the benefits of an American-led Pacific order are obvious: a security umbrel-

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