



Government Payment for Health Care — Causes and Consequences

Victor R. Fuchs, Ph.D.

From modest beginnings in the late 19th century, government's role in paying for health care has expanded greatly in every high-income country. Today, most of these countries have some form of

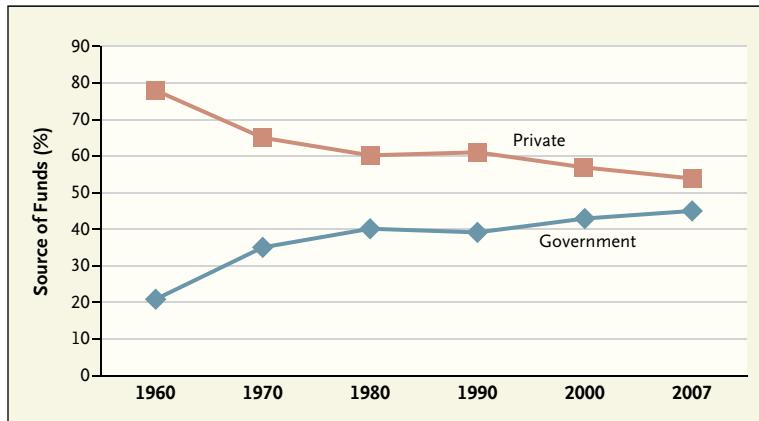
national health insurance — that is, all or virtually all of the population is eligible for health care that is paid for in full or in large part by a government-organized insurance system. The United States has long been criticized (and praised by some) for being an exception to the rule in its approach to financing health care. Even in this country, however, government's role in paying for care has increased greatly over the past 50 years (see graph). Government's share of total personal health care expenditures in the United States grew from 20% in 1960 to almost 50% in 2007 and will undoubtedly exceed the private sector's share when the pro-

grams that were enacted in the 2010 health care reform legislation become activated.

What explains the widespread role of government in paying for health care? Some U.S. critics argue that it is all a big mistake. But in 1775, Samuel Johnson contended that “uniformity of practice seldom continues long without good reason.”¹ Two centuries later, George Stigler, a Nobel Prize winner in economics, wrote, “If an economic policy has been adopted by many communities, or if it is persistently pursued by a society over a long span of time, it is fruitful to assume that the real effects were known and desired.”² If we follow Stigler's line

of thought, we should observe the consequences of a policy and from them infer the cause or causes.

The most obvious, easily quantifiable difference between the United States and countries that have national health insurance is that those countries spend much less on health care, whether measured per capita or as a share of the gross domestic product. Not only is the United States the highest spender, but the gap between it and the other countries is unnaturally large — we spend 50% more than the next-highest spender and twice as much as the average country in the Organization for Economic Cooperation and Development. One explanation that is frequently offered is the role of “special interests” in the United States. There is little doubt that the suppliers of health care goods and services — manufac-



Source of Funds for Personal Health Care Expenditures in the United States, 1960–2007.

turers of drugs, devices, and equipment, as well as physicians and hospitals — prefer higher expenditures to lower ones. But isn't that true in every country? The difficult question is why the special interests have more influence over health policy in the United States than they do elsewhere. The answer probably lies in part in the structure of the U.S. political system, including the role of primary elections, long and expensive election campaigns, the separation of powers, the numerous congressional committees and subcommittees with overlapping authority, and the need for supermajorities in the Senate in order to pass meaningful legislation. But the quirks of the political system can't be the whole answer. If the U.S. public wanted a different outcome, over time they could move policy in that direction.

It should be noted that the higher expenditures in the United States do confer some benefits. There is less likelihood of having to wait for a diagnostic or therapeutic procedure or to travel far to obtain it. Also, the amenities in hospitals, clinics, and physicians' offices are usually superior to those in other

countries that have a per capita income close to that of the United States. It would be of interest to determine how these benefits are distributed and how they are valued by people at different income levels.

A second large difference between health care in the United States and in countries with national health insurance is the more important role of redistribution in the latter countries. Such redistribution is evident in the greater equality of access to care and in the sharing of costs through taxes on income or payroll, value-added tax or sales tax, or other forms of taxation that are either proportional or progressive with respect to income. Of course, all insurance is redistributive after the fact. The large amount of care utilized by a small proportion of policy holders is paid from the premiums of others who use little care. The important distinction is that under a national health insurance system, the redistribution occurs before the event, since it is clear that some individuals will pay much less tax than the value of their insurance and some will pay much more.

Since redistribution plays a greater role in the health care systems of other countries than it does in the United States, there is an implication that a more egalitarian ethos holds sway in Europe, Canada, Australia, and New Zealand. From de Tocqueville to the present, many observers have commented on the stronger role of individualism in the United States than elsewhere, but there is no consensus regarding its explanation. Possible contributors to the phenomenon include the heterogeneity of the population, the revolutionary origins of the country with its dedication to "life, liberty, and the pursuit of happiness," and the absence of many centuries of a common language, history, and culture. In speculating about the possible rise of despotism in a democracy, de Tocqueville painted a grim picture of individualism taken to the extreme. He wrote, "Each . . . living apart, was a stranger to all the rest — his children and private friends constitute to him the whole of mankind; as for the rest of his fellow citizens, he is close to them, but he sees them not; he exists but in himself and for himself alone."³

The lower spending and the greater redistribution in countries that have national health insurance are not independent phenomena. If spending in these countries were at U.S. levels, the taxation required to accomplish their redistribution goals would probably wreck the economy. Given the social or political desire to redistribute health care resources, constraints on spending become a necessity. These constraints take various forms, such as controls over the number and specialty mix of physicians, limits on facilities

and acquisition of expensive technologies, hard bargaining over prices charged by drug companies and other suppliers, and restraints on physicians' fees and incomes, among others.

Because the governments in these countries pay for most medical care — usually 70 to 90% of total expenditures — they are in a good position to apply these cost-restraining measures. They have what economists call “monopsony power.” The U.S. government, although it pays for almost 50% of health care, makes very little use of its power to restrain costs. Thus, in one sense,

Americans wind up in the worst of all worlds, with government bearing a big part of the burden of paying for health care, with the concomitant large burden of taxes, but exercising very little control over the cost of care. As an indication of how absurd the situation is in the United States, government currently spends more per capita for health care than eight European countries spend from all sources on health care. Though life expectancy is far from a perfect measure of the quality of care, it is not without interest to note that life expectancy at birth in every one of

these eight countries is higher than that in the United States.

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://www.nejm.org).

From Stanford University, Stanford, CA.

1. Johnson S. A journey to the western islands of Scotland (originally published 1775). (<http://www.history1700s.com/page1209.shtml>.)

2. Stigler GJ. Supplementary note on economic theories of regulation. In: Stigler GJ, ed. *The citizen and the state: essays on regulation*. Chicago: University of Chicago Press, 1975:140.

3. DeTocqueville A. *Democracy in America*. Trans., Henry Reeve. Vol 2. *The social influence of democracy*. New York: Barnes & Co., 1840.

Copyright © 2010 Massachusetts Medical Society.

Influenza Vaccine — Safe, Effective, and Mistrusted

Katherine M. Harris, Ph.D., Jürgen Maurer, Ph.D., and Arthur L. Kellermann, M.D., M.P.H.

On August 10, 2010, the World Health Organization (WHO) declared an end to the 2009 influenza A (H1N1) pandemic. It is fortunate that the virus that had spread worldwide so quickly turned out to be less severe than was first feared. It is worth remembering, though, that an earlier strain of H1N1 influenza — the one that emerged in 1918 — sparked the worst closely observed and recorded pandemic in history, killing an estimated 20 million to 40 million people worldwide.

The 2009 H1N1 virus did give us one gift of inestimable value: it provided a full-scale test of the ability of the United States to counter pandemic influenza. If we draw the right lessons from the response, we can considerably strengthen our country's public health preparedness.

The most obvious lesson is

that we currently lack the capacity to develop, produce, and distribute a new vaccine in time to counter a fast-moving pandemic — a fact that reinforces the need for continued federal investments in the processes, policies, and infrastructure required to swiftly produce and distribute a pandemic vaccine. In addition to protecting vaccinees themselves against the effects of the virus, vaccination decreases the likelihood that an exposed person will pass virus on to others. If sufficient numbers of people can be vaccinated in time, an epidemic can be slowed or even stopped in its tracks.

Before March 2009, when the new H1N1 influenza burst onto the scene, the conventional wisdom held that the next pandemic strain would originate in Southeast Asia, and we would have weeks, if not months, to develop

a pandemic vaccine. The conventional wisdom proved wrong. Despite an all-out effort that generated a safe and effective vaccine in record time, adequate stocks did not reach the public until December 2009. By that point, the pandemic had passed its peak, and public demand for vaccination was in swift decline. In the end, manufacturers were left with 70 million unused doses.¹

The second lesson of the pandemic may be less obvious, but it is just as important as the first. Accelerating vaccine production is necessary but insufficient to counter a future pandemic. For no matter how quickly a safe and effective vaccine is produced, it will do little good if large numbers of people refuse to be vaccinated. In other words, any increase in supply must be matched by an equally substantial increase in demand — and the