
Health Care Is Worse Here than Elsewhere? It Just Ain't So!

BY DAVID R. HENDERSON

In the November 13, 2007, *Washington Post*, columnist Eugene Robinson attacked former Republican presidential candidate Rudy Giuliani's claim that health care is better in the United States than in countries with socialized medicine. Robinson offers evidence that socialized medicine in various industrialized countries isn't much worse, and is sometimes better, than U.S. health care, but his case is weak. Indeed, with a little more knowledge of the facts and background, one can make a strong case that Giuliani is right: the U.S. health-care system, although it is highly regulated and somewhat socialized, is still better than systems of medicine that have an even bigger socialist component. Moreover, as we shall see, even Robinson seems unconvinced by his own argument.

Robinson begins by criticizing the data Giuliani cited on survival rates from prostate cancer. Giuliani had claimed that his chance of surviving prostate cancer was 82 percent and would have been only 44 percent in England. Of course, we can't know whether Giuliani actually had an 82 percent chance because his particular probability depended on his specific characteristics. He was clearly talking about the chances of a random man in this country.

Health-policy analyst David Gratzer says that Robinson's challenge falls flat. Robinson and other critics point out that, in his words, "death rates from the disease in the two countries are basically the same."

Gratzer agrees but says that this fact is misleading because a much higher percentage of Americans than Britons are diagnosed with prostate cancer in the first place. Once diagnosed, a man's chances of survival in the United States versus England are as Giuliani laid out. Score one for the United States.

Then Robinson cites a survey done by the Commonwealth Fund and Harris Interactive. The survey

was of adults in Australia, Canada, Germany, the Netherlands, New Zealand, Britain—all of which, Robinson writes, have single-payer health care—and the United States. Already, though, Robinson states the facts incorrectly: While the other six do have a large degree of socialized medicine, the one that comes closest to single-payer is Canada. Canadians are legally barred from paying individually for most health-care services. The other five countries have safety valves of various degrees. Although Australia, Britain, and New Zealand are the next-most socialized, people in those countries are allowed to buy private services. Britain, the granddaddy of socialized medical systems in the industrialized world, started allowing people to pay for medicine

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decades ago as the failures of the National Health Service became too big to hide. The Netherlands and Germany have a complicated hybrid of socialism and private enterprise.

The first thing Robinson cites from the Commonwealth study is that a lower percentage of respondents in the United States said that their health-care system “works well” and a higher percent saw a need for “fundamental” change. But the problem with such a question is that it asks people to answer as health-care analysts, not as consumers. Moreover, there has been a drumroll in the United States media for, oh, about 20 years about how bad our health-care system is. One major reason for this emphasis is that many people in the media dislike capitalism and want a socialist health-care system. In the countries with more socialism, on the other hand, there’s no contrary media bias in favor of free-market health care. So it shouldn’t be surprising that people who are surveyed are affected somewhat by this propaganda campaign.

Robinson points out that the survey data conclusively refute the idea that people in socialized medical systems don’t have a regular doctor. In fact, of the people surveyed in the other six countries, a higher percentage had a regular doctor than in the United States. This surprised me. Still, it’s hard to know what to conclude. Do people in more-socialized systems not go looking for other primary-care doctors because those other doctors will turn them away, unlike in the United States? Robinson doesn’t say, and the survey didn’t ask.

You get better information from surveys, as surveyors can tell you, if you ask people about their own experiences—their local knowledge, so to speak. And when it comes to their experiences with the system, Americans who were surveyed tell a more positive story. The United States comes up looking much better on waiting periods. Here’s how Robinson delicately puts it: “It’s true that in the United States, the wait for elective surgery is likely to be shorter than in the other countries (except Germany, which has the shortest wait of all). But onerous delays of six months or more were

significantly more common only in Australia, Canada and Britain.”

Note that the delays were more common in the countries with the greatest degree of socialism. Also interesting is that this is one of the few parts of Robinson’s article in which he doesn’t give the actual data. But they are quite striking. Whereas 62 percent of surveyed Americans had waited a month or less for elective surgery, only 32 percent of Canadians and 40 percent of Brits had waited a month or less. And whereas only 4 percent of Americans had waited six months or more, 14 percent of Canadians and 15 percent of Brits had waited six months or more. That’s a big difference in waiting times.

Out-of-Pocket Spending

Robinson also points out that Americans “were much more likely than any other national group to have spent at least \$1,000 out of pocket on medical expenses over the past year.” This is not surprising. When patients are more financially responsible for their own health-care expenditures, they tend to pay more out of pocket. But that makes doctors and other medical providers more responsive to their demands. One of the oldest economic principles is that he who pays the piper calls the tune. I want my doctor to depend on me for his livelihood rather than to know that there are many more like me lined up, none of whom can affect what he or she is paid: I’ll get better service that way.

Robinson seems to think he’s hit the mother lode by pointing out that of the countries surveyed, the United States has the highest infant mortality. But this fact has little to do with health care. Some of the major factors that influence child mortality, as John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick point out in *Lives at Risk*, are race, geography, income, and education.

Robinson ends, surprisingly, by writing, “I agree with Giuliani that if I had a life-threatening illness, I’d rather be treated here.” The question for Robinson, then, is, “Why?” His answer might have made for a more interesting article.

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