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Did Reagan Rule In Vain? A Closer Look at True Expenditure Levels in the United States and Europe

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They called it the Reagan revolution….Ours was the first revolution in the history of mankind that truly reversed the course of government.

—Ronald Reagan, farewell address to the nation, January 11, 1989

If you tell a lie big enough and keep repeating it, people will eventually come to believe it. The lie can be maintained only for such time as the State can shield the people from the political, economic, and/or military consequences of the lie.

—Unknown[1]

It is generally believed that the United States is a country of low taxes and small government, at least when compared with countries in Europe (and until the financial crisis so greatly expanded the role of the federal government in the United States in late 2008). Fully accounting for the role, size, and effect of the government in an economy is a complex endeavor, however, and it is hardly accomplished by repeatedly restating differences in top marginal tax rates, overall tax burdens, or gross sizes of governments in GDP terms.

This policy brief looks beyond the alleged, fundamental transatlantic differences between the United States and European countries in the role of government and the state-market tradeoff. Instead it focuses on the actual total flow of resources—both public and private—toward government tasks and social spending using a comprehensive method to control for the effects of US and European tax systems.

In so doing, this policy brief shows that, when properly measured, there is essentially no difference between the United States and European countries in the share of national economic output spent on either government tasks or social expenditures. In fact, this policy brief shows that the only meaningful difference between the United States and Europe is that US private-sector expenditures on healthcare dwarf private-sector healthcare expenditures in European countries.

FOLLOW THE MONEY—STATE-MARKET TRADE-OFFS AND GOVERNMENT TASKS

One of the most frequently debated, alleged axiomatic differences in social and economic policy between Europe and the United States is in their total taxation levels. And it is beyond doubt that Europe has a far higher total tax burden than the United States.[2] The latest OECD data (figure 1) reveal that general government tax revenues amounted to 28 percent of US GDP in 2006. Meanwhile the EU-15 average was about 40 percent of GDP, with a high of just over 50 percent in Sweden, close to double the US total.[3]

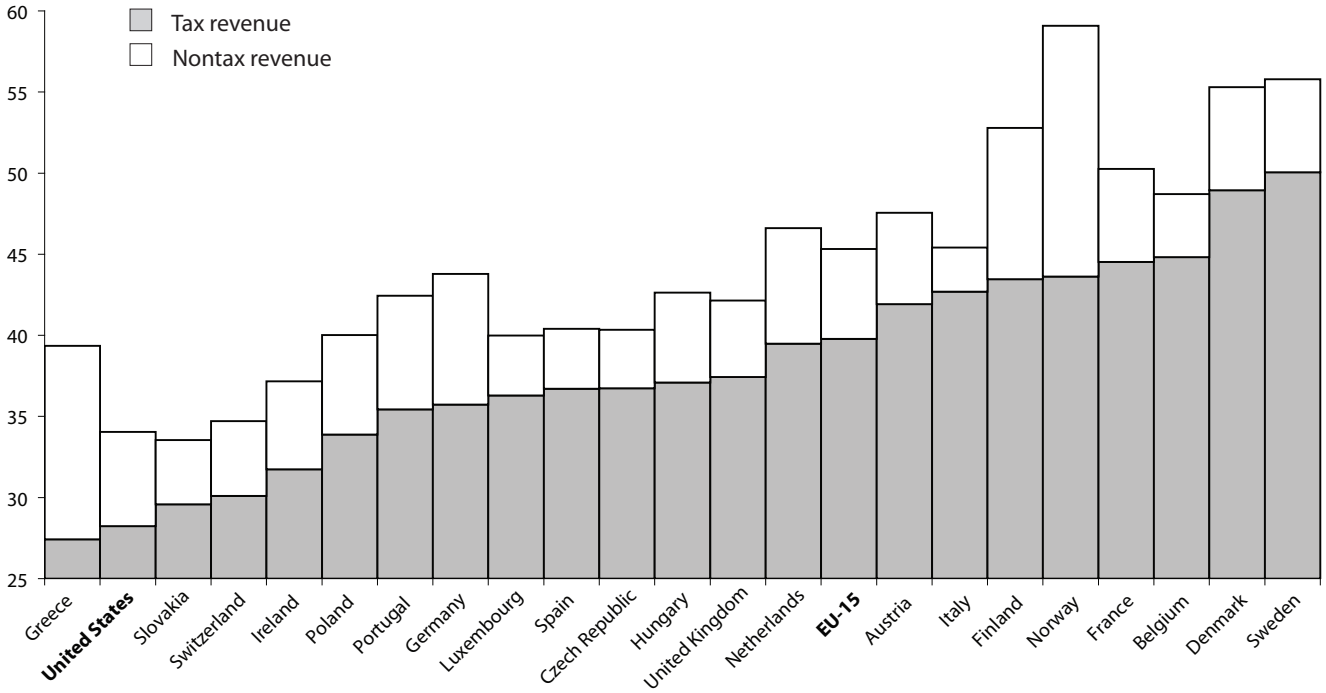
At the same time, figure 1 shows that US and EU-15 nontax

1. This quote is almost invariably attributed to Joseph Goebbels, but scholars of World War II have not been able to find any primary sources linking this quote to the German propaganda minister. Its true source is, therefore, unknown. See Bytwerk (2004).

2. Tax burden is usually defined as the amount of compulsory transfers imposed by units of the general government sector (i.e., all levels of government: central/federal, state, and local) on the rest of the economy. This policy brief will follow the demarcation of OECD revenue statistics and include all tax revenue and compulsory social security contributions. See IMF (2001) for details.

3. All EU averages in this policy brief are weighted by countries' nominal GDP for the year in question.

Figure 1 General government tax and nontax revenue, 2006 (percent of GDP)



Source: OECD (2007a).

general government revenue—i.e., revenue from sources such as property income, rents and fees for the use of government land, dividends from other public entities, and fines and grants from other levels of government—are quite similar: Both are roughly 5 to 6 percent of GDP.[4] This transatlantic similarity is also found in fiscal deficits: From 2000 to 2007 the average annual government deficit in the United States was 2.9 percent of GDP, precisely the same as in Italy and France and only marginally worse than the EU-15's roughly 2 percent average annual deficit for the period (OECD 2008a, annex table 27). With similar nontax revenues and deficits, the United States and Europe differ only in terms of tax revenue.

However, when making cross-country comparisons, a focus on tax rates alone is analytically unproductive. Taxes say little about real-world differences in government structure and, more importantly for the purposes of this policy brief, they are a very poor predictor of the amount of resources societies channel toward particular government and social purposes.

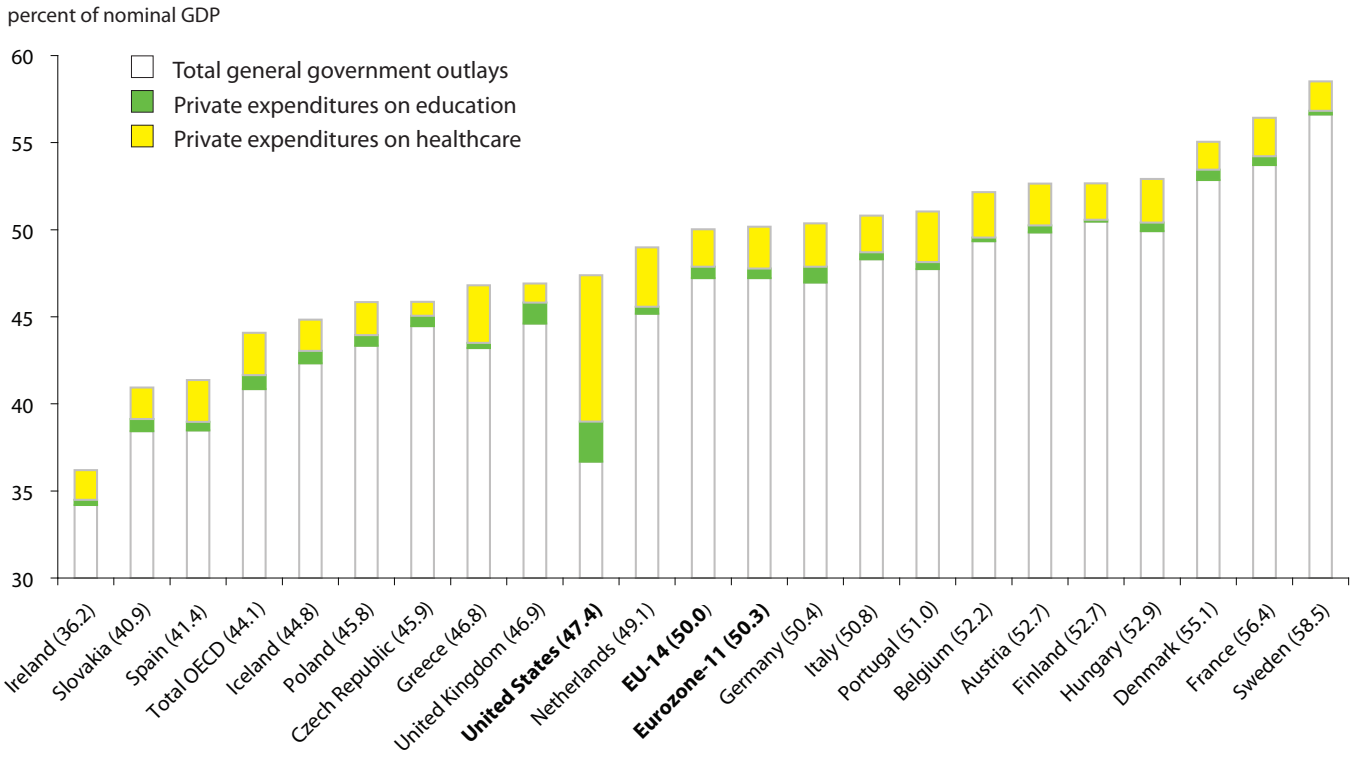
A large part of the difference in total tax burden and consequently reported general government activity levels between European countries and the United States arises from the fact that in Europe the healthcare and educational sectors, including tertiary education and universities, are overwhelmingly organized within the public sector, whereas in the United States the private sector provides a much larger share of these services. This general divergence remains despite rising private spending on healthcare and education in Europe in recent years and a general European movement toward US expenditure distribution in these two social policy areas (OECD 2008b, 2008c).

As a result, a much more instructive metric of comparison is total expenditures on typically governmental functions, which combines total general government expenditures with total private-sector expenditures on healthcare and education. This sum provides the combined total expenditure of a country on typically governmental functions, irrespective of whether the spending entity is in the public or private sector.[5] This comparison, as share of nominal GDP, is made with data from 2005

4. The largest sources of nontax government revenues in the United States are state and local government revenues from federal grants, property income, and the sale of goods and services by state and local governments. Federal nontax government revenues are a relatively small part of the total. See OECD (2007a, table 198).

5. The characterization of these services as "typically governmental functions" reflects two things: First, in most OECD countries—although of course not in the United States—both healthcare and education are overwhelmingly financed and provided by the government. Second, this terminology—admittedly rather simplistically—assumes that general government outlays go only toward tasks and functions that are usually performed by governments.

Figure 2 Total expenditures on typically governmental functions, 2005



Note: No data are available for Luxembourg. Countries are ranked by combined total, which is shown in parentheses.

Sources: OECD (2008a, 2008b, 2008c).

(the latest year available) in figure 2, with countries ranked by the combined total, which is shown in parentheses along the x-axis.

Figure 2 shows that, ignoring the sectoral classification of spending, total US expenditures on these typically governmental functions amount to nearly half of nominal GDP—47.4 percent in 2005. This total level of US spending is basically identical to average European total expenditure on these services—50 percent in the EU-14 and the eurozone. In other words, the share of total resources that the United States and European countries channel toward typically governmental functions is very similar.

In many respects, people convinced of the primacy of so-called economic pocketbook issues over professed ideological convictions should welcome these similar levels of expenditure. Following the pocketbook rule would predict that US and European citizens—two large, relatively similar groups of aging people with roughly the same level of wealth—would demand that equal shares of their productive capacities be spent on the same typically governmental functions, regardless of whether they claim to be small-government Reaganites or traditional European social democrats.

Going further with the comparison, it is useful to compare, in isolation from other government expenditures, the total levels of expenditure on both education and healthcare in the United States and Europe (see boxes 1 and 2 on OECD definitions of expenditures on education and healthcare, respectively). Figure 3 shows the most recent available data for both public and private expenditures on education and healthcare. As can be seen from the left-side stacked bars, US public expenditures on education

[T]he only meaningful difference between the United States and Europe is that US private-sector expenditures on healthcare dwarf private-sector healthcare expenditures in European countries.

Box 1 OECD definition of educational expenditure

The OECD defines educational expenditure in the following manner: Expenditure on educational institutions includes expenditure on both instructional and non-instructional educational institutions. Instructional educational institutions are educational institutions which directly provide instructional programs (i.e. , teaching) to individuals directly in an organized group setting or through distance education. Business enterprises or other institutions providing short-term courses of training or instruction to individuals on a one-to-one basis are not included. Noninstructional educational institutions provide administrative, advisory or professional services to other educational institutions but do not enroll students themselves. Examples include national, state, and provincial ministries or departments of education; other bodies that administer education at various levels of government. Included are also financial and human resources invested in education or analogous bodies in the private sector; and organizations that provide education-related services as vocational or psychological counseling, placement, testing, financial aid to students, curriculum development, educational research, building operations and maintenance services, transport of students, and student meals and housing. This definition of institutions ensures that expenditure on services, which are provided in some OECD countries by schools and universities and in others by agencies other than schools, are covered on a comparable basis. Public expenditure includes public subsidies to households attributable for educational institutions, as well as including direct expenditure on educational institutions from international sources. Private expenditure is net of public subsidies attributable for educational institutions.

Source: OECD (2008b).

Box 2 OECD definition of healthcare expenditure

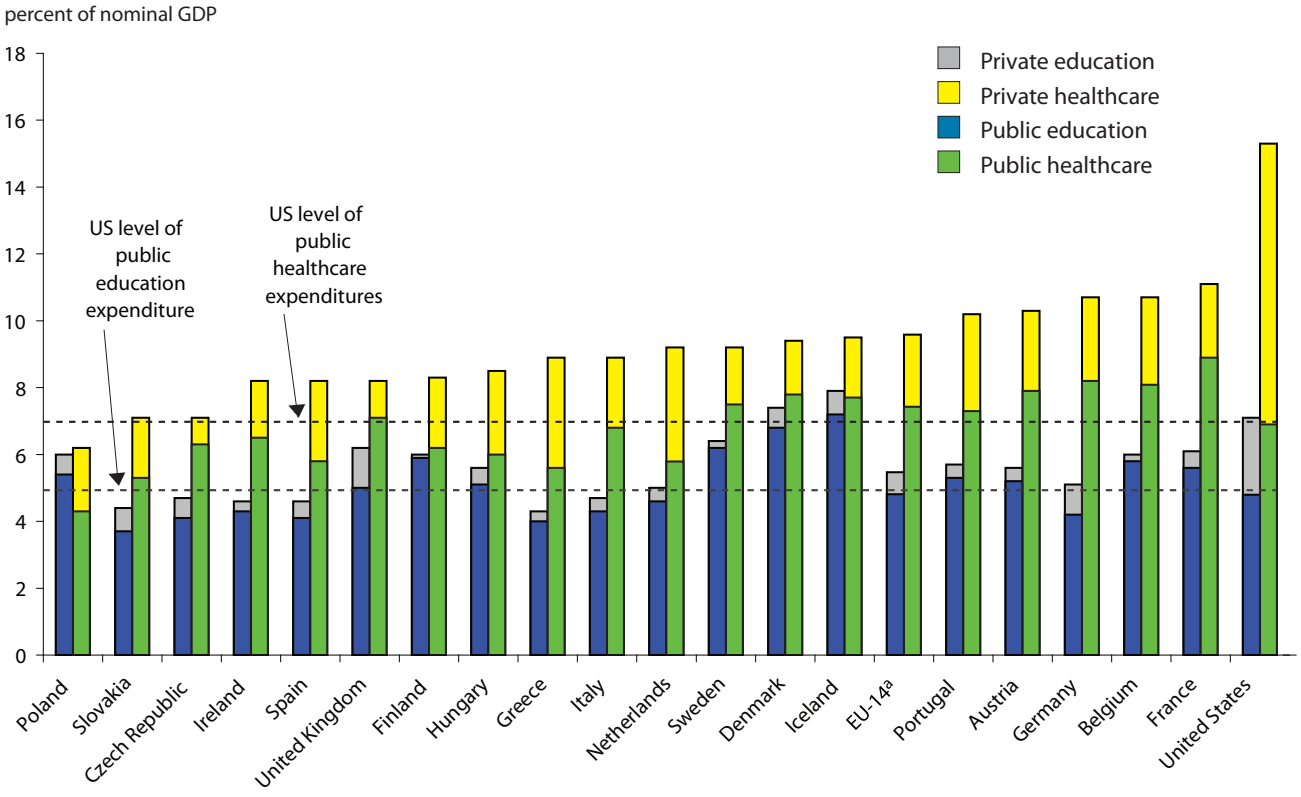
The OECD defines total expenditure on health in the following manner: The sum of expenditure on activities that—through application of medical, paramedical, and nursing knowledge and technology—has the goals of: 1) Promoting health and preventing disease; 2) Curing illness and reducing premature mortality; 3) Caring for persons affected by chronic illness who require nursing care; 4) Caring for persons with health-related impairments, disability, and handicaps who require nursing care; 5) Providing and administering public health; and 6) Providing and administering health programs, health insurance and other funding arrangements. Included in public expenditure is health expenditure incurred by public funds. Public funds are state, regional and local government bodies and social security schemes. Public capital formation on health includes publicly financed investment in health facilities plus capital transfers to the private sector for hospital construction and equipment. Included in private expenditure is the privately funded part of total health expenditure. Private sources of funds include out-of-pocket payments (both over-the-counter and cost-sharing), private insurance programs, charities and occupational health care.

Source: OECD (2008c).

in 2005 were just below 5 percent of GDP, a level quite similar to that in Europe. Only the Scandinavian countries spent somewhat more on public education, while Greece and Slovakia spent a little less. In terms of private expenditures on education, the US 2005 level of 2.3 percent of GDP was clearly higher than that of any European country, but this was not enough to push total US education expenditure levels far above the European (EU-14) average. In 2005 the United States in total spent about 1 percent more of GDP on education than did Europe on average but a little less than some of the Scandinavian countries.

The right-side stacked bars of figure 3 show that in 2005 US public expenditures on healthcare were essentially equal to the European average, equaling about 7 percent of GDP. Thus despite having a healthcare system that is often described as being much more oriented to the private sector, the United States actually spends the same share of its GDP on public healthcare as Europe. Figure 3 shows clearly that the only significant difference between the United States and Europe on education and healthcare expenditures is in the level of private healthcare expenditures. The United States spends about three times more

Figure 3 Public and private expenditures on education and healthcare, 2005



a. No data are available for Luxembourg.

Sources: OECD (2008b, 2008c).

on private healthcare than any European country, an amount of over 8 percentage points of (the larger) US GDP. As a result of this greater level of private healthcare expenditures, the United States spends greater than 50 percent more on healthcare than the EU-14 countries do on average. As such, it is a fair conclusion that the only reason in expenditure terms that the United States has a more private-sector oriented healthcare system is that its healthcare system is far more expensive for the private sector than is the case in Europe.

It may, of course, be argued that this difference, as well as the comparison of total expenditure levels on typically governmental functions found in figure 2, is somewhat of a red herring: Total expenditures on healthcare and typically governmental functions in general have politically been allowed to reach 15.3 and 47.4 percent of GDP, respectively, in the United States precisely because a far greater share of these services is provided by the private sector than in European countries. Underpinning this argument would be the frequently displayed, deep-rooted political hostility in the United States toward so-called big government and the associated belief that private-sector expenditures are inherently more efficient than similar expenditures by the public sector. While this latter statement could be true, a brief comparison of healthcare and educational outcomes in the United States and Europe raises some fundamental questions about this statement's validity, particularly whether it is empirically well-founded to have any a priori assumptions about the optimal state-market trade-off in delivering services in these two sectors (see box 3 on page 8).

A CLOSER LOOK AT THE TRUE LEVELS OF SOCIAL EXPENDITURES IN THE UNITED STATES AND EUROPE

Combining total government outlays with private-sector expenditures on education and healthcare is probably too crude a measure for analyzing the domestic social institutions pertinent to any discussion of meaningful differences between the United States and Europe. A more useful analytic concept is that of social expenditures. Most would probably agree that different social expenditure levels and the resultant levels of social transfers and redistribution are what ultimately epitomize any transatlantic divide on the role and scale of government. To find

the true difference between Mars and Venus, as Robert Kagan called the United States and Europe in his 2003 book *Of Paradise and Power: America and Europe in the New World Order*, one would have to look at social expenditure.

Fortunately, the OECD now collects data on social expenditures that allow for a detailed comparison between the United States and Europe in this area. The standard OECD definition of "social spending" is:

> The provision by public and private institutions of benefits to, and financial contributions targeted at, households and individuals in order to provide support during circumstances which adversely affect their welfare, provided that the provision of the benefits and financial contributions constitutes neither a direct payment for a particular good or service nor an individual contract or transfer.[6]

According to the OECD's Social Expenditure Database (SOCX), gross public social expenditures in the United States amounted to 15.9 percent of nominal GDP in 2005 (the most recent available data). This was about 10 percentage points less than the EU average and only slightly more than half the level in the highest spending country, Sweden, at 29.4 percent of GDP in 2005.[7] These data, therefore, superficially seem to validate notions of large differences between the United States and Europe in social expenditures and in their societal models, perhaps even illustrating the long-term success of the 1980s "Reagan revolution" in scaling back big government in the United States.

However, focusing solely on gross social expenditure levels is fundamentally misguided. The conceptual problem, related to what was illustrated in figures 2 and 3, concerns focusing only on gross public social expenditures. Presenting gross public social expenditure data alone is misleading because it neglects at least two crucial facts:[8]

1. *The tax treatment of social expenditures matters.* Social expenditures consist of two types: social services provision (e.g., healthcare, childcare, and care for the elderly) and cash benefits (e.g., pension benefits, unemployment benefits, and direct income support). Social expenditures of the latter type are subject to different tax treatment across countries, as direct and indirect taxation levels vary wildly. In some European countries, which have high indirect tax rates, such as the approximately 25 percent general value-added tax (VAT) on all transactions in Scandinavian countries, and high direct income tax levels, close to half of the gross social benefits the government hands out may be recovered in taxes.[9]
2. *Private social expenditures almost always incur some cost to the government.* As discussed earlier for education and healthcare, social expenditures may originate from either public or private entities. It is critically important to note, however, that social spending by private entities is usually carried out on a tax-preferred basis, which has substantial associated costs (so-called tax expenditures) for the government. Tax expenditures can be thought of as the amount the government would have received in tax receipts if no tax breaks had been granted toward specific purposes.[10] As is the case with the taxation of social benefits, the degree to which governments use tax breaks as a social policy instrument varies greatly between the United States and Europe. Europe tends to rely overwhelmingly on "direct public service provision" by the government, whereas the US has traditionally seen far higher levels of "social policy initiatives via tax breaks." The numbers are far from trivial: In 2006 alone the US federal government "spent" over $100 billion in tax breaks toward private pension provision and

6. As described in detail in OECD (2007c, 6–11), social spending does not include remuneration for work, since it does not cover market transactions, i.e., payments in return for the simultaneous provision of services of equivalent value. Employer costs such as allowances toward transport, holiday pay, etc. are part of remuneration in this sense. Social expenditures can be in the form of cash benefits (e.g., unemployment benefits or pensions), social services (e.g., childcare or care for the elderly), and tax breaks for social purposes (e.g., for private healthcare plans, pensions, or children). Expenditures are divided into the following nine categories: 1) old age benefits—pensions, early retirement pensions, home help, and residential services for the elderly; 2) survivor benefits—pensions and funeral payments; 3) incapacity-related benefits—care services, disability benefits, benefits accruing from occupational injuries and accidents, and employee sickness payments; 4) health benefits—spending on in- and out-patient care, medical goods, and prevention; 5) family benefits—child allowances and credits, childcare support, income support during maternity/paternity leave, and sole-parent payments; 6) active labor-market policies—employment services, youth training programs, subsidized employment, and employment services for the disabled; 7) unemployment benefits—unemployment compensation, severance pay, and early retirement for labor-market reasons; 8) housing benefits—housing allowances and rent subsidies; and 9) other social policy areas—uncategorized cash benefits to low-income households and other social services and support programs such as food subsidies, which are prevalent in some non-OECD countries.

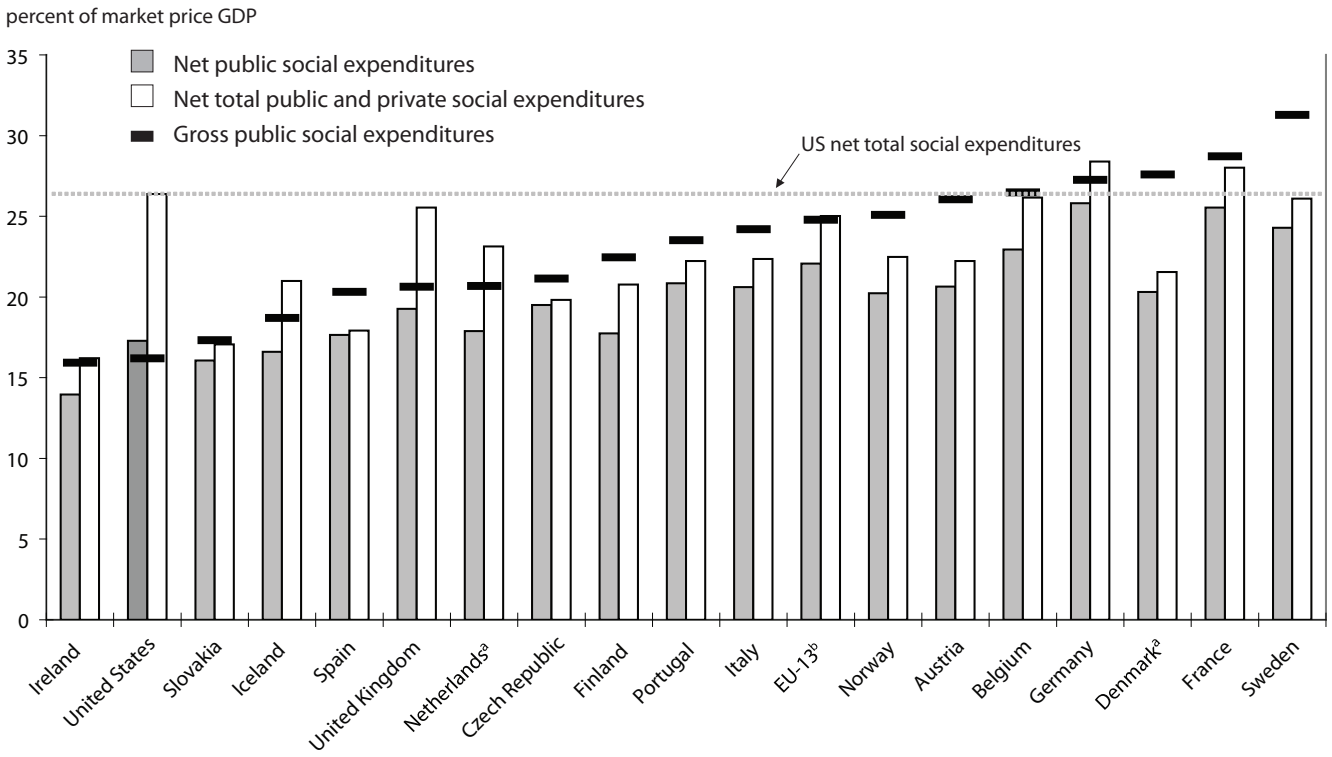
7. Preliminary data are available in OECD (2008e).

8. The following section draws from OECD (2007c). Due to space constraints, this policy brief cannot do justice to the many data and methodological issues and uncertainties surrounding the data in this section, which are extensively described in OECD (2007c). However, these issues and uncertainties are not of a magnitude that will materially impact the broader conclusions presented in this policy brief.

9. This reasonably assumes that all cash benefits are consumed within the providing country's tax jurisdiction.

10. US law defines tax expenditures as: "Revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or deferral of liability." See OMB (2007, 285ff) for a discussion of US federal tax expenditures.

Figure 4 Social spending, 2003



a. No data are available for value of tax breaks toward old-age pensions.

b. No data are available for Luxembourg and Greece.

Source: OECD (2007c).

$125 billion in tax preferences toward employer contributions for medical insurance premiums and medical care (OMB 2007, table 19.1).[11] A quick, back-of-the-envelope calculation reveals that on these two tax breaks alone the US federal government spent an average of about $750 for each of 300 million Americans in 2006.

Figure 4 shows how great an impact a switch from gross public social expenditures to the more analytically useful net after-tax total social expenditures (both public and private) has on the comparative levels of social expenditures for 2003 (the most recent data). It includes three data series: the starting point of gross public social expenditures (black lines), by which the countries are ranked on the x-axis; net public social expenditures (grey bars), which adjust gross public social expenditures for the effects of direct and indirect taxation and the public costs of tax breaks toward social purposes; and net total public and private social expenditures (white bars), which adds net private social expenditures to net public social expenditures. All data are presented as share of nominal GDP at market prices.[12]

Figure 4 shows several important things: First, as mentioned above, when measured by gross public social expenditures alone, the United States, at just over 16 percent of GDP, ranks among the least generous countries. Its spending is far below the levels of most European countries, which are often 10 percentage points of GDP higher in gross expenditure terms. However, figure 4 also shows that after accounting for the effects of taxation net public social expenditure levels in the United States and Europe are significantly more equal than suggested by gross public expenditure levels. This is due both to the far more extensive

11. Included in pension-related expenditures are tax expenditures toward employer plans, individual retirement accounts (IRAs), Keogh plans, and 401(k) plans.

12. The use of GDP at market prices was chosen to facilitate the comparison of gross and net expenditure levels. This choice raises some methodological considerations. OECD (2007c, annex 3), from which these data originate, notes in this regard that "the construction of net social spending indicators involves adjusting for indirect taxation of consumption out of benefit income, net social expenditure is related to GDP at factor cost, as GDP at factor costs does not include the value of indirect taxation and government subsidies to private enterprises and public corporations. However, in order to facilitate comparison with gross social spending indicators which are usually related to GDP at market prices for international comparisons, these are also estimated."

Box 3 Efficiency in education and healthcare spending in the United States and Europe revisited

The quality of educational and healthcare services may ultimately be in the eye of the beholder, and it is far beyond the scope of this policy brief to perform any detailed evaluation of these services. However, when considering state-market trade-offs in the United States and Europe, it is nonetheless informative to compare total expenditure levels with crude but intuitive performance measures in these two public policy areas, where the sectoral expenditure patterns, as seen in figures 2 and 3, differ substantially between the two sides of the Atlantic. In both cases, the United States allocates a substantially larger share of its total expenditures through the private sector.

In such an undertaking, it is important to distinguish between effectiveness and (economic) efficiency. Effectiveness in public policy can be conceptually defined as a scenario in which policymakers set a policy goal and achieve it (or not). One hypothetical, healthcare-related example of effectiveness would be that elected officials decided to make it a public policy priority to reduce the incidence of breast cancer. Policymakers, therefore, directly allocated resources toward this goal and achieved a marked reduction in breast cancer mortality rates through, for example, improved preventive measures and an expansion of treatment options.

However, effectiveness is a purely goal-oriented notion—i.e., was the goal achieved or not?—and is completely separate from the notion of (economic) efficiency. The efficiency of any policy can be established only by considering the resources spent on achieving a particular goal. Continuing the example above: A particular anti–breast cancer policy—e.g., mandatory annual mammographic screenings provided for free to all women—may be effective, but it would not be deemed efficient if it required that healthcare resources be transferred away from other policies that were more effective at achieving the same goal of lowering breast cancer rates with the same resources. Simply throwing money at a problem may be effective, but it is almost never efficient.

Given that in most OECD countries the government is the monopoly supplier of healthcare and educational services and that because of this there are no alternative, large-scale private suppliers, it is usually impossible to compare public provision of services with private-sector provision of the same services at the national level. Hence one can rarely establish in much detail whether government provision of these services is efficient or not in healthcare or education. The lack of real counterfactuals in many OECD countries precludes such comparative analyses.

It is possible, however, to take advantage of the cross-country differences in the financing of education and healthcare illustrated in figures 2 and 3. Using these cross-country spending differences and output variables that intuitively approximate effectiveness for the sector in question, it is possible to gauge, at least superficially, whether a particular country has a relatively more efficient total level of spending and public-private resource allocation than other countries. Such comparisons are made in figure B3.1 for education and figures B3.2 and B3.3 for healthcare.

As the output variable for education (the y-axis), figure B3.1 uses the total sum of graduation rates for "at least upper-secondary" and "at least tertiary" education in 2005 for the age group 25–34. This variable captures the output of educational spending as the share of labor-market entrants in this age group who have achieved one or both of these two educational thresholds.[1] This is a broad, quantitative measure that simply assesses the percentage of the eligible total who graduate from a country's educational system; there is no attempt to adjust for the quality of a degree.[2] As a sum of two rates, the total may exceed 100. The resource variable (the x-axis) is total (i.e., both public and private) educational expenditures on all educational levels. The size of the bubbles indicates the share of private educational expenditures in the total.

Figure B3.1 shows that total educational expenditures vary from 3.5 percent of GDP in Greece to 8 percent in Iceland, with the United States close behind at 7.4 percent of GDP in 2004. More importantly, it is evident that educational outcomes (the y-axis) vary widely, too, with Portugal, Italy, and Poland at the bottom, the Scandinavian countries and the United States at the top, and the rest of the European countries massed in the middle. The relative positions of the United States and the European countries indicate that the United States, in the upper right corner, has generally effective educational expenditures in relative terms, with high levels of expenditure and a high sum of graduation rates, but that the Scandinavian countries are more efficient by this measure in their educational expenditures than the United States. They spend fewer resources (significantly fewer in the case of Finland) than the United States to achieve roughly the same outcome.

(box continues on next page)

1. The focus is on secondary and tertiary education, since primary education is compulsory in all of the countries in question and the inclusion of this measure would, therefore, not add any informative variation to the sample.

2. Measuring the quality of a given education is an extremely complex task and lies beyond the scope of this policy brief. See, for example, OECD (2006).

Box 3 Efficiency in education and healthcare spending in the United States and Europe revisited *(continued)*

Of particular importance to the discussion at hand, figure B3.1 also illustrates that the United States has by far the greatest share of private educational expenditures among the included countries (indicated by its relatively large bubble). There is very little to indicate that private educational expenditures are—in the broad average sense illustrated here—inherently more efficient than public educational expenditures. Figure B3.1 also shows that in many European countries suffering from too little public investment in education there is ample room for greater private educational expenditures and that this increase would likely be conducive to educational effectiveness—i.e., it would raise the number of graduates.

Turning to healthcare spending, the output variable chosen for figure B3.2 (the y-axis) is healthy life expectancy (HLE) as estimated by the World Health Organization (WHO). This variable was chosen because it captures the effects of a wide range of healthcare outcomes in just one variable. Unlike standard life expectancy estimates, which simply capture the average years of life in a population until death, irrespective of the condition of these years, HLE considers nonfatal health outcomes and provides a summary measure of population health status: HLE captures how many healthy years of life a population enjoys on average, rather than just the average age at which people die.[3] Similar to figure B3.1, the x-axis expenditure variable is total public and private healthcare expenditures, and the size of a country's bubble indicates the share of private healthcare expenditures in that country.

Several things are evident in figure B3.2: First of all, the United States spends far more per capita—over $2,000 purchasing power parity (PPP) more—on healthcare than any European OECD country. Second, it is immediately obvious that the US HLE of just 69 years in 2003 is 3–4 years lower than most rich, EU-15 countries and is on par with Portugal. Yet Portugal spent a total of just $2,119 PPP per capita on healthcare in 2006, just one-third of the $6,714 PPP per capita spent by the United States. Third, only Greece and, to a lesser extent, Switzerland have a share of private healthcare expenditures approaching that of the United States. And fourth, there is a very strong statistical correlation between total healthcare expenditures and HLE in Europe, whereas the United States is very obviously an outlier to this trend.

One might argue that using HLE is too broad a measure because it captures the effects of a plethora of other issues, such as diet, sedentary lifestyles, or smoking habits, rather than just healthcare-system outcomes. It might be better to use a measure more narrowly focused on the immediate result of a crucial, ubiquitous healthcare-system service (one usually requiring hospitalization), namely child bearing. Infant mortality rates are probably the most widely used such healthcare-quality indicator. Figure B3.3 replicates figure B3.2 using infant mortality rates instead of HLE.

The picture provided by figure B3.3 is similar in many ways to that of figure B3.2, except that the United States fares even worse in figure B3.3 than in figure B3.2.[4] The most recent US infant mortality rate (from 2005) of 6.9 per 1,000 live births is worse than any included European country and is nearly twice the EU-15 average of 4 per 1,000 live births in 2006, even though the United States spends significantly more resources on healthcare than any European country. As such, measured by infant mortality, the United States has an extremely wasteful and highly inefficient healthcare system. It is also noteworthy that measured by infant mortality rates, there is again a statistically significant correlation between expenditure levels and outcomes in Europe, while the United States remains an outlier to this trend.

In other words, a reasonably clear trade-off exists in Europe between expenditures and outcomes in healthcare, and relative efficiency levels are thus in the aggregate reasonably comparable: A given level of expenditure yields a given level of healthy life expectancies and infant mortality in Europe. Figures B3.2 and B3.3 make it clear that European efficiency levels, in terms of achieving a broadly healthy population and reducing infant mortality rates, are far above those found in the more private sector oriented US healthcare system. Indeed, figures B3.2 and B3.3 suggest that in efficiency terms socialized medicine in Europe delivers, whereas the more private sector oriented US healthcare system does not.[5]

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3. The starting points of HLE estimates are standard life tables providing the mortality level and life expectancy of a given population. Regular life expectancy estimates are then augmented by estimates of the number of healthy years of life lost to circumstances associated with a comprehensive list of health conditions. In the WHO data used here, survey data on the incidence of 135 disease and injury categories are combined with medically determined severity distributions of the 135 categories and used to provide as comprehensive a picture as possible of the morbidity (rather than merely the mortality) situation of the included populations. Research cited in Mathers et al. (2001) found that data reliant on self-reported health status were neither compatible across countries nor across time periods due to differences in survey design and different cultural thresholds of sickness.

4. The *y*-axis in figure B3.3 is inverted because the lowest infant mortality rate possible is the desired outcome.

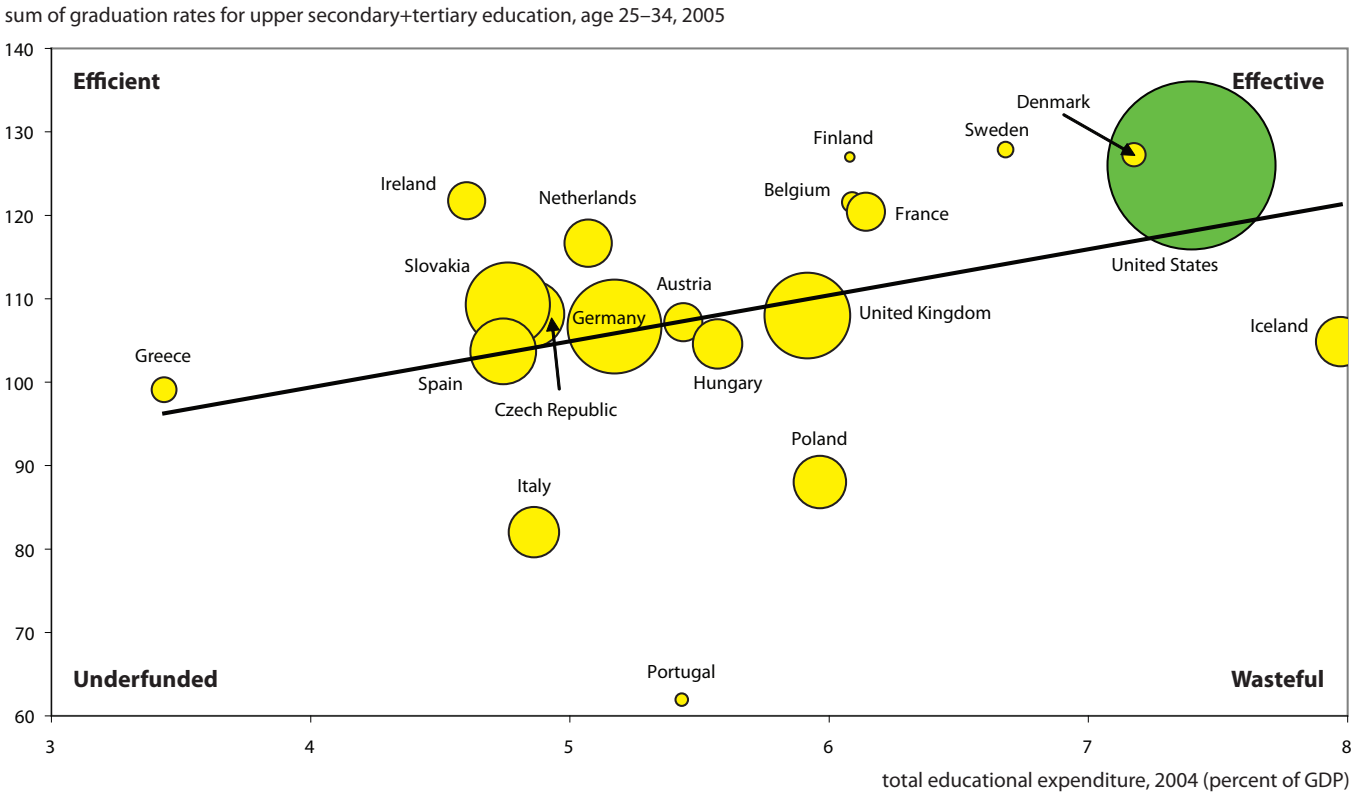
5. Other broad measures of healthcare outcome yield the same overall result. For example, Nolte and McKee (2008) showed that the United States has the highest level of amenable mortality (i.e., the number of premature deaths from preventable causes) of 18 surveyed OECD countries, 14 of which are European. Meanwhile Or (2000) shows that increasing the share of public expenditure in total healthcare expenditures has significantly reduced mortality (particularly male mortality) in OECD countries since 1980.

Box 3 Efficiency in education and healthcare spending in the United States and Europe revisited *(continued)*

At the same time, though, the United States is a far larger country than any in Europe, so this is not a straight apples-to-apples comparison. These comparative data might plausibly suggest that, in terms of healthcare provision, it just is more difficult and expensive to run a healthcare system that spans an entire, highly diverse continent, and smaller European countries, therefore, have a structural size advantage. It simply may not be possible for a more centralized, small-state healthcare system, such as that of Sweden, to work in the continent-sized United States, and this may explain the large cost differentials. In many ways, such an argument reflects the same fundamental geographic differences that also explain why it is far more expensive to provide nationwide broadband coverage to a vast, sparsely populated country like the United States than it is to a small and densely populated country like the Netherlands.

This train of thought, however, ultimately concerns itself with the optimal size of a sovereign state as determined by the efficient delivery of healthcare services. Since historically states' borders have never been determined in this way—although in some countries subsovereign government entities are organized in this manner, i.e., county and municipality sizes are determined by their ability to support and sustain a full-service hospital—such an argument is purely academic. Moreover, the argument that this American exceptionalism in terms of geographic size and diversity is the cause of its high and comparatively inefficient healthcare costs is very different from the standard, supply-side argument that private-sector healthcare expenditures are inherently more efficient than public expenditures.

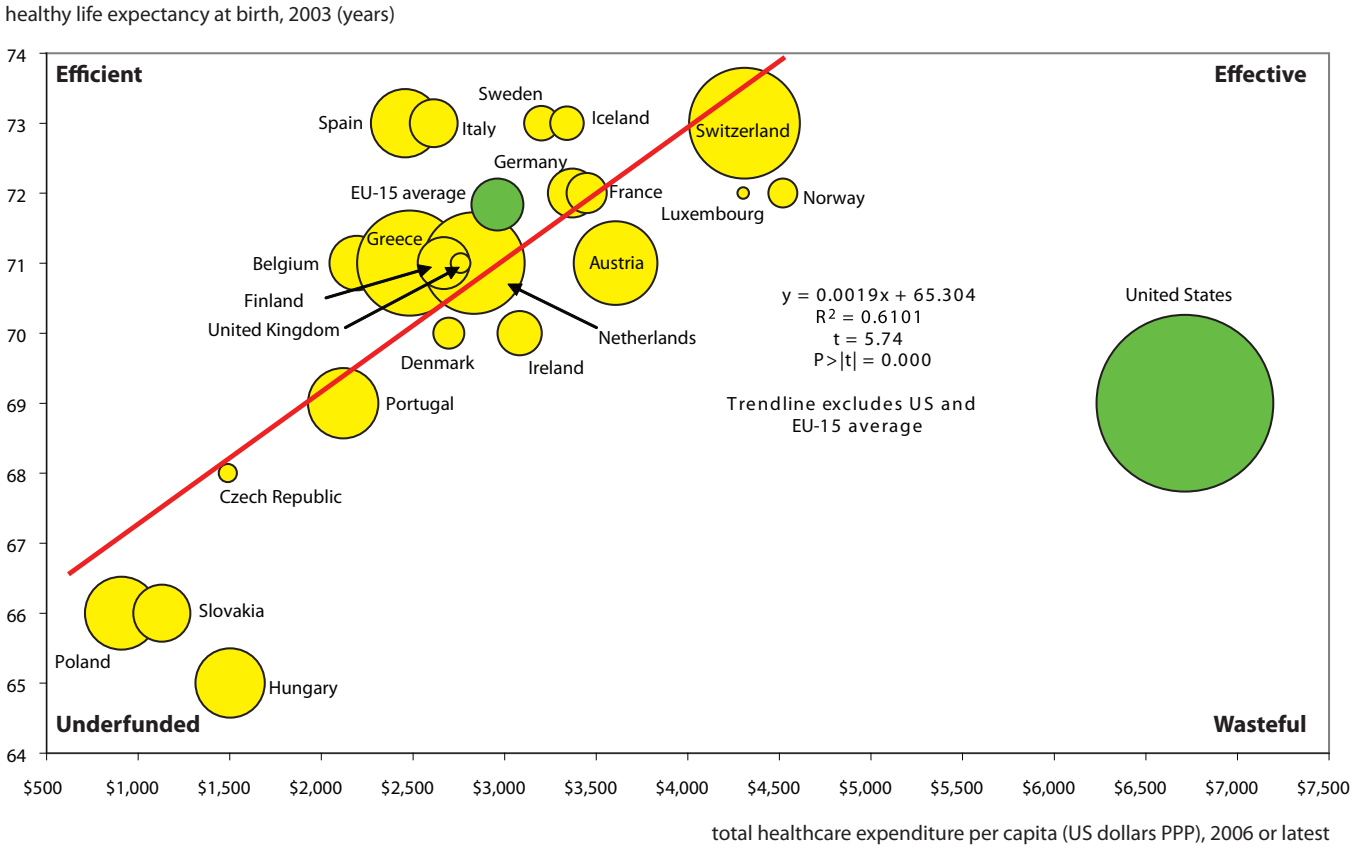
Figure B3.1 Educational expenditure and attainment



Note: Size of bubbles indicates percent share of total educational expenditures that comes from the private sector. Relative differences between countries magnified (raised to the second power) to facilitate reading of the figure.

Source: OECD (2007b).

Figure B3.2 Healthy life expectancy of total population and total healthcare expenditure per capita



Note: Size of bubbles indicates percent share of total health expenditures that comes from the private sector. Relative differences between countries magnified (raised to the third power) to facilitate reading of figure. EU-15 average is the GDP weighted average.

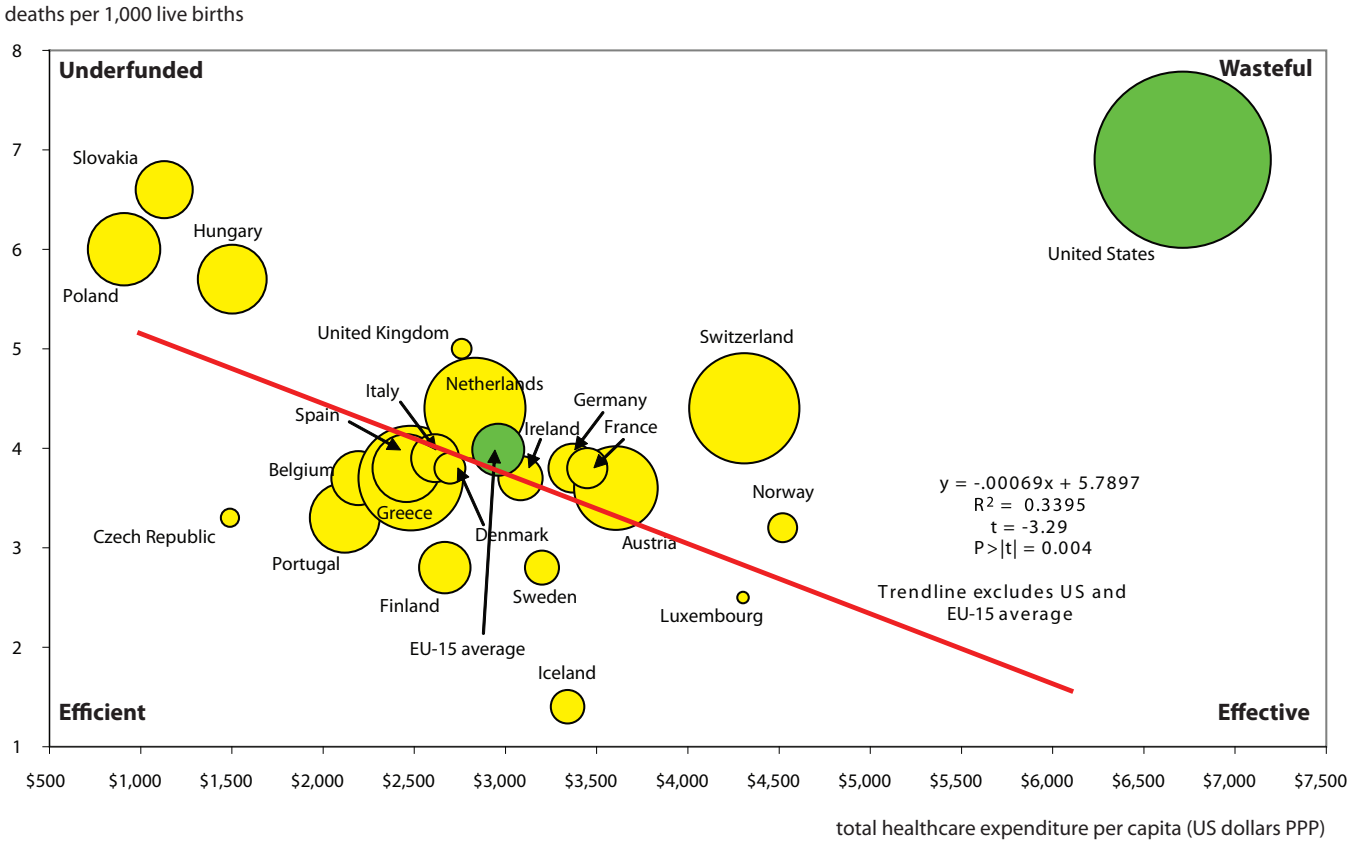
Sources: OECD (2008c); WHO (2008).

taxation of cash-benefit payments in many European countries and to the prevalence of costly tax breaks toward social purposes in the United States. It is thus noteworthy that net public social expenditures in all European countries are lower than the gross levels, in some cases significantly so, while the opposite is the case in the United States, where net public social expenditures are higher than the gross levels would suggest (the left bar is higher than the black line for the United States in figure 4). European "welfare states" are, therefore, relatively cheaper to run on an after-tax basis than the gross data would suggest, whereas the US welfare state is more expensive on an after-tax basis. Finally, figure 4 shows the same distribution for total social expenditures that figure 2 did for typically governmental functions: When net private-sector social expenditures—which in the United States are significantly larger than in Europe—are added to net public social expenditures, the total after-tax shares of societal resources channeled toward social purposes in the United States and Europe are very similar. In fact the total after-tax social expenditure level in the United States, at 26.4 percent of nominal GDP, is more generous than in any European country except France and Germany and is actually higher than the EU-13 average of 25 percent.[13] When viewed on an all-inclusive basis, the nominally limited US welfare state actually has a similar (or even greater) level of resources available to it than do most of the

Tax breaks and subsidized private-sector provision of services obscure the true (higher) level of total US expenditures on government tasks and social spending.

13. No data are available for Luxembourg and Greece.

Figure B3.3 Infant mortality and total healthcare expenditure per capita, 2006 or latest



Note: EU-15 average is the GDP weighted average. The y-axis is inverted because the lowest infant mortality rate possible is the desired outcome.

Source: OECD (2008c).

so-called comprehensive European welfare states.

When one follows the money rather than the rhetoric, the perceived differences between the total resources allocated to social expenditures in the United States and Europe prove to be illusory. As was the case with the similar levels of expenditure on government tasks described earlier, this finding should embolden proponents of the primacy of pocketbook issues over ideology. Regarding social expenditures, the relatively similar US and EU populations, ceteris paribus, seem to demand and receive access to similar shares of output.

While obviously the specific target areas, intentions, and objectives of countries' social expenditures are too numerous to even approximate, it is nonetheless worth recalling that the United States, despite roughly equivalent net total spending levels, does significantly worse than European countries on widely used social policy indicators. The recent OECD report (2008d), *Growing Unequal? Income Distribution and Poverty in OECD Countries*, finds that in the mid-2000s, the United States had a significantly more unequal income distribution[14] and higher poverty levels[15] than European countries.[16] What matters is not a country's level of total social expenditures but how and to the benefit of whom it spends those resources.

CONCLUDING REMARKS

Kaganist proponents of a massive transatlantic divide have it almost entirely wrong. When it comes to the share of total resources spent on government tasks and social spending, after accounting for the effects of the tax systems and including both public and private-sector spending, the transatlantic differences between the United States and European countries are minus-

14. Income distribution was measured as the Gini coefficient for disposable income after taxes and transfers.

15. Poverty was measured as income at various percentages (40, 50, and 60 percent) of the median income.

16. Only Portugal had a slightly higher Gini coefficient than the United States in the mid-2000s.

cule. Properly measured, Mars and Venus spend the same share of income on these tasks. Soapbox politics aside, the dominance of pocketbook issues causes relatively similar populations in the United States and Europe to spend relatively similar shares of their incomes on similar tasks and services. The only meaningful difference between US and European expenditure levels is in private-sector healthcare spending, where the US private sector spends about three times more on healthcare than its European private-sector counterparts.

This leaves three further implications to consider. First, in some respects, this striking similarity of actual expenditure levels in the United States and Europe in areas full of ideological posturing is positive. It indicates that the debate about how the United States should reform its domestic social and economic institutions for the 21st century age of globalization should not be bogged down in disagreements about the need to spend a lot more on government tasks and social services, at least not if European spending levels are any guide. Instead the US domestic reform debate should focus exclusively on how and for whose benefit the United States spends its already sizable allocated resources.

Second, tax breaks and subsidized private-sector provision of services obscure the true (higher) level of total US expenditures on government tasks and social spending. These expenditures are kept "under the radar screen," perpetuating the perception that the US government (and, by implication, US taxpayers) spends very little on government tasks and social spending. This obscurity obviously benefits those groups in the United States who profit most from these "partially hidden" government transfers. And tax breaks and subsidized private-sector services provision disproportionally benefit higher-income Americans (see, for instance, GAO 2005 and CBO 2007). Well-off recipients of such indirect government transfers are, consequently, clearly advantaged by not having their "government handouts" receive the same public scrutiny as explicit transfer payments to other (usually low-income) groups of Americans made directly by the government.

Third, this obscurity in the level of total US government transfers and expenditures is almost certainly a substantial part of the explanation for the much greater public hostility toward higher taxes in the United States compared with Europe, where the governments directly provide the social services as a quid pro quo (see also Campbell and Morgan 2005 and Morgan 2007). Considering that today all Europeans are covered by universal, government-provided health insurance, which they never need worry about losing; have access to positively adequate and often remarkably generous social transfers; and benefit from free or very heavily subsidized education, including at the tertiary level, it is not surprising that they do not seem to mind paying taxes as much as Americans seem to.

Finally, returning to the question in the title of this policy brief, we can conclude that, at least in terms of levels of expenditure on government tasks and social services, Reagan's ostensible revolution was a myth—and was so long before government bailouts became fashionable again in 2008.

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