28th out of 30: Poor medicine and unhealthy Americans

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06. October 2009

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Poor Medicine and Unhealthy Americans

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October 6, 2009

Abstract

In 1970 the USA spent 7% of its GNP on healthcare, in 200716%. Whereas the OECD average per capita expenditure on healthcare in 2007 was $2,964, the USA spent $7,290. Yet in that same period, the health of America's citizens relative to those of other developed countries declined dramatically, so much so that the CIA lists 49 countries whose citizens now can look forward to on average living longer than Americans. This paper looks for the causes of this colossal disparity between expenditure and results. It argues that they are due to the unique **economic institutions** that, beginning during WWII, have grown up around healthcare in the USA. Because the magnitude of the relative decline in healthcare in the USA is poorly appreciated, especially by Americans, this paper begins with a set of OECD data tables documenting that decline. The main body of the paper is an historical analysis of the institutional economics of American healthcare from 1940 to the present. The paper concludes with a brief consideration of the possibilities for serious reform.

JEL Categories
H00, H4, H51, I11, I12, I18, J5, N32, N34, P5, Y10

Health indicators and expenditure for OECD countries

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Health Indicators for the 30 OECD Countries

Life expectancy at birth - Total population

Definition: The average number of years to be lived by a group of people born in the same year, if mortality at each age remains constant in the future. Life expectancy at birth is also a measure of overall quality of life in a country and summarizes the mortality at all ages.
Source: CIA World Factbook, 21 September 2009

Rank	Country	Description
1	Japan	82.12 years
2	Australia	81.63 years
3	Canada	81.23 years
4	France	80.98 years
5	Sweden	80.86 years
6	Switzerland	80.85 years
7	Iceland	80.67 years
8	New Zealand	80.36 years
9	Italy	80.20 years
10	Spain	80.05 years
11	Norway	79.95 years
12	Greece	79.66 years
13	Austria	79.50 years
14	Netherlands	79.40 years
15	Luxembourg	79.33 years
16	Germany	79.26 years
17	Belgium	79.22 years
18	United Kingdom	79.01 years
19	Finland	78.95 years
20	Ireland	78.24 years
21	South Korea	78.72 years
22	Denmark	78.30 years
23	Portugal	78.21 years
24	**United States**	**78.11 years**
25	Czech Republic	76.81 years
26	Mexico	76.06 years
27	Poland	75.63 years
28	Slovakia	75.40 years
29	Hungary	73.44 years
30	Turkey	71.96 years

Healthy life expectancy at birth - Total population

Definition: Healthy life expectancy at birth (years) 2007 - Total population.
Source: *World Health Statistics 2009*, World Health Organization

Rank	Country	Description
1	Japan	76
2	Switzerland	75
5	Sweden	74
5	Iceland	74
5	Italy	74
5	Australia	74
5	Spain	74
11.5	France	73
11.5	Norway	73
11.5	Canada	73
11.5	Germany	73
11.5	Luxembourg	73
11.5	Ireland	73
11.5	Netherlands	73
11,5	New Zealand	73
18.5	Finland	72
18.5	Greece	72
18.5	Belgium	72
18.5	United Kingdom	72
18.5	Austria	72
18.5	Denmark	72
23.5	Portugal	71
23.5	South Korea	71
24.5	Czech Republic	70
24.5	**United States**	**70**
27	Slovakia	67
27	Poland	67
27	Mexico	67
29.5	Hungary	66
29.5	Turkey	66

Probability of not reaching 60

Definition: Probability at dying between 15 and 60 years (for the year 2007).
Source: *World Health Statistics 2009*, World Health Organization

Rank	Country	Description
1	Iceland	5.8%
2.5	Switzerland	6.2%
2.5	Italy	6.2%
4.5	Australia	6.3%
4.5	Sweden	6.3%
6	Japan	6.6%
7	Netherlands	6.8%
8	Norway	6.9%
9	Canada	7.2%
10	Spain	7.4%
11	New Zealand	7.3%
12	Ireland	7.5%
13	Austria	7.8%
14.5	Greece	7.9%
14.5	United Kingdom	7.9%
16	Germany	8.0%
17.5	Luxembourg	8.1%
17.5	South Korea	8.1%
18	Belgium	8.6%
19	France	8.9%
20.5	Portugal	9.3%
20.5	Denmark	9.3%
23	Finland	9.6%
24	Czech Republic	10.6%
25	**United States**	**10.8%**
26	Turkey	11.9
27	Mexico	12.1
28	Slovakia	13.3%
29	Poland	14.5%
30	Hungary	17.4%

Infant mortality rate

Definition: The number of deaths of infants under one year old in a given year per 1,000 live births in the same year. **Source:** CIA World Factbook, 24 September 2009.

Rank	Country	Description
1	Sweden	2.75 .
2	Japan	2.79
3	Iceland	3.23
4	France	3.33
5	Finland	3.47
6	Norway	3.58
7	Czech Republic	3.79
8	Germany	3.99
9	Switzerland	4.18
10	Spain	4.21
11	South Korea	4.26
12	Denmark	4.34
13	Austria	4.42
14	Belgium	4.44
15	Luxembourg	4.56
16	Netherlands	4.73
17	Australia	4.75
18	Portugal	4.78
19	United Kingdom	4.85
20	New Zealand	4.92
21	Canada	5.04
22	Ireland	5.05
23	Greece	5.16
24	Italy	5.51
25	**United States**	**6.26**
26	Poland	6.80
27	Slovakia	6.84
28	Hungary	7.86
29	Mexico	18.42
30.	Turkey	25.78

Obesity, percentage of adult population

Definition: Percentage of total population who have a BMI (body mass index) greater than 30 Kg/sq. meters (Data for 2006 or latest year available).
Source: *OECD Factbook 2009*

Rank	Country	Description
1	South Korea	3.3
2	Japan	4.3
3	Switzerland	7.5
4	Norway	8.0
5	Italy	10.0
6	Sweden	10.3
7	France	10.4
8	Denmark	11.8
9	Ireland	12.0
10	Iceland	12.4
11	Poland	12.5
12.5	Netherlands	12.7
12.5	Austria	12.7
14	Germany	12.8
15	Belgium	13.4
16	Portugal	14.0
17	Finland	14.1
18	Turkey	14.5
19	Spain	14.7
20	Czech Republic	17.0
21.5	Slovakia	18.0
21.5	Hungary	18.0
23	Greece	18.2
24	Luxembourg	18.5
25	Canada	19.0
26	Australia	21.4
27	United Kingdom	24.2
28	New Zealand	25.6
29	Mexico	34.5
30	**United States**	**35.3**

Overall Health System Performance

Definition: Health system attainment and performance ranked by eight measures; disability adjusted life years, level of responsiveness, distribution of responsiveness, fairness in financial contribution, overall goal attainment, health expenditure per capita, and livel of health.
Source: *The World Health Report 2000*, World Health Organization

Rank	Country
1	France
2	Italy
3	Spain
4	Austria
5	Japan
6	Norway
7	Portugal
8	Greece
9	Iceland
10	Luxembourg
11	Netherlands
12	United Kingdom
13	Ireland
14	Switzerland
15	Belgium
16	Sweden
17	Germany
18	Canada
19	Finland
20	Australia
21	Demark
22	**United States**
23	New Zealand
24	Czech Republic
25	Poland
26	South Korea
27	Mexico
28	Slovakia
29	Hungary
30	Turkey

Practising physicians per capita

Definition: Practising physicians per 1000 people
Source: OECD Health Data 2007

Rank	Country	Description
1	Greece	5.4
2	Belgium	4.0
3	Switzerland	3.9
4	Netherlands	3.9
5	Norway	3.9
6	Austria	3.8
7	Italy	3.7
8	Iceland	3.7
9	Spain	3.7
10.5	Czech Republic	3.6
10.5	Sweden	3.6
12	Germany	3.5
13	Portugal	3.5
14	France	3.4
15	Denmark	3.2
16	Slovakia	3.1
17	Ireland	3.0
18	Finland	3.0
19	Luxembourg	2.9
20	Hungary	2.8
21	United Kingdom	2.5
22	Australia	2.8
23	**United States**	**2.4**
24	New Zealand	2.3
25	Poland	2.2
26	Canada	2.2
27	Japan	2.1
28	Mexico	2.0
29	South Korea	1.7
30	Turkey	1.5

Acute care hospital beds per capita

Definition: Acute Care Hospital beds per 1000 people in 2005.
Source: Health at a Glance 2007, OECD Indicators

Rank	Country	Description
1	Japan	8.2 per 1000 people
2	South Korea	6.5 per 1000 people
3	Germany	6.4 per 1000 people
4	Austria	6.3 per 1000 people
5	Czech Republic	5.7 per 1000 people
6	Hungary	5.5 per 1000 people
7.5	Luxembourg	5.2 per 1000 people
7.5	France	5.2 per 1000 people
9	Slovakia	5.0 per 1000 people
10	Poland	4.7 per 1000 people
11	Belgium	4.4 per 1000 people
12.5	Australia	3.6 per 1000 people
12.5	Switzerland	3.6 per 1000 people
14	Greece	3.5 per 1000 people
15	Italy	3.3 per 1000 people
16	New Zealand	3.2 per 1000 people*
18	Denmark	3.1 per 1000 people
18	Netherlands	3.1 per 1000 people
18	United Kingdom	3.1 per 1000 people
20	Norway	3.0 per 1000 people
21	Portugal	3.0 per 1000 people
22.5	Canada	2.9 per 1000 people
22.5	Finland	2.9 per 1000 people
24	Ireland	2.8 per 1000 people
25	**United States**	**2.7 per 1000 people**
26	Spain	2.6 per 1000 people
27	Sweden	2.2 per 1000 people
28	Turkey	2.0 per 1000 people
29	Mexico	1.0 per 1000 people

Data not available for Iceland.
* for the year 2004

Health Indicators Combined

USA's rankings among the 30 OECD countries for the 8 health indicators are as follows:

Life expectancy at birth	24
Healthy life expectancy at birth	24.5
Probability of not reaching 60	25
Infant mortality rate	25
Obesity	30
Overall health system performance	22
Practising physicians per capita	23
Acute Care Hospital beds per capita	25
Average ranking	**24.750**

Average Rankings for the 8 Health Indicators

Rank	Country	Average
1	Japan	5.625
2	Iceland	6.129
3	Switzerland	6.500
4	France	8.500
5	Italy	8.687
6	Norway	8.937
7	Sweden	9.375
8	Austria	10.500
9	Spain	11.500
10	Netherlands	11.750
11	Germany	12.187
12	Australia	13.625
13	Belgium	13.812
14	Greece	14.250
15	Luxembourg	14.937
16	Ireland	16.062
17	South Korea	16.375
18	Denmark	16.875
19	Canada	17.000
20	Czech Republic	17.437
21	New Zealand	17.687
22	Finland	17.750
22	Portugal	17.750
24	United Kingdom	18.500
25	Poland	22.500
26	Slovakia	23.062
27	Hungary	23.375
28	**USA**	**24.750**
29	Mexico	27.500
30	Turkey	27.625

Health expenditure as a share of GDP in 2007

Source: .*OECD Health Data 2009*

Rank	Country	Description
1	**United States**	**16.0%**
2	France	11.0%
3	Switzerland	10.8%
4	Germany	10.4%
5	Belgium	10.2%
6.5	Canada	10.1%
6.5	Austria	10.1%
8	Portugal [1]	9.9%
9.5	Netherlands	9.8%
9.5	Denmark	9.8%
11	Greece	9.6%
12	Iceland	9.3%
13	New Zealand	9.2%
14	Sweden	9.1%
15	Norway	8.9%
16.5	Italy	8.7%
16.5	Australia [1]	8.7%
18	Spain	8.5%
19	United Kingdom	8.4%
20	Finland	8.2%
21	Japan	8.1%
22	Slovakia	7.7%
23	Ireland	7.6%
24	Hungary	7.4%
25	Luxembourg [1]	7.3%
26.5	South Korea	6.8%
26.5	Czech Republic	6.8%
28	Poland	6.4%
29	Mexico	5.9%
30	Turkey [2]	5.7%

[1] 2006. [2] 2005.

Health expenditure per capita in 2007

Source: .*OECD Health Data 2009*
Data are expressed in US dollars adjusted for purchasing power parities (PPPs).

Rank	Country	USD (PPP)
1	**United States**	**7,290**
2	Norway	4,763
3	Switzerland	4,417
4	Luxembourg [1]	4,162
5	Canada	3,895
6	Austria	3,763
7	France	3,601
8	Germany	3,588
9	Netherlands	3,527
10	Belgium	3,462
11	Ireland	3,424
12	Denmark	3,362
13	Sweden	3,323
14	Iceland	3,319
15	Australia [1]	3.137
16	United Kingdom	2,992
17	Finland	2,840
18	Greece	2,727
19	Italy	2,636
20	Spain	2,671
21	Japan [1]	2,581
22	New Zealand	2,510
23	Portugal [1]	2,150
24	South Korea	1,688
25	Czech Republic	1,626
26	Slovakia	1,555
27	Hungary	1,388
28	Poland	1,035
29	Mexico	823
30	Turkey [2]	618

[1] 2006. [2] 2005.

Analysis

Introduction

The American healthcare system is a failure on a scale heretofore unknown by human civilization. The figures which describe it are so mind-boggling that it is tempting to dismiss them as a statistician's paranoid fantasy. But their reality is confirmed from many sources. Even so, the true scale of the failure only becomes manifest when placed in a context of international comparison, something that Americans are generally loath to do.

When considered in isolation, the American healthcare system looks to be in deep trouble because it consumes an ever increasing share of the nation's resources, while at the same the time decreasing year by year the proportion of Americans who have ready access to it. Back in 1970 the USA spent 7% of its GNP on healthcare. In 2007 it spent 16%. By 2015 that figure is expected to reach 20.0%. Such an enormous increase in the share of a nation's wealth having to be spent on combating illness is amazing in itself. But it shocks when juxtaposed to the fact that the services of that healthcare system are available to a decreasing share of the American public. For reasons that will be explained, every year the number and percentage of Americans who are not covered by government programs (Medicare and Mediaid) and who also either have no health insurance or do but are seriously underinsured increases. This means that Americans, including middleclass Americans, more and more have to do without health services that the citizens of other OECD countries take for granted.

Between 1960 and 2009 life expectancy at birth in the USA increased by 8.3 years. Standing by itself that statistic sounds impressive. But placed in the context of what other countries have achieved in terms of longevity of its citizens, it is third-rate. In that same period Japan increased its citizens' life expectancy at birth by 14.5 years. Spain increased its by 11 years, France by 10.8, Austria by 11 and etc.. Once a leader, today the USA is in the third division among OECD countries when it comes to life expectancy. According to the American Civil Intelligence Agency, the citizens of 49 countries now can look forward to on average living longer than Americans.[1] The French, for example, now both live three years longer and enjoy a healthy life expectancy three years longer. The Swedes and the Australians have 4 more years of healthy life, and the Swiss 5. And these are not exceptions. Today the USA is tied with the Czech Republic for 24th place out of 30 in the OECD league table for healthy life expectancy. Furthermore, this ranking is computed so that being clinically obese, as are 35.3 percent of the USA's adult population, does not exclude one from the "healthy" category.

If America allocated less of its Gross Domestic Product (GDP) to health than do other countries, then the ever declining health of its people relative to other nationalities would be both more understandable and not nearly so frightening. But the opposite is the case. No other country in the world spends nearly so much of its GNP or so much per capita on healthcare. The 16 percent of GNP that the USA spent on healthcare in 2007 was nearly double the OECD's average of 8.9 percent. On an expenditure per capita basis the disparity in the USA between expenditure and results is even more shocking. Whereas the OECD average in 2007 was $2,964, the USA spent an astonishing $7,290 per capita. By contrast Japan's healthcare system in 2007 spent only $2,581 per capita. That is only 35% of the USA amount for that year.

We must remind ourselves that things were not always like this. Not so long ago the USA was a winner nation in health, not a loser. For example, back in 1960 before America's health system began to collapse, Americans had a life expectancy over two years longer than the Japanese, whereas now

the Japanese live 4 years longer and enjoy 6 more years of good health. To understand how this American tragedy happened we need first to look briefly at the strange history of the USA's health system, especially since 1970. Then we are going to look at what American health scholars call "The Death Spiral", a terrifying phenomenon whose expanding reach traps millions more Americans every year. We will also investigate where all that money goes, all those annual billions that should go to improving Americans' health, but that obviously do not. Finally, before trying to guess the future, we will examine America's obesity epidemic, including how big business targets children.

A Brief History of the American Health System

The American health system is largely an historical accident. What looked like a good turn half a century ago has led the proud nation ever deeper into a noxious quagmire from which it lacks the will and know-how to escape.

The wrong turn came during the Second World War. Only a few years before, the USA had been in the depths of the Great Depression. In 1939 its unemployment rate had been 17.2 percent, but by 1944 it had dropped to only 1.2 percent, and its Gross National Product had grown by nearly 75 percent. Once again big profits were to be made, except that big business's opportunity to do so was limited by an acute labour shortage. Moreover, firms could not compete for workers by offering higher wages, because wartime price and wage controls had been instituted to combat the threat of runaway inflation. There existed, however, a loophole. Additions to fringe benefits, including healthcare, were permitted. So as a means of recruiting more workers and retaining those they already had, firms began offering their employees free health insurance. This ruse came with a double-edged tax advantage. The employers could deduct the cost of the premiums from their taxable profits and the employees paid no income or social security taxes on the money spent for their health insurance.

After the war this tax loophole was retained as part of the tax code. Unions and their members came to see, no less than did their employers, the advantages of exploiting it. The failure to tax the value of the premiums as income meant that the government was substantially subsidizing the purchase of health insurance if, but only if, it was obtained through an employment contract. Moreover, because of progressive rates of income tax, the size of this subsidy was greater the higher the individual's income. Consequently, in the immediate post-war period in the USA health insurance came be to be part of the standard employment package for all levels and types of corporate employees.

In 1941 less than 10 million Americans (less than 8 percent) were covered by health insurance, all of it private, that being the only kind available. Ten years later the number covered had increased seven-fold to 71 million, virtually half the population.

This was an enormous advancement in a short space of time, but already downsides of America's accidental approach to healthcare were beginning to emerge. The dictates of insurance policy clauses had begun to overrule medical judgement. Deciding on the type of care provided was no longer always the doctor's prerogative, and paradoxically it meant that the cost of the care sometimes escalated unnecessarily. It also often worked to the patient's disadvantage. Insurance coverage tended to kick in only when the patient was hospitalized, creating a strong incentive to hospitalize people unnecessarily. This incentive extended to diagnostic tests best performed, but uninsured, on an outpatient basis. Facing days in a hospital or large medical bills, many people chose to forgo the tests that medical opinion said they should have. Thus the pattern of today's American medical care, inflated costs and diminished care, was already being set.

In the post-war years medical costs began to rise for two reasons. One cause was common to all advanced industrialized nations. Medical science could now prevent or cure major diseases that previously were beyond its reach, but these new capabilities were expensive. The second cause of rising medical costs in the USA was a by-product of its system of insurance. With the vast majority of hospitalized patient's now carrying private insurance, and with the profit motive increasingly in play in the provision of healthcare, there emerged a strong upward pressure on prices and unnecessary expenditure.

These accelerating costs began to undermine the private health insurance system at its margins. In the 1930s, prior to the spread of employment-linked health insurance, a private but not-for-profit insurance system had developed called Blue Cross. It had 6 million subscribers in 1942 and 18.9 million by 1946. It had a communitarian method of setting premiums called "community-rating", whereby it charged the same premium to everyone who subscribed. The premium was calculated on the basis of the average risk in the community and the hospital costs associated with it. Thus everyone, young or old, healthy or unhealthy, with a safe or a dangerous job, etc. was charged the same premium. But with the accelerating costs of the 1950s the communitarian approach became increasingly unworkable. The rising premiums led the young and healthy to look to the commercial sector for insurance where premiums were experience-rated and therefore, for them, cheaper. This leakage pushed Blue Cross premiums still higher, causing further losses of healthy subscribers. So inevitably Blue Cross, and its sister programme Blue Shield, shifted gradually toward experience-rating.

That was the beginning of the American healthcare nightmare. The end of community-rating meant that those people not covered by employment-based insurance and most in need of healthcare, especially the elderly, faced either sky-rocketing insurance premiums or, increasingly, no insurance coverage at all. For the latter, occasionally private charity was available, and some cities and counties maintained substandard public hospitals that admitted, for example, road accident victims. But more and more the hospital emergency room became the only source of care for uninsured Americans.

Beginning in the late 1950s the plight of the elderly under this system increasingly became a public scandal. The 65s-and-over were the group both most in need of healthcare and the least likely to be insured for it. They no longer had access to employment-based insurance nor could they afford experience-rated insurance. As a group they were well-defined, highly visible, politically active and regular voters, and from the late fifties onward politicians took an increasing interest in their plight. In 1965 Congress passed an act which provided a programme, called Medicare, of healthcare assistance for the elderly. Its basic structure remains in place today. (The beneficiary may receive up to sixty days of hospital care, but only after paying a large deductible, another 30 days of care with another deductible payment required, and a lifetime "reserve" of 60 days with further payments from the patient.) Medicare does not offer the comprehensive coverage that the citizens of all ages of other economically advanced nations enjoy, but it did and continues to significantly alleviate the suffering of America's senior citizens. Also in 1965 the US Congress passed an act that established a program called Medicaid that would pay for medical and nursing-home care for the very poor. With these two new programmes of publicly funded healthcare and with the now nearly universal employer practice of offering its employees comprehensive health insurance, the American healthcare system appeared to be on the mend.

But alas, this trend was not to continue. From the 1970s onward the USA's turn in the 1940s toward employment-based insurance and its miserly rejection of universal coverage for its citizens has increasingly compromised the physical and emotional health of the nation. Internal contradictions

together with wider economic and political forces have interacted to cause the nation's health system to progressively self-destruct.

The Medicare and Medicaid programmes had been set up without any cost controls. Although the beneficiaries had to pay large deductibles and their entitlements were limited, the providers – hospitals, pharmaceutical companies, laboratories and doctors – were allowed to charge whatever they wanted. Inevitably, profit-seeking began to drive up medical care prices. These accelerating costs were not confined to the Medicare and Medicaid programmes, but instead spread through the whole system. When in 1974 alone the Consumer Price Index for medical care services increased by 10.3 percent, the 1960s issue of access to medical care was overtaken by the issue of cost containment.[2] Moreover, the focus of this cost cutting was in the private insurance industry and its employment-linked policies.

There came into being something called "health maintenance organizations" or HMOs. The idea was to combine both the insurer and the deliverer of care into one for-profit organization. The HMO would agree to deliver all covered health care services to members of a group, usually the employees of a company or branch of government, for a predetermined monthly premium. The idea was to decrease the utilization by insured patients of heath care services. Doctors would no longer work for fees, but instead would be placed on salaries and given bonuses for decreasing hospitalization rates and the number of lab tests. And of course under the HMOs the patients no longer could choose their doctor. Worse, this was not only rationing by the back door, it also was a further erosion of the principle that medical opinion rather than profit-maximizing should determine medical decisions. As HMOs began to take over the private insurance industry, it would have taken a fool not to realize that the quality of American healthcare was about to plummet.

Contemporaneous with the spread of HMOs was a huge growth in for-profit hospitals, especially chains of them, and also even the corporatization of much of medical practice. When by the mid-1980s USA health expenditures had increased to over $400 billion and comprised nearly 11 percent of its GNP, Wall Street had identified healthcare as a major sector of the American economy. This had profound implications. Whereas traditionally hospitals in the USA had been subject to local control and community involvement, now more and more they belonged to huge corporations, like Hospital Corporation of America, which made decisions at corporate headquarters behind closed doors. All this, along with the HMOs, was part of the general move in American healthcare away from an ethos that, as in other countries, emphasized and prioritised quality and patient needs to one that made profits king.

In addition to the change from medicine-led to business-led healthcare, the 1980s saw the beginning of another radical shift in American healthcare, one that now increasingly threatens the middle classes. The backbone of the nation's system of provision, employment-based insurance, is in an advanced stage of osteoporosis, brought about by the spread of corporate globalization.

The tight linking of healthcare to employment worked reasonably well for the majority of Americans so long as their employment relationships were stable and long-term. Through the 50s, 60s and 70s, millions of blue-collar workers enjoyed long-term union contracts and white-collar workers could expect to remain with the same company until retirement. For both groups a key part of their conditions of employment was comprehensive employer-paid health insurance for themselves and their families.

But with growing globalization an ever expanding proportion of America's labour force finds this vital link broken. The nature of employment in the USA has changed fundamentally in two ways. First, the

majority of workers can no longer expect to remain in their job for long, and, second, employers are either withdrawing health insurance altogether or drastically curtailing its coverage. This has created what American health authorities call "the death spiral".[3]

The American Death Spiral

The USA's linkage between employment and access to healthcare has always posed a potential trap for the American worker. There have always been two ways he or she might fall into it. A health problem could lead to loss of job and hence loss of insurance coverage and so the loss of the means to treat the health problem. Alternatively, a job disruption, such as being laid off or caring for small children or elderly parents, meant the loss of health coverage which could easily result in health problems going untreated which would make the person less employable and less likely to regain access to health care. Either way, the person, and often their family, found themselves caught in a downward spiral, downward both in terms of income and health. Two Harvard University scholars explain it as follows:

> Whatever the starting point, once a person enters the death spiral, it is difficult to escape. Because employment adversity is so thoroughly intertwined with medical adversity, those caught in the spiral cannot amass either the bodily or the financial resources needed to break out.[4]

What in the last 20 years has changed, and continues to change, is that the reach of the American death spiral has expanded exponentially. The post-war sense of reciprocal responsibility and loyalty of the American employer to his workforce, the partnership that made the USA economically so successful, has been pulverised in the face of globalization and the ideology of neoliberalism. With the shift overseas, first of industrial production and now increasingly of all kinds of white-collar work, there has been a rush by Stateside employers to reduce or, where possible, eliminate completely fringe benefits. Of these, the first to be attacked, because it is the most costly, is employee health insurance. In addition to the downgrade in quality of care brought on by the ascendancy of HMOs, health coverage has suffered and increasingly suffers assaults on four fronts.

First, the escalating overpricing of healthcare in the USA and the ending of community-rating for premiums means that fewer and fewer Americans can afford non-employment based health insurance. Second, the premiums, the deductibles and the co-payments that the employee must pay under employment based insurance increase year by year. For example, in the five years from 2000 to 2005 the average employee contribution to company-provided health insurance in the USA increased by 143 percent and out-of-pocket costs for deductibles and co-payments by 115 percent.[5] Third, the range of the coverage provided by these policies is shrinking, sometimes drastically, as for example withdrawing coverage for the employee's children or for "pre-existing conditions". Fourth, employers may withdraw all insurance coverage, either directly (60% of firms now do not provide health benefits for their employees) or by the outsourcing of work. A favourite tactic has been to reduce the number permanent full-time positions while increasing the number of temporary and part-time jobs which offer no benefits.

These "contingent workers", as they are now called, constitute 25 percent of the American workforce.[6] For young Americans this is becoming the new world of work, so much so that already a third of adults in the USA between the ages of eighteen and twenty-four lack health care protection. Amongst all fulltime workers, 17.8 percent of them had no health insurance at all in 2004. For the population as a whole, 15.7 percent or 45.8 million Americans had no health insurance for the whole of 2004.[7] But

these figures, which come from the U.S. Bureau of Census, understate the case. The transitory nature of employment in the USA today means that a person may be covered one day and not the next. Hence, in any year now over 80 million people, **one out of every three Americans under 65**, is without any health insurance for at least part of the year. Of these, nearly eight out of ten are working.[8]

So what is it like to be an American without health insurance or unable to afford the "co-payments" or to have a "pre-existing condition"?

> This means that small tumors may be left untreated until they become big and metastasize. Diabetes is not managed properly, leading to amputations, end-stage renal failure, and expensive dialysis treatment. Asthma goes untreated until the individual ends up unable to breathe, turning blue in the emergency room. Hypertension progresses until it becomes a completely disabling disease, preventing the individual from working. A small cavity in the tooth becomes a huge abscess, requiring an extraction. Sore throats become systemic infections, bladder infections become kidney infections, and earaches become the source of hearing loss. Americans without health insurance rarely go to the doctor for a checkup, rarely receive ongoing supervision of chronic problems, and rarely get treatment until pain becomes unbearable or intractable complications set in.[9]

It also often means bankruptcy. In 2002 there were 1.57 million personal bankruptcies in the USA. Of these it is estimated that between a third and half resulted from medical bills[10]. The plight of the uninsured is mercilessly aggravated by the well-established practice of charging them more for medial services than the insured. For example, the New York Methodist Hospital in Brooklyn charges HMOs $2,500 for a two-day stay for an appendectomy but charges uninsured patients approximately $14,000.[11]

Even when Americans do manage to get professional medical care it too often isn't very good. For example, the Institute of Medicine says that about 100,000 die annually in the USA as the result of medical errors.[12] American babies are three times more likely than Japanese babies to die in their first month. The USA has the 6th highest infant mortality rate of the 30 OECD countries. Only 6 percent of hospital emergency departments in the USA keep all the necessary supplies for childhood emergencies.[13] It ranks in the OECD only 23rd in practising physicians per capita, and only four countries have fewer acute care hospital beds per capita. Half of all Americans from 55 to 64 have high blood pressure and 35.3% of all adult Americans are clinically obese.[14] It is no wonder then that the USA has the 6th lowest life expectancy of the 30 OECD countries and the 6th lowest healthy life expectancy. Today's Americans will die younger and have fewer healthy years of life than will most of their OECD contemporaries, and meanwhile over a third, because of obesity, have difficulty walking from their car to the fast-food counter.

These are the statistics of an enormous and deepening tragedy, given the USA's potential to be a member of the first division of OECD countries in health instead of in the bottom half of the third and falling. If the USA were miserly when it came to spending on health, its plight would still be tragic but easily explained. However as noted at the beginning of this chapter, the USA is an extravagant over-spender on healthcare to a staggering degree. Per capita health spending in the United States ($7,290 in 2007) is now nearly two and a half times the median for the thirty member nations of the OECD. So . . .

Where Does All The Money Go?

Given that other countries spend only half as much or less per capital as does the USA but achieve for their people more results, greater longevity and better health, it follows that most of the money that the USA spends on healthcare does not actually go toward providing for Americans' health. Instead it is siphoned off at various places in the system. Among healthcare experts and higher-ups in the industry these multi-billion dollar leakages are well-known, but naturally the incentive to keep the public uniformed and misinformed regarding them is overwhelming for those into whose pockets the money flows. There are two primary leakage networks, the private health insurance system and the pharmaceutical industry.

Private Health Insurance

As a means of allocating expenditure on health, the American private insurance approach is inherently and hugely inefficient because it suffers from four major leakages of funds not found in universal healthcare systems.

First, private insurers must continually fight "adverse selection", which means identifying and screening out customers who are apt to fall ill. Besides being perverse in terms of the goals of healthcare, fighting adverse selection is expensive.

Second, and proportionately much greater, is the amount of funds that the private health insurance companies spend trying to stick each other (over 350 of them, each with a portfolio of policies) and the two public systems, Medicare and Medicaid, with the bill. Moreover the bill necessarily includes the huge costs that healthcare providers (hospitals, labs, and doctors) incur in coping with the labyrinthine payment system. Because private health insurance policies are webbed with exclusion clauses, deductibles, co-payments and etc., the possibilities for an insurance company declining payments to its policy holders are rich. The partial nature of individual policy coverage has also led to the need for Americans to carry more than one health insurance policy. These policies exist in an astonishing number of variations, each with their own variety of complexity. Furthermore, because Medicare, although universal for Americans over 64, only offers them partial coverage for medical expenses, the over 64s still need private health insurance (and often more than one policy) to cover, when possible, the huge coverage gaps.[15] Inevitably all these gaps and under and overlaps between the multitudes of private policies and between private and public ones are numerous, ambiguous, complex and continually shifting so that the opportunities they afford for protracted clarifications and disputes, including America's favourite, litigation, are boundless and a source of employment and fees for hundreds of thousands of Americans. Of course none of this enormous expenditure of human effort does a damn thing for Americans' health. It is a hugely costly game generating an amount of paperwork inconceivable under a universal system.

Third, all of the roughly 350 private insurers have to market their products which means employing armies of sales people, over 50,000, and spending vast sums on advertising.

Finally, most of these firms will succeed in making a healthy profit paid for, like all the rest, out of people's premiums.

It is important to understand that health care insurance companies are merely administrative bodies. They do not provide medical care of any kind. Instead they merely administer funds. Whereas other advanced nations keep the share of all healthcare expenditure going to administration at 10 percent or less, in the USA it is more than 30 percent, with estimates running as high as 50 percent.[16] That

includes not just the sums spent by insurance companies, but also the vast administration costs that the system of multiple insurance payers, including HMOs, impose on the healthcare providers.

The Pharmaceutical Industry

Prescription drug prices in the USA are much higher than anywhere else in the world. For example, in 1997-1998 they were 52 percent higher than in the UK, 58 percent higher than in Canada, 74 percent higher than in France and 92 percent higher than in Italy.[17] For the Fortune 500 companies the median profit rate as a percent of revenue runs at about 5, but American drug companies, with their inflated prices, enjoy a rate of about 19 percent.[18] The industry also employs a sales force of over 60,000 and spends 22 percent of its revenue on marketing, a vastly higher percentage than any other major industry. Annual company reports also show that it spends nearly three times as much on marketing and administration as it does on research and development.[19] But this greatly understates the case because American drug companies make lavish use, like Enron did, of creative accounting so as to exaggerate the amount of their R&D expenditures. Moreover, much of their R&D has little or no medical value, because it is not about developing new medicines, but merely of finding ways ("copycat drugs") of sidestepping patents that their competitors have on existing medicines.

Most of the real research in the USA on new medical treatments is done in universities and paid for by taxpayers and charitable foundations. But the financial benefits of this work accrue to drug companies in the form of patent monopolies which the government confers on them when they package the research results as a marketable product. The same pattern exists in many other OECD countries, but with a fundamental difference. The existence of a system of universal healthcare means that the governments of other countries are compelled to restrict the drug company giants in their pursuit of monopoly profits. These governments have immense bargaining power and, like supermarket chains buying from food producers, they use it. But in the USA the drug giants are free to charge, in what in many cases are life-or-death situations, whatever they want.

The cost of this exploitation to American healthcare is enormous. If prescription drug prices in the USA were to be cut by 50 percent, which would put them at roughly their level in Italy, it would amount to a savings of more than $100 billion a year, given 2005 spending levels. Even a 50 percent cut would leave American prescription drug prices approximately two-thirds higher than what they would be if the patent monopolies were withdrawn and competitive pricing was allowed to take place.[20] Sometimes it is falsely argued that the American pharmaceutcal industry's uncontroled monopoly pricing makes possible the USA's dominance in the development of new medicines. But the USA does not have this presummed dominance. Even American drug companies acknowledge the fact when talking among themselves. For example, the website of their industry trade group, The Pharmaceutical Research and Manufactures of America (PhRMA) reported that the USA accounted for 45% of all new drugs developed from 1975 to 1994, while France, Germany, Great Britain, Sweden, Belgium and Switzerland with a combined smaller population accounted for 40%.[21]

Campaigns for Bad Health: Promoting Obesity

The U.S. National Center for Health Statistics reports that in 2003-2004 "17.1% of children and adolescents 2-19 years of age (over 12 and a half million) were overweight." In 2005-2006 34.2% of adults were obese and 67% of adults (excluding the 2 million plus imprisoned) were overweight or obese.[22] Along with the picture these statistics paint and with the images one has of Americans in the flesh, it is worth remembering that America was not always a nation of fatties. I can even recall when Americans prided themselves, and with some justification, on their good health relative to Europeans.

The self-inflicted reversal began slowly. By the late seventies the American obesity rate, although alarming, was still only 15%. But in the next 25 years the obesity rate more than doubled, and astonishingly, since the year 2000 the percentage of adult Americans afflicted with obesity has not only continued to increase but does so at the rate of 2.5 percent a year.[23] The effects of this epidemic on American life expectancy are already beginning to emerge. Throughout the 1990s American life expectancy increased at the rate of 1.5 percent a year, slow by comparison to other countries but nevertheless significant. Since 2000, however, despite continuing medical advances, that increase has slowed to just 0.3 percent – an 80 percent decrease in the rate of improvement. This is thought to be the tip of the obesity iceberg. Already between 2000 and 2005 America's premature death rate (before age 75) increased. In the years to come life expectancy for Americans is expected not only to decrease relative to other nations, but to decrease absolutely as the long-term health effects of obesity and overweight take their toll.[24] These effects are diverse. Whereas smoking targets the lungs and heart, obesity can kill you in many ways, including diabetes, heart disease, stroke, various kinds of cancer, kidney disease and dementia.

Meanwhile the obesity epidemic grows more sinister. Until relatively recently it was mainly an adult disease. But the obesity rate among children and adolescents has now passed 17 percent and is growing faster than for any other age group. This is not surprising, given that American children, including toddlers, are bombarded daily with propaganda designed to lead them into a life of unhealthy eating. It is estimated that each year the average American child views more that 20,000 TV commercials aimed at inducing them to indulge in high-calorie foods and beverages. These industries spend between 10 and 20 billion dollars annually marketing directly to kids.

The American junk food industry has even colonized the ad-free television channels, Public Broadcasting Service (PBS) and Disney. According to a study published in *Paediatrics Magazine*, "82 percent of sponsored ad-fee preschool programming blocks on PBS and 36 percent on the Disney Channel are fast food focused."[25] Ronald McDonald, for example, appears on both channels and Chuck E. Cheese mouse on PBS. Also many toys in the USA are co-branded with the junk food industry, part of their attempt to get kids to identify junk food with a healthy lifestyle.

Meanwhile these industries have also invaded American schools. A report from the U.S. General Accounting Office revealed that junk food was sold in 98 percent of secondary schools, 74 percent of middle schools and 43 percent of elementary schools. In most cases advertising accompanies these sales.[26]

The horror of this exploitation of children is that the medical profession believes that the effects of childhood obesity on life span are greater, maybe much greater, than adult obesity. Dr. David S Ludwig of Children's Hospital in Boston has put the problem in perspective.

> Obesity rates are increasing fastest among children, and they will carry obesity-related health risks throughout their lives. An adult who gains a pound or 2 a year through middle age will be at increased risk. But that is much less dire than the over weight 4- to 6-year old who gets diabetes at age 14 or 16 and has a heart attack before age 30.
>
> But we still have a little time before these children become young adults with diabetes and start to have heart attacks, stroke, kidney failure, and increased mortality. ... It is a massive tsunami headed for the United States. One can know it is coming. But if we wait until we see the ocean level rising over the shore, it will be too late to take action.

And he adds:

> We continue to condone a multibillion-dollar campaign by the food industry to get children to eat the most unhealthy foods imaginable.[27]

Prognosis

Nothing stands in the way of Americans recovering their health and returning their healthcare system to respectability except their will to do so. Within a year their Congress could pass and their President sign into law measures that would reconstruct their health system along the lines of one of the world's most successful systems, like Japan's, Norway's, Italy's or France's. Within only a few years the reconstructed system would become part of the everyday reality of American life, with all the accruing benefits and with more than five percent of the nation's GNP released for spending on other things. At the same time there could occur within the general population an upsurge of moral decency such that corporate campaigns to lure the nation's children into harmful and deadly eating habits would, like paedophiles, no longer be tolerated. Parents might also feel morally compelled to set a good example for their children, thereby improving their own health.

But all this seems unlikely to happen. There are many reasons why this is so. I will mention only a few.

First of all, Americans are grievously and increasingly uniformed about the rest of the world and so fail to appreciate how much better, and at less cost, their healthcare could be. Although you may find it difficult to believe, ignorance on the matter is so extreme that one can still easily find American's who think that their health system is the best in the world. This ignorance translates into inertia when contemplating fundamental reforms of the American health system.

Second, Americans also suffer from extreme ignorance regarding what constitutes healthy eating habits. For example, in 2006, 12,000 adults comprising a balanced national sample were asked if they considered their eating habits healthy or not. Only 4.3% of people clinically obese and 2.4 % of those overweight regarded their eating habits as "not healthy".[28] Also the American school system inculcates a lets-always-feel-good-about-oneself mentality that tends to create adults without enough moral fibre to resist persistent overeating.

Third, Americans generally prefer forgoing good healthcare to giving up their strange ideological beliefs. Opponents of serious reform in the USA have always preached that a national healthcare plan, such as enjoyed by other countries, would be the not-so-thin wedge of Communism, with enslavement soon to follow. For the most part they have been believed and continue to be. Worse, today the obstacle of ideological fanaticism is even more entrenched following the rise of Neoliberalism, whose extreme American variety teaches that for a government to influence any market, except for enforcing property rights (especially patents) or bailing out big banks, is always a bad thing.

Fourth and hardest to overcome is the power of those with vested interests in maintaining the present arrangements. The American healthcare system is by far the biggest cash-cow that humankind has ever created. It follows that a great many people have so much to loose, some their riches, others their livelihoods. Not only will they fight to the bitter end to perpetuate the American health tragedy, but they also are extremely well organized and have been for generations. And, most significantly,

they have all that money, those annual billions that they siphon off from the sick and potentially sick and rake in from the "super-sizers", and which they use to confuse and misinform the American public through the media and to buy, over-the table with campaign contributions and under-the-table with brown envelopes, the votes of senators and congressmen.

But miracles do happen. And once upon a time they happened in the USA. Today on the healthcare front there is an emerging ray of hope, still faint, but potentially lethal to the status-quo. Traditionally the medical profession has not only been an integral part of the coalition of the health insurance industry, pharmaceuticals, hospital owners and assorted beneficiaries, it has also served as the coalition's acceptable public face. But as noted, under the new regime of HMOs doctors have been hard done by, not only in terms of their conditions of employment and of their freedom to practice sound medicine, but they also have seen their earnings reduced, especially in comparison to doctors in other countries. One comparison is particularly telling. American doctors used to look with horror at the earnings of their British counterparts under what they dubbed "socialized medicine". But today, under the same system, the earnings of British general practitioners or family doctors are 46% higher than their American opposite number and the gap is growing.[29] Unsurprisingly, discontent among doctors in the USA is also growing. Already if one listens one can hear in their ranks rumbles of rebellion. In time their displeasure could become a movement that embraced the spirit of their Hippocratic Oath. If in large numbers American doctors found the courage to speak out loudly and often, it is conceivable that they could not only save their bacon, but also the health of their nation.

But without a miracle the future of American health looks set to become increasingly grim. The proportion of Americans without health insurance and the proportion underinsured will continue to mount, and HMOs will continue to exert a downward pressure on healthcare quality. Meanwhile the long-term effects of the nation's contemporary dietary practices will become increasingly manifest. More and more Americans will sink prematurely into ill health, and for the first time since the Black Death a major Western nation will experience decreasing life expectancy. In terms of its ranking in health indicators among OECD nations, the USA is already in the third division and third from bottom. The two countries below it are the anomalies of OECD, Turkey and Mexico, neither being an advanced industrialized nation. By now all of the former Soviet Bloc countries have shot ahead of the USA. At the same time the gap between USA health standards and those of countries in the OECD's first and second divisions looks almost certain to grow.

Obama's recent election is, of course, the biggest hope of all. But it remains uncertain that the new President intends to bring about a genuinely fundamental reform of the American healthcare system and, if he does, that he has the stomach for the fight. The health related industries have their ill-got billions and lack of scruples with which to defend the status quo. A more daunting political task than victory over those forces is hard to imagine and yet no more than his campaign for the White House and certainly no more than many of the reforms that President Roosevelt led through in the 1930s. We must wait to see which Obama values more: his popularity with the ultra elite with whom he now works and lives, or the health of his fellow citizens.

Notes

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[7] U.S. Department of Commerce, Bureau of the Census, People With or Without Health Insurance Coverage by Selected Characteristics: 2003 and 2004, August 2005.

[8] Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, Oxford: Oxford University Press, 2005, p. 3.

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[12] L. Leape and D. Berwick, "Five Years After *To Err is Human* What Have We Learned?" *Journal of the American Medical Association,* May 18, 2005: Vol. 293, No. 19, 2384-2390.

[13] The Future of Emergency Care – facts.

[14] http://mwhodges.home.att.net/healthcare.htm

[15] For example, although Medicare pays the first $2,250 of a patient's medication costs and medication costs above $5,100, the patient has to cover all of the $2,850 gap.

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[22] "Fact Sheet" "FASTATS – Overweight Prevalence", National Coalition on Health Care, available at (http://www.nchc.org/facts.shtml And "Table 70. Selected health conditions and risk factors: United States, 1988–1994 through 2005–2006", National Center for Health Statistics, http://www.cdc.gov/nchs/data/hus/hus08.pdf#070

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