Health Care Consumers *Know Something* Government Planners *Don't*

By John Goodman

Many, many years ago, the Nobel Prize-winning economist Kenneth Arrow wrote an article about asymmetry of information in medical care (your doctor knows more than you do). Since then, countless textbook authors, op-ed writers, and policy wonks have seized on Arrow's observation to argue that a free market will not work in health care. Ergo, we need a regulated, institutionalized, bureaucratized market—like what we have in the United States and almost everywhere else.

The problem with this line of reasoning is that it commits what logicians call the fallacy of the excluded middle. The unstated, and therefore unexamined, minor premise is: Regulated markets can solve the problem, or at least do better than free markets. As it turns out, this minor premise is difficult, if not impossible, to defend.

MEDICAL TOURISM REVEALS THE POWER OF MARKET COMPETITION

What brings all this to mind is medical tourism. In the international marketplace, a booming, bustling, vibrant, completely free market for medical care is emerging. Indeed, the words "free market" do not do it justice. It's as close to laissez faire capitalism as anything Adam Smith might have hoped for.

And guess what? In this market, patients are getting information about price, quality, you name it—the very information no one can get back home. The reason: Since almost all medical tourists pay with their own money, providers compete based on price and quality. By contrast, providers back home do not compete based on anything.

Here's what's happening: Estimates vary, but as many as half a million Americans travel outside the United States for health care every year, and the number is growing by leaps and bounds. Amazingly, 70,000 British patients (who are supposed to be getting health care for free!) will leave the United Kingdom this year for health care abroad. These patients are going to such places as India, Thailand, and Singapore, as well as countries south of our border. Americans are finding package prices (that may include airfare and hotel rooms) that are one-third, one-fourth, or even one-fifth of what they would pay in the United States.

Virtually every major U.S. insurer is actively studying how to enter this international market.

Despite lower cost, the quality of health care abroad can be high. For example:

• Foreign doctors are often board certified in the United States.

• About 140 hospitals abroad are accredited by the Joint Commission International (an arm of the organization that accredits American hospitals participating in Medicare), and that number will double in the next few years.

• Some foreign hospitals are owned, managed, or affiliated with prestigious American universities or health care systems such as the Cleveland Clinic and Johns Hopkins International.

• The best foreign hospitals not only post quality data (e.g., their case-adjusted mortality rates) but also compare their rates to those at the best U.S. hospitals.

• There are even medical travel bureaus that help patients find high quality care to meet their needs.

In general, quality is not a medical problem; it is a political problem. Host countries must be willing to allow facilities that cater to foreigners to operate and to provide a level of care to which most local citizens do not have access.

In general, quality is not a medical problem; it is a political problem. Host countries must be willing to allow facilities that cater to foreigners to operate and to provide a level of care to which most local citizens do not have access.

Health care economist Uwe Reinhardt has said: Medical tourism "has the potential of doing to the U.S. health care system what the Japanese auto industry did to American carmakers."

Here is my prediction: Long before the last American hospital closes its doors, the industry will undergo radical change. Already there are centers of excellence around the country gearing up to (you guessed it!) compete on price and quality.

DEBUNKING SOCIALIZED MEDICINE

As medical tourism reveals the power of consumer choice, new information helps debunk three persistent myths that have been used to build the case for a thoroughly socialized health care system such as that in Canada.

The Myth of Low Administrative Costs. In a series of articles in medical journals, David Himmelstein and his wife Steffie Woolhandler, both associate professors at Harvard Medical School, claim that the administrative costs of Canada's government-run health care system are much lower than those of the U.S. system. Himmelstein and Woolhandler argue that by adopting a similar system, the United States could insure its uninsured through the administrative savings alone.

However, Himmelstein and Woolhandler count the cost of private insurance premium collection (e.g., advertising, agents' fees), but they ignore the cost of tax collection to pay for public insurance.

Economic studies show the social cost of collecting taxes is very high. Using the most conservative of these estimates, Benjamin Zycher, a fellow at the Manhattan Institute, has shown that the excess burden of a universal Medicare program would be twice as high as the administrative costs of universal private coverage.

The Myth of High Quality. Himmelstein and Woolhandler say that Canadian life expectancy is two years longer than ours, implying that the health care systems of the two countries have something to do with that result. Yet doctors don't control overeating, overdrinking, etc. Where doctors do make a difference, the comparison does not favor Canada. In a National Bureau of Economic Research study, David and June O'Neill draw on a large U.S./Canadian patient survey to show that:

• The percent of middle-aged Canadian women who have never had a mammogram is double the U.S. rate.

• The percent of Canadian women who have never had a pap smear is triple the U.S. rate.

• More than eight in 10 Canadian men have never had a PSA test, compared with less than half of U.S. men.

• More than nine in 10 Canadians have never had a colonoscopy, compared with seven in 10 in the United States.

These differences in screening may explain why U.S. cancer patients do better than their Canadian counterparts. For example:

• The mortality rate for breast cancer is 25 percent higher in Canada.

• The mortality rate for prostate cancer is 18 percent higher in Canada.

• The mortality rate for colorectal cancer among Canadian men and women is about 13 percent higher than in the United States.

Amazingly, there are quite a few people in both countries who are not being treated for conditions that clearly require a doctor's attention. However:

• Among senior citizens, the fraction of Canadians with asthma, hypertension, and diabetes who are not getting care is twice the rate in the United States.

• The fraction of Canadian seniors with coronary heart disease who are not being treated is nearly three times the U.S. rate.

Apparently, putting everyone in Medicare (i.e., creating a universal system like Canada's) leads to worse results than having only some people in Medicare (i.e., having a mixed public/private system).

The Myth of Equal Access. The most common argument for national health insurance is that it will give rich and poor alike the same access to health care. Surprisingly, there is no evidence of that outcome. Indeed, national health insurance in Canada may have created more inequality than otherwise would have existed. (Similar results have been reported for Britain.) The O'Neills' study shows that:

The most common argument for national health insurance is that it will give rich and poor alike the same access to health care. Surprisingly, there is no evidence of that outcome.

• Both in Canada and in the United States, health outcomes correlate with income; low-income people are more likely to be in poor health and less likely to be in good health than those with higher incomes.

• However, there is apparently more inequality in Canada; among the non-elderly white population of both countries, low-income Canadians are 22 percent more likely to be in poor health than their American counterparts.

CONCLUSION

Globalized medicine means that socialized systems like Canada's must face competition in an international market. Unless Canada wants to make it illegal for its citizens to travel and pay for medical services abroad, Canadian health care will have to change. And when it does, Canadians will get healthier. The good news for all health care consumers is that global competition gives them choices—in spite of the best efforts of health care bureaucrats to design one-size-fits-all plans.

Mr. Goodman, called the "father of health savings accounts" by the Wall Street Journal, *is president and founder of the National Center for Policy Analysis. This article is adapted from material previously published at John Goodman Health Blog* (www.john-goodman-blog.com).