How and Why US Health Care Differs From That in Other OECD Countries

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UNITED STATES HEALTH CARE, OFTEN HAILED AS "THE best health care system in the world," is also faulted for being too costly, leaving many millions of individuals uninsured, and having avoidable lapses in quality. Criticism often draws on comparisons with other countries of the Organization for Economic Co-operation and Development (OECD). This Viewpoint also makes such comparisons, over a broad range of variables, and reaches one inescapable conclusion—US health care is very different from health care in other countries. Potential reasons for the differences are discussed, leading to the conclusion that future efforts to control cost, provide universal coverage, and improve health outcomes will have to consider the United States' particular history, values, and political system.

US vs OECD: Health Expenditures and Outcomes

Compared with the average OECD country, US health care expenditures differ in 3 important ways.[1] First, as a percentage of gross domestic product, US expenditures are twice as high. Second, the US share of health expenditures funded by government is much lower, 46% vs 75%. Third, the mix of services provided (technology intense vs more basic care) is very different (eTable, available at http://www.jama.com).

The larger role of government in health in OECD countries and the difference in mix of services are the main proximate explanations for the higher level of spending in the United States. Because funding in most OECD countries is usually through a tax-supported system, administrative costs are usually much lower than in the United States, with its fragmented sources of funding and payment. Also, the OECD countries use the concentration of funding to negotiate aggressively with drug companies and physicians and to control investment in hospitals and equipment. The United States could try to use the buying power of Medicare in a similar way, but legislation and political pressure prevent such an approach. The OECD countries provide more physicians and more acute care hospital beds, whereas the United States provides much more high-tech services, such as magnetic resonance imaging (MRI) scans and mammograms, proportionately more specialists, more amenities (privacy and space in hospitals), and more standby capacity as evident in a higher ratio of MRI scanners available to MRI scans performed. The greater number of physician visits and hospital days in OECD countries does not result in higher spending because of differences in services provided during a visit or a hospital day. In general, the United States has an expensive mix, whereas the OECD countries have an inexpensive one.

The effect of these differences in mix and total expenditures on health outcomes is uncertain. Measured by life expectancy, the OECD countries do slightly better than the United States, but firm conclusions are elusive because life expectancy depends on many factors in addition to medical care. For instance, the percentage of population in poverty is much higher in the United States than in the OECD countries (17% vs 9%), and poverty is a predictor of early death. Health is probably distributed less equally in the United States than in the OECD countries because the United States has more individuals without insurance and greater income inequality.

Why the Differences?

Three basic differences between the United States and most other OECD countries might explain why health policy differs. First, US individuals appear more distrustful of government, a distrust that has deep historical roots. It was an armed rebellion against the government of King George III that led to the founding of the United States. It was Thomas Jefferson, a principal founding father, who said, "That government is best which governs least." The initial antigovernment sentiment has received recurrent "booster shots" from waves of immigrants who came to the United States seeking freedom. Their willingness to risk life in a new land was frequently fueled by negative experience with government in their home country, a government that oppressed them because of their political beliefs, religion, ethnicity, or social class. Medicare and Medicaid appear to be an exception to distrust of government, but these programs pro-

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vide insurance for populations that were not and could not be served by private insurance. A Pew public opinion survey of a representative sample of US individuals about their attitude toward elected officials showed more than twice as many negative as positive views.[2]

Closely related to the weaker support for government action in the United States is a reluctance to achieve more equal outcomes for the population through redistributive public policy. Although US individuals have always rejected European-style class distinctions that required deference and subservience,[3] the declaration that "all men are created equal" did not carry any suggestion of equality of outcomes, such as in income or health. The income tax is less progressive in the United States than in most OECD countries, and the redistributive effect is augmented in the OECD countries by more egalitarian transfers of money and services. In response to a Pew survey,[2] 4 of 5 US individuals agreed that "everyone has it in their own power to succeed." Only 1 in 5 agreed that "success in life is pretty much determined by forces outside our control." Whether this view reflects reality is another matter. It is attitude and beliefs that shape voting behavior.[4]

Heterogeneity of the US population tends to strengthen resistance to redistribution. Diversity of race, religion, ethnic origin, and sometimes language contribute to a weaker sense of empathy for less fortunate members of society, whose identity may differ greatly from one's own. In more homogeneous nations, such empathy is more likely to be experienced and acted upon. Weak support for redistribution at the national level in the United States stands in sharp contrast with redistribution within self-defined more homogeneous groups (for example, Mormon Relief Societies, Jewish homes for the aged in almost every major city, and the founding of Baptist, Catholic, Lutheran, Methodist, and other sectarian hospitals).

The third, and probably most important, difference between the United States and most OECD countries is the political system. Many observers attribute US failure to enact comprehensive health care reform to the opposition of "special interests," such as pharmaceutical and device manufacturers, insurance companies, physicians (especially those in high-income specialties), and hospitals. But all countries have special interests; only in the United States have they been particularly successful in blocking comprehensive reform. This success can be explained in part by noting that the US political system is different from the parliamentary systems of most OECD countries in ways that make special interests more effective. Some of these differences are built into the US Constitution, including the checks and balances provided by 2 separate houses of Congress with their powerful committees, plus an independent executive branch with veto power. Some differences have evolved over time, such as expensive primary election battles, long election campaigns, and the Senate filibuster. Thus, the US system provides many "choke points" for special interests to block or reshape legislation. Also, in recent years, contributions from special interest groups significantly influence who runs for office, who gets elected, and how elected officials vote.

Lessons for Future Reform

President Obama's Affordable Care Act (ACA), if fully implemented, would involve significant redistribution with tens of millions of poor and sick persons obtaining health insurance paid for by others. If the ACA is pared back, there will be less redistribution and tens of millions of persons would not have coverage, and the more difficult task of controlling health costs would remain. This review suggests a strategy for obtaining further reform.

First, government's role should be limited to what is necessary, not just desirable. Efficiency and equity in financing require a dedicated tax to fund basic care for all.[5] Second, provision of basic coverage for all should not require equality for obtaining additional coverage. As in Australia, Israel, the Netherlands, and Switzerland, individuals should be free to purchase more than basic care. Third, reform should have features that would appeal to some special interests, or to some elements within each special interest group (for example, some physicians or some health plans). Comprehensive health care reform in the United States is necessary to avoid a financial disaster, but enactment of such reform will require attention to US history, values, and politics.

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