

Gesundheit !

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Commentary

Play it again, Sam! Health Care and the Race to the White House – David Torstensson

Fifteen years ago a new word entered the English language: “Hillarycare”. Following his presidential win in early 1993 President Bill Clinton launched his administration’s first big domestic initiative: the Task Force on National Health Care Reform. The taskforce was headed by then first lady Hillary Rodham Clinton, now New York Senator and contender for the Democratic presidential nomination. It had as its goal to medically insure every American, providing the closest thing to European-style universal health care coverage possible. But just 18 months after its launch “Hillarycare” was dead in the water, President Clinton’s political standing was diminished, and the Republican Party geared up against “socialized medicine”, proving victorious in the mid-term elections of November 1994. Since then systematic health care reform on the federal level has been virtually off the table with only more limited types of legislation, such as the State Children’s Health Insurance Program (SCHIP), being introduced. Now America is, once again, in the thick of a big political battle over how to provide health care for all.

Over the past 25 years, health care costs in the United States have almost doubled from 9.1% of GDP in 1980 to 16% in 2005 and all the projections point to continued growth. Higher costs, less coverage, and a majority of medical insurance linked to employment, means that all Americans are being affected by the systemic problems of the current model. Indeed, over the past year opinion polls consistently show that health care is frequently at the top of the list of voter’s concerns. At the same time, big companies and employers are feeling the strain of providing insurance to current and former employees. For example, General Motors today has health care obligations for 1.1 million people; a burden which adds an additional

\$1500 to the price of each GM-manufactured vehicle.¹

Undoubtedly the presidential nominating contests have played a key role in bringing health care to the fore, but counter-intuitively, this is not just an issue being talked about in the Democratic contest or pushed by the Democratic Party. Certainly, health care is, and was, central to all Democratic hopefuls from Hillary Clinton to Bill Richardson – with former South Carolina Senator and 2004 Democratic Vice Presidential candidate John Edwards being the most vocal (and angry) about making it a central theme of the Democratic nomination.

But over the course of the primary elections, the Republicans have also addressed the issue. In fact, both former Presidential candidates Rudy Giuliani, Mitt Romney and the now confirmed presumptive Republican nominee, Arizona Senator John McCain, all presented relatively detailed plans for what they would do in the field of health care. As neither Giuliani nor Romney are still in the race their plans are of less significance than McCain’s, but suffice it to say that both felt compelled to campaign on the issue. Romney – harking back to his experience in Massachusetts as the first US Governor to introduce a system of universal coverage in 2006 – even made a specific point of stating that health care ‘isn’t a Democrat issue, it’s a Republican issue.’²

So, what are the remaining three candidates – Democratic hopefuls Barack Obama, Hillary Clinton and Republican John McCain – actually proposing? Both Obama and Clinton’s plans focus primarily on the issue of coverage and of providing more of it, either through existing government health care schemes, such as Medicare, Medicaid and SCHIP, or putting in

¹ <http://www.washingtonpost.com/wp-dyn/articles/A15828-2005Feb10.html>

² Mitt Romney at a Republican Debate in Florida 2008. http://www.metacafe.com/watch/899810/gov_romney_not_going_hillarys_way_on_healthcare/

place regulations that provide the uninsured with either private or public coverage. The big difference between the two is that Senator Obama only mandates coverage for children, whereas under Clinton's plan all individuals would be required to obtain either public or private health insurance. Both would also supplement the private insurance market either by making insurance available through an extended Medicare model – Senator Clinton's plan – or, in Obama's case, creating a new program based on the existing Federal Employee Health Benefit Program.³

Senator McCain, on the other hand, is not seeking to expand on existing federally-run programs nor does he propose the creation of any new ones. Instead, the *Arizonian* wants to put more competition into the existing model by introducing a national health insurance market.⁴ Under this plan individuals would be able to purchase insurance from any provider regardless of where they themselves live or where the provider is based. This is in marked contrast to the current regulatory system in which insurance can only be sold in a state if it has been approved by that state's insurance commissioner. Now there are 50 different sets of state-regulated insurance models, and, in effect, 50 independent insurance markets, few, if any, providing a competitive market. McCain's proposal would replace these state regulations by introducing national insurance regulations.

Where US health care goes from here will be up to the electorate this coming November. What seems beyond doubt is that Americans will face a pretty clear choice as to what kind of health care model they wish to adopt. This special edition of *Gesundheit!* aims to introduce the state of the current, and coming, residential debates on this topic to a European audience.

³ PwC's Health Research Institute, *Beyond The Sound Bite, Review of Presidential Candidates' Proposals for Health Reform*, Nov. 2007.

⁴ Ibid.

We are privileged to have the contributions of several expert commentators from the American policy community. Grace-Marie Turner, President of the Galen Institute, has written a thought-provoking piece on the current state of the US health care system and some of the possible ways forward. Catherine Fisher, of the Hudson Institute, provides her view of the many problems with the Medicare system and of attempting to reform American health care entirely through government or the private sector. The Stockholm Network's, Kristian Niemietz, takes a fresh look at some of the more common misperceptions and stereotypes of the American and European health care systems. Last but not least, in this issue's Head-2-Head our columnists – David Kendall, Senior Fellow for Health Policy with the Progressive Policy Institute, and David Freddoso, political reporter with the *National Review* – provide a hard-hitting take on the big philosophical difference between Democrats and Republicans on health care.

We hope you enjoy this issue.

Topic of the Month

A profile of the American health sector – Grace-Marie Turner⁵

Many Europeans believe that health care in the United States is entirely delivered through the private sector in a largely unregulated free market. However, health care financing and delivery are in fact characterised by significant government involvement, both through large public sector programmes that finance health benefits for more than 100 million Americans and through a private sector that is highly regulated by the states.

⁵ Grace-Marie Turner is the president of the Galen Institute.

The system is often criticised too, both at home and abroad, for the high number of people without insurance. But new ideas are being offered to increase access to health insurance while providing new incentives for the market to offer better, more affordable health care.

A Profile of the Health Sector in the United States

Health spending in the United States is nearly equally divided between the public and private health sectors. Both sectors are highly regulated, and both are facing significant cost pressures.

In 2006, health care expenditures totalled more than \$2.1 trillion, representing 16% of GDP. Of the total, 46%, or more than \$992 billion, was spent through public programmes.

Two taxpayer-supported health care programmes are dominant in the United States: Medicare and Medicaid. Medicare is the federal government's health programme serving Americans who are age 65 and over as well as the disabled of any age. Medicaid is a joint federal-state programme designed primarily to finance health care for the poor. Together, Medicare and Medicaid provide health services to more than 107 million Americans.

In addition, there are many other federal programmes for specific populations, such as children, veterans, and Native Americans, plus many state and local health care programmes, including more than one thousand community health centres providing free or low-cost care.

Tax revenues provide the largest share of funding for public programmes. Medicare beneficiaries and Medicaid recipients are entitled to receive health care services through the same public and private hospitals that serve the general public. However, doctors, hospitals, and other providers are paid at government-determined rates that often are below those paid by private health plans.

More than \$1.1 trillion, or 53%, of total health spending in 2006 was through the private

sector.⁶ More than 67% of Americans, or almost 201 million people, were covered by private health insurance in the year 2006.⁷ The majority received their coverage through the workplace, with a combination of employer and employee payment for premiums.⁸ The average annual health insurance premium for a job-based policy for a family is more than \$12,000. Twenty-seven million people purchase health insurance in the private market. Private health insurance for individuals and small businesses is heavily regulated by the states, often discouraging competition among health plans and providers that could help to lower costs and increase options.

But there are some bright spots on the horizon: one of the newest options for health insurance is Health Savings Accounts which were created by Congress in 2003 to give people a different way of financing their health care. HSA holders can put tax-free money aside to pay for routine health expenses as long as they purchase a high-deductible health insurance to cover major medical bills. A large percentage of those with HSAs were previously uninsured. They find the premiums for the high-deductible⁹ coverage generally are lower, making the coverage more affordable.

In addition to new financing options, employers are creating a number of innovative programmes to engage consumers as partners in managing their health care. Health information technologies, prevention and wellness incentives, price transparency, quality

⁶<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>.

⁷ Numbers may not add up because some people are covered by more than one programme, such as retirees who have public Medicare coverage but also have supplementary private insurance through previous employers, or people who may be covered by more than one policy.

⁸http://pubdb3.census.gov/macro/032007/health/h01_001.htm.

⁹ In the UK, a deductible is known as the policy excess.

improvements, and chronic care management all are being advanced by private companies in efforts to get prices down, keep quality up, and get more value for their health spending.

The Uninsured

In 2006, an estimated 47 million Americans did not have health insurance. While the numbers change, the profile of the uninsured remains constant. According to U.S. Census Bureau data, the uninsured are primarily minorities, especially Hispanics; lower and lower-middle income working Americans who cannot afford or do not get coverage at work; and young adults for whom buying health insurance is not a high priority.

45% of uninsured citizens were without insurance for six months or less, an indication that many are uninsured because they lose health insurance temporarily as they move from job to job. A 21st century solution would allow individuals to own and control their own health insurance and take it with them from job to job.

The Safety net

Even though the United States has millions of people who don't have health insurance at any one time, the Emergency Medical Treatment and Active Labor Act requires hospitals to provide medical treatment to any patient who presents them with a medical problem, whether or not that patient is insured or can pay the bill. Billions of dollars in federal subsidies go to hospitals to compensate them for the free care they provide. The U.S. spends an average of \$1,000 a year on medical care for every person without health insurance.

Therefore, the uninsured are protected by an official and unofficial safety net and receive medical care through:

- Hospital emergency rooms and other hospital admissions.

- Joint private-public sector health programmes, including community health centres.
- Free clinics operated by churches and other philanthropic organizations
- Private payments to doctors and hospitals.
- Care at private clinics operated in pharmacies and other retail establishments and at the workplace.

The Search for solutions to the problem of millions of uninsured

The United States is seeking new ways to finance health coverage, not only to solve its own problems and bring millions of people into the system but also to demonstrate how free-market solutions can create a health care system that can respond to the pressures and demands of the modern economy, including access to life-saving technologies.

The United States is recognised around the world for the quality of the medical care it offers, including development of and widespread access to the latest technologies. One of the major reasons for the continued progress in medicine is the system of rewards and incentives for innovation, including competitive pricing and strong intellectual property protection laws.

A number of public policy initiatives are being considered in Washington and in state capitals that would allow greater portability of health insurance and direct subsidies for health insurance for those who need assistance in purchasing private health insurance. These measures will go a long way toward solving the problem of so many Americans being uninsured.

All the Republican presidential candidates have offered plans that would increase the options for individually-owned health insurance. They would also give states new incentives to fix problems, especially regulations and mandates, which have dried up competition and made

health insurance so expensive in the first place. They believe that rationalising the financing and bringing millions of new buyers into the health care marketplace will expand competition and force insurers and providers to offer more affordable options.

The issue of what direction the health system takes is at the centre of the 2008 presidential debate in the United States. The ultimate question for voters will be: will reforms lead to more government control or will it empower consumers in a free and competitive marketplace?

Think Tankers Corner

A view from the Hudson Institute— Catherine M. Fisher¹⁰

Contrary to the popular belief that the burdens of health care expenditures are placed entirely on American citizens, the United States government spent over \$700 billion on health care expenditures in 2006. Recent data from the National Health Expenditure Accounts depicts the burden of health care expenditures. The major components are out-of-pocket payments (12.2%), private insurance (34.4%), and major federal, state, and local government health care expenditure (33.8%). Although private and out-of-pocket expenditures are the bulk of all health expenditures in America, major government expenditures are equally as significant to the health care system.

Established in 1966, Medicaid and Medicare provided the first nationalised health care system and have continued to be the primary safe guards for public health in the United States. These programmes focus on providing access to health care and health insurance for American citizens who may not have the ability

¹⁰ Catherine M. Fisher is a Research Assistant at the Hudson Institute in Washington D.C.

to procure private health care options. Medicaid is a federal and state initiative that focuses on providing health insurance and long-term care to low income citizens. It also provides health care services for the blind and disabled, children under 21, non-citizens that need emergency medical assistance and those that receive supplemental security income. In 2006, over 38 million Americans received \$256.5 billion worth of services from Medicaid.

As a safeguard to protect America's aging citizens, Medicare is a federal initiative that focuses on providing health insurance to American citizens of the age 65 or older, and under the age of 65 with certain disabilities and illnesses. In 2006, over 43 million Americans received \$408.3 billion worth of services from Medicare.¹¹

The most interesting feature of Medicare is the programme's integration of private health care into the federal programme. Part C of Medicare – Medicare Advantage – provides beneficiaries with the opportunity to receive Medicare benefits through private health insurance plans, and Part D – Medicare Prescription Drug Coverage – provides beneficiaries with several private stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription plans (MA-PDs). In 2006, 16% of the Medicare beneficiaries were enrolled in Medicare Advantage plans or Medicare Prescription Drug Coverage. These options provide Medicare beneficiaries with the freedom to use public health care expenditures in a method most comfortable for them, so that they can obtain the best coverage for their needs.

The United States has a long tradition of capitalism and private industry, and ignoring this when reforming the American health care system would not help the uninsured. Instead of viewing the private and public health care systems as separate entities, it is more beneficial

¹¹ U.S. Department of Health and Human Services. [National Health Expenditure Accounts 2006 Highlights](#). Centers for Medicare and Medicare Services; Washington, D.C., 2007. pg. 2

to see these health care systems as equal partners trying to achieve better health care in America. An overhaul of the public health care system's focus and target goals is critical for this partnership to work. In the current state, the public health care system focuses on very niche groups in American society. A comprehensive policy reform would shift the public health care systems focus from niche groups to an expanded primary and preventative style of health care for all Americans while still providing full coverage for certain cases. Therefore, the goal of the public health care system would be to hedge against the staggering cost of long-term chronic and preventative diseases in American society. One can speculate that this type of public health care system would result in an alleviation of costs associated with primary and preventative health care on the private sector. Additionally this improved public health care system would reduce costs on the private sector as all Americans would benefit from the effects of having a universal primary and preventative health care system.

In essence, the American people would no longer bear the costs of a piecemeal public health system. With a universal primary and preventative health care system, all Americans would have health care and private health care insurance would become affordable. And rather than 43.6 million American being without health insurance, they would then have the opportunity to see a doctor whenever they needed one.

Objection, your Honour!

Socialised medicine in Europe, free market health care in America? – Kristian Niemietz¹²

I recently told a former fellow student from Berlin about the desperate struggle of finding a reasonable flat in London. He asked why landowners would not simply respond to the shortage by building new dwellings *en masse*? So I explained that British land use planning laws were among the most restrictive in the world. He was very surprised to hear this. Hitherto, he had believed that in the “Anglo-Saxon Economic Model”, there was little, if any, state regulation. When looking at specific sectors of an economy, buzz phrases like “Anglo-Saxon Model” or “Rhineland Model” are not much use. One sector for which this is particularly true is health care. Long before Michael Moore’s film “Sicko” arrived in the cinemas, Europeans tended to distrust the idea of the United States’ model of free market health care. Americans, in turn, often believe that Europe has a uniform model of so-called ‘socialised medicine’. Rampant capitalism there, command-and-control-style health care here: what about the facts?

In reality, there is not much truth to the notion that American health care is solely based on free markets and individual choice. Most Americans cannot even choose their health insurance company themselves. Only 6% of the population are covered through an individual or family contract; most are automatically enrolled in an employer-based scheme. There is no inter-state competition between health insurers. A citizen of New York cannot sign a contract with an insurer based in New Jersey. This is not only a severe limitation on customer choice, but also prevents health insurance companies from exploiting efficiencies related to economies of scale. Again, many observers

¹² Kristian Niemietz is the Stockholm Network’s Health and Welfare Research Officer

argue that the United States' medical market could absorb many more medical graduates than there are currently places in medical schools.¹³ This might be a nice situation for established physicians, but it means overpriced consultations and hospital bills for patients.

As far as the second notion, socialised medicine in Europe, is concerned, matters are likewise more complex. While it is true that throughout Europe, the bulk of health care spending is government spending, it is also true that the state tends to shape the contractual relationships between patients, providers and insurers. That said, in some parts of Europe, there is a degree of free choice in health care which in some instances is more market-oriented even than America.

Take, for example, the development of Health Maintenance Organizations (HMOs) in Switzerland. HMOs first emerged in the USA as an alternative to traditional health insurance policies. Insurance systems suffer from one basic problem: neither the provider nor the consumer of a service has an incentive to economise. Both know that a third party will pay. But if all clients of an insurance company want to get the most for the premiums they have paid, these premiums will have to be raised. HMOs are one way - there are several others - to evade this shortcoming. An HMO is an organisation which runs health care centres and hospitals for its members, so it is, on the one hand, a health care provider. Its clients pay a monthly fee in exchange for free treatment in case of need, so it is also an insurer. Operating as both an insurer and a provider means that there is no third party payer anymore. HMOs offer a very restricted choice of physicians and clinics, but their premiums are lower. They are not 'better' or 'worse' than traditional health insurance; they are an alternative for people who do not value choice in health care very much, but who still want a reasonable quality of

care. They are an additional option that increases diversity.

Since 1996, Swiss workers have had the option of joining an HMO instead of an insurance company. One study showed that even after adjusting for the fact that HMO clients are generally healthier than the traditionally insured, they still record a cost advantage of 32% vis-à-vis the latter.¹⁴ The overall market share of HMOs in Switzerland is now 7%, but this is an incomplete picture. One of the main cost advantages of HMOs is that they provide care in a more subsidiary way. They are less likely to hospitalise a patient who could also be treated in ambulatory care. But, hospitals in Switzerland are mostly paid for by the cantons, not the insurers. And this means that the lower hospitalisation rates of HMOs cannot be fully translated into lower premiums.

But it is striking that the business model of the HMO, originally an American idea, has fared better in alpine exile than in its home country. American HMOs have been subject to furious attacks, and surveys reveal that patients' confidence in them is at rock bottom. They have been accused of denying care at will to keep costs down. This, however, is an American debate. To date, to the author's knowledge, no "Swiss Sicko" is in the making. Could the difference consist in the fact that all clients of Swiss HMOs have numerous alternatives at hand? Does this model work better when it has to prove its merits in stiff competition with other models?

Another example of an American-inspired model thriving elsewhere can be found in the Netherlands. Dutch health insurers can offer their clients two types of policy. In the more expensive one, they can go to any doctor in the country. Alternatively, the insurer offers to go shopping for the doctors who offer the best

¹³ See, for example, Günter Ederer: *Die Sehnsucht nach einer verlogenen Welt*; Munich (2000)

¹⁴ Rita Baur & Johannes Stock: *Schweizer HMOs überzeugen in puncto Qualität und Kosten*; forthcoming in *Gesundheit und Gesellschaft* 80/9 (1998)

value for money. It establishes a contract network with these, and clients who commit only to see physicians which are part of the network can get a good rebate. A similar arrangement has been known for a long time in the US as a Preferred Provider Organization (PPO). This started out as a way to contain health care costs without sacrificing quality or accessibility. In the Netherlands, this 'contracted care' option is now conquering the market. Three out of five Dutch citizens provide for their health in this manner.

The Dutch health system in general offers lots of choices. Following a thorough overhaul in 2006, 93% of the Dutch population are now privately insured, ahead of the US with 74%¹⁵ of those covered. The Dutch can choose tariffs with deductibles, or with no-claims bonuses. Another interesting feature is the possibility of group insurance. In the Netherlands, patients' initiatives can negotiate a group contract for their members. People with specific health needs who, as individuals, would perhaps not be very attractive customers for the insurers, can increase their bargaining power in this way. In times when chronic conditions become the greatest challenges in health care, the group insurance could turn out as an innovative way to make a health system responsive to these patients' needs.

But the Dutch model also has some drawbacks. While price competition takes place between GPs, specialists and hospitals are to some extent shielded from it. Their remuneration is regulated by the government, not subject to free bargaining. Also, people are only faced with half of the cost of health insurance, as the remainder is concealed as 'employer contributions'. This creates the illusion that somebody else is paying, which weakens incentives to actively enquire who offers the best value for money.

So there may not be a shining example of free market health care anywhere, but there are market-based success stories in a number of places outside of the United States. They may not always fit well into the wider economic and social model they operate in. But in their own local ways, and most importantly, for patients, they actually seem to work.

¹⁵ Not counting the uninsured.

Head2Head

Lower costs through higher coverage, or higher coverage through lower costs?

Which came first, the chicken or the egg? In the American debate, some say the way to lower runaway health care costs is to expand insurance coverage. Young and healthy people would join as contributors and emergency care facilities would be relieved. Others say that first of all, prices have to be brought down. Insurance would then become more affordable and coverage would increase – as a consequence, not as a cause.

David B. Kendall¹⁶

The emerging debate in the United States over health care may finally settle this tumultuous issue. Unlike other developed countries, the US does not cover every resident and its costs are way above all other countries, especially since our health care system does not deliver much better outcomes for patients. Reform efforts have failed many times during the 20th century. This time is different because the problems of high costs and declining coverage are much worse, and there appears no end in sight. But more importantly, Democrats who have always led the fight for reform have finally adopted proposals that emanate from the centre of the political spectrum.

Government-run health care will not work in the United States because of our political tradition of distrust of centralised authority. The two Democratic presidential candidates, Sens. Hillary Clinton and Barack Obama have both proposed a shared responsibility model for coverage. Instead of making coverage a governmental responsibility, coverage would be the responsibility of individuals and employers with the government providing financial assistance for those who cannot afford it. Unlike past Democratic proposals, the Republicans cannot legitimately call this government-run health care (although they will try).

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¹⁶ David B. Kendall is a senior fellow for health policy at the Progressive Policy Institute.

David Freddoso¹⁷

No government policy can reduce the final cost of care without sacrificing its quality. Only technological and surgical innovation can reduce real medical costs, and even this applies only for existing treatments. Part of the reason total medical expenditures increase over time is that we keep discovering how to treat more conditions in better (and often costly) ways. As much as we would like to see people spend less on health care, an end to this trend would seem both unlikely and undesirable.

In most fields, government has two means of controlling costs - rationing (queues) and price controls. In the case of medicine, both of these solutions inevitably diminish quality of care. Yet some believe medicine to be an exception, for government action to increase coverage could reduce costs by improving health, causing a marked decrease in the most common preventable diseases. But major savings are unlikely in America, if only because we have just 16% of our population left to insure. Some favour a government takeover of medicine, in order to enjoy economies of scale. But our federal and state governments, wherever they enjoy near-monopsony power, have a clear record of *inflating* costs -- usually under pressure from lobbyists and professional organisations. This has been particularly true in the fields of education and the military.

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¹⁷ David Freddoso is a political reporter with the *National Review*.

Democrats have not abandoned progressive principles, however. They believe that health care should be universal and include everyone. Republican Presidential candidate Sen. John McCain does not share that goal. His proposal would only make a small dent in the number of uninsured Americans.

Democrats believe health insurance shouldn't cost more for the sick. Individuals would buy coverage through large purchasing pools that encourage stiff competition much like Switzerland and the Netherlands have. Sen. McCain would deregulate insurance so insurance companies could charge the sick higher premiums, and people would buy health insurance policies as individuals.

Finally, Democrats believe that reform will require an upfront investment in health information technology, prevention, and chronic care management that will pay dividends over time. Sen. McCain has proposed similar ideas but not the means to pay for them.

The debate will be spirited, but in the end, the United States will finally have a health care system about which it can be proud.

The debate will be momentous. With a little luck and lots of effort, it will produce a distinctly American approach to health care and be a source of pride for generations to come.

It is also true in medicine: in 2006, our Medicaid programme (which insures the indigent) paid nearly 60% more per beneficiary than American private insurers paid out for their average client's care.

Instead of focusing on costs, government should focus on *prices* and repeal laws that currently make medical insurance unaffordable to the consumer. Our 50 states have passed more than 1,800 laws forbidding the sale of insurance policies that do not cover extremely rare medical conditions, or even such non-health-related items as wigs, marriage therapy, pastoral counseling, *in vitro* fertilization, and acupuncture. In states with many such laws (such as New Jersey and Massachusetts), health insurance can cost, on average, three times as much as it does in other states (such as Utah and Iowa). These and other laws should be repealed, freeing up consumers to purchase plans that better suit them. Given that nearly 40% of our 47 million uninsured make over \$50,000 per year, a repeal of the mandates could go a long way toward increasing coverage.

The best medicine for government is first to stop doing harm.

Movie Review

Michael Moore's *Sicko* – Kristian Niemietz

The film *Sicko* is a frontal attack on America's health care industry. It is not about the uninsured, but about those who do have health insurance and are let down by the companies when they desperately need them. Based on interviews with affected patients, health care workers and ex-employees of the insurance industry, Mr Moore paints a gloomy picture of health care in America. His central message: even if you have comprehensive health coverage, you are not safe in America. When you really need your insurer, he will look for a loophole to sneak out of his obligation. He will leave you alone with a severe illness, or, in the worst case, leave you to die.

Some of the anecdotes are based on interviews with relatives of the affected patients. The person with the main part in the film has since died - as a consequence of denied care, according to Michael Moore.

But things need not be like this. Mr Moore travels abroad allegedly to find free, universal and high quality health care in Canada, the UK, France, and Cuba.

Moore's evidence is anecdotal. From these stories alone, we do not know if the affected persons were really denied care for reasons of sheer greed, or whether a medical, administrative or other error was committed. Foremost, we do not know how representative these lamentable cases are for American health care in general. But all of this is absolutely fine. *Sicko* is a movie, not a doctoral thesis, so it has every right to generalise, assert, exaggerate and polarise. The weaknesses are in the interpretation Mr Moore offers, and in the alternatives he proposes.

According to Mr Moore, American health care is the way it is because health insurance

companies are private and for-profit. In their logic, Mr Moore asserts, denied care means saved costs, which in turn means increased profits. However, any for-profit business has an incentive to keep costs down, be that a brewery, a telephone company, or a gym. At large, this does not seem to work against the customer. Even if the health insurance sector was the grand exception, then it should be so everywhere, not only in America. Millions of Europeans, too, take out private insurance, some as a complement, and some as primary coverage. Interestingly, two of the places that Mr Moore praises to the skies have front row seats: 66% of Canadians and even 87% of the French have private complementary insurance. Cuba, of course, is a different matter. In the 2005 election, a bill that would have abolished private primary insurance was debated in Germany – not because it worked so badly, but because it worked so well. Many of the publicly insured had the impression that the privately insured were being favoured. Does private health insurance work differently in Canada, France and Germany than it does in the United States? Possibly, but Mr Moore does not ask this question.

Also, Mr Moore obviously did not take the trouble of reading a UK newspaper during his stopover in Britain. Had he done that, he would probably have come across a story about denied medical care on the basis of costs, not too dissimilar to the stories he shows in his own movie. Nowadays such rulings often come from the National Institute for Health and Clinical Excellence (NICE) though before NICE came along cost limits were set in a more implicit way. Cost-based medicine is not uniquely American.

The bottom line is that *Sicko* is a missed opportunity. It is undeniable that Americans spend a lot of money on health care and sometimes receive mediocre outcomes in return. It would have been extremely interesting to explore the reasons. But unfortunately, *Sicko* did not provide any answers.

New Initiatives and Publications

CEE Ahead – A vision for sustainable health care

CEE Ahead is an independent, non-partisan initiative promoting high quality healthcare solutions for Central and Eastern Europe (CEE). The Stockholm Network acts as the initiative's secretariat. Partners involved in the project seek to create a better understanding of best practice in healthcare from around the world. How can a more competitive market be created without sacrificing social solidarity? How can CEE countries attract greater investment in their health systems? Is there a way to allow patients to take more control of their own treatment and care? How can new innovation and respect for intellectual property rights be encouraged?

<http://www.stockholm-network.org/Conferences-and-Programmes/Health-and-Welfare/CEE-Ahead>

Minutes and presentations from Cost Pressure on the German health system – Is Health Technology Assessment the Solution? (March 2008)

To what extent is Health Technology Assessment an objective and scientific tool, and to what extent is it just another political construct aimed at the systematic rationing of medicines? In a joint event, the Stockholm Network and the Institute for Free Enterprise addressed this and other questions. The event, which took place in the famous *Hackesche Höfe* right in the heart of Berlin, was attended by more than 40 people from academia, the health care sector, patient initiatives and the media.

<http://www.stockholm-network.org/Conferences-and-Programmes/Health-and-Welfare/HTA/htataskforce/HTAEvents>

The above forms part of the Stockholm Network's **new website section on Health Technology Assessment**

<http://www.stockholm-network.org/Conferences-and-Programmes/Health-and-Welfare/HTA>

What price for a year of life? The Threshold Discussion in Health Technology Assessment – Kristian Niemietz and Meir P. Pugatch (forthcoming)

This paper looks at the sensitive issue of how cost constraints in health care are handled. We often read that the role of institutions like NICE in Britain consists of checking whether a medical treatment provides 'value for money'. But what precisely does 'value for money' mean? What is an 'appropriate' relation of costs and benefits? This paper, the fourth piece in a topical series on HTA, analyses how this question is answered in a selection of countries. It also explains why in some health systems, this issue is more sensitive than in others.

State of the Union – Susie Squire (ed.) (April 2008)

The State of the Union tracks economic and social policy reform across all 27 EU countries, with many chapters written by regional experts from our network of Europe's most influential think tanks.

Whether you wish to drill down into what has been happening in a particular member state or get a flavour of the reform climate in the EU as a whole, *The State of the Union* aims to provide readers with an easily-digestible summary of the current state of Europe's economy and its inclination to welfare state reform and, perhaps more importantly, to offer some hints as to where it is heading.

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