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Chairman Sanders, Ranking Member Burr, members of the committee, thank you for this opportunity to testify before you. My name is David Hogberg and I am a health care policy analyst for the National Center for Public Policy Research. The National Center for Public Policy Research, founded in 1982, is a non-partisan, free-market, independent conservative think-tank.

Let me begin by stating that nothing I say today should be construed as a defense of the entire U.S. health care system. While our system has many beneficial aspects, both the system prior to Obamacare and the system we have now are best described as being too encumbered by government interference. Reform should move our health care system in a free market direction.

That said, I think the best lessons we can take from other nations is what NOT to do to our health care system. The most important lesson is that we should avoid putting more and more of our health care system under the control of politicians. Politicians, like everyone else, face a system of incentives and constraints. Specifically, most politicians want to get re-elected and that will have a substantial impact on health care policy. Groups that have political clout, that can influence a politician's reelection chances, are more likely to get good treatment under government-run health care systems. Groups that lack such clout are more likely to be neglected by politicians and receive inferior care.

Unfortunately, people who are quite sick—those who need an operation or cancer treatment or have a serious chronic condition—usually lack such political clout. First, the very sick are relatively few in number, which means they amount to a very limited number of voters, too limited to have much impact on elections. Second, they are too sick to engage in the type of political activities such as organizing, protesting, etc., that can bring about change in health care policy. Furthermore, they may be completely unaware of how government health care policy has affected their plight, in which case they will not feel a need to vote or organize to change health care policy. Ultimately, under a government system, those with the most medical need are the most likely to have difficulty getting the care they need.

Both Denmark and France provide good examples of this.

Denmark

The Danish health care system is changing. What was once best described as a single-payer system is beginning to see private insurance play a much larger role. Every citizen of Denmark is guaranteed access to publicly-financed insurance, but Mia Holstein, a senior consultant at the Danish think-tank CEPOS, noted that close to 52 percent of Danes now have some form of private insurance. Until recently, though, over 85 percent of health care expenditures were publicly financed while less than 15 percent came from private sources.[1]

Health care in Denmark is largely "free" at the point of consumption. This has consequences for how health care resources are allocated. If patients pay nothing at the point of consumption—if health care resources aren't rationed by price—then patients will overuse health care, putting strain on government budgets. Health care must be rationed in another manner, and like most systems that are single-payer, Denmark rations by using wait times for the treatment of serious conditions.

For example, Danes must wait an average of 48 days to get a herniated disc repaired, 57 days for a knee replacement and 81 days for cataracts treatment.[2] Data on cancer treatment shows there is a mean wait time of three weeks to receive surgery and just under a three week wait to receive radiation treatment from the time a patient is diagnosed.[3] This does not include the time a patient must wait from when he first sees the doctor to when he is referred to an examination—data for that does not appear to exist for Denmark.

Table 1: Wait Times For Surgery In Denmark, 2012

Procedure	Mean Wait in Days
Hernia	55
Prostate	65
Hip Replacement	49
Knee Replacement	57
Herniated Disc	48
Cataracts	81

Source: Statems Serum Institut

The national standard in Denmark for cancer treatment is about 28 days—that is, not more than four weeks should elapse between the time a patient presents to the physician for diagnosis to the time of treatment. However, a 2010 study in the European Journal of Cancer found that less than half of Danish patients diagnosed with head or neck cancer were treated within that national standard.[4] This can have serious consequences for patients. A recent meta-analysis found that for every month treatment is delayed for head and neck cancer the probability that the cancer will recur after treatment increases by 3.7 percent.[5]

In an attempt to alleviate wait times, the Danish government in 2002 passed a waiting time "guarantee" allowing patients who were not given treatment at a public hospital

within two months of referral to seek treatment at a private hospital in Denmark or at hospitals abroad. In 2007, it was shortened to one month. In 2009, 60,000 Danish patients made use of this waiting time guarantee.[6]

Wait times have plagued Denmark's system for decades. The reason they persist is that they are politically tolerable. Those who suffer due to wait times each year is relatively small, not enough to have any impact on election day. Making matters worse, according to Mia Holstein of CEPOS, is that most Danes don't connect the wait times to the single-payer system. When forced to wait for treatment, they are more likely to blame the doctor or the hospital, not the single-payer system that is the root of the problem.

France

The French health care system is financed heavily through the government, yet also has an extensive market of private insurance. The government funds about 77 percent of health care expenditures while the other 23 percent comes from private sources.[7] About 90 percent of the population is enrolled in private insurance.[8]

Private insurance pays for a multitude of costs in France including the copayments the government requires for many services and for health care expenses the government does not cover. It also covers the fees that physicians can charge their patients above the government set rates, something that many physicians do. In Paris, for example, about 80 percent of physicians charge more than the government rate.[9]

When a patient visits a physician, he or she must pay the cost directly. He or she is then reimbursed by the government and the private insurer. The patients must cover any cost that is not reimbursed. The method of payment and the extensive system of private finance is what allows France to avoid using wait times to ration care.

However, health care costs have long strained government finances—the health care portion of France's budget has been running a deficit since 1988.[10] As a result, the government in France has used other methods to ration care.

One rationing method is limiting capital investment. More specifically, the French system fails to invest in new medical technology. The number of CT scanners, PET scanners and magnetic resonance imagining machines per million people is one of lowest among industrialized nations.[11]

Table 2: Medical Technology Per Million Population, 2011

	Denmark	France	U.S.	OECD Avg
CT scanners	29.3	12.5	40.9	28.6
PET scanners	5.6*	1.1	4.7	2.4
MRIs	15.4*	7.5	31.5**	16.2

Source: OECD

*2009, **2010

Rationing pharmaceuticals is another method. The government does this in two ways. Under the first the government withholds approval of new drugs that are only an "incremental innovation" over existing drugs.[12] The second is the de-listing of such drugs that are already on the government formulary.[13] Patients who use such drugs will not be reimbursed for their cost.

Incremental innovations come in many forms, such as new drugs to treat depression that have fewer side effects than existing drugs, beta-blockers that reduce blood pressure by more selectively targeting the causes or turning a drug from an injectable form to one that can be taken in pill form such as the cancer drug Glivec. Such rationing has consequences. According to one study, only about one quarter to one third of Alzheimer's patients in France are receiving state-of-the-art medication.[14]

These rationing methods fall hardest on people with serious illnesses since they are the ones most likely to benefit from new technology or incremental improvements in pharmaceuticals. Yet these are also methods that, in general, do not cause trouble for politicians, since the people affected seldom are a significant political force.

Costs

There are three lessons that can be learned about costs by examining recent data on health care expenditures as a percentage of gross domestic product. The first is that Denmark, would probably yield few insights into controlling costs. While Denmark spend less on health care than we do, their rate of growth has exceeded ours since 2003.

Table 3: Health Care Expenditures As Percent of GDP, 2003-2011

	Denmark	France	U.S.	OECD Avg
Total				
2003	9.1	10.4	15.0	9.2
2011	10.5	11.2	17.0	10.0
Increase	14.6%	7.5%	13.1%	10.4%
Government				
2003	7.7	8.2	6.7	6.3
2011	8.9	8.7	8.3	7.3
Increase	15.8%	5.6%	23.2%	13.7%
Private				
2003	1.5	2.2	8.3	2.6
2011	1.6	2.6	8.7	2.7
Increase	8.7%	14.8%	5.0%	5.0%

Source: OECD

Second, expanding government control over our health care system is not a solution to controlling costs. Since 2003, government expenditures on health care in the U.S. have

grown faster than not only the countries we are examining today but even the average growth rate among major countries in the Organization of Economic Cooperation and Development.[15]

Third, while France appears to have a better record of controlling costs than we do, it may be doing so by using methods that the U.S. has already tried and rejected. Since 2005, the French government has embarked on a delivery system dubbed "coordinated care pathways" (CCP). CCP entails using primary-care physicians as "gatekeepers." A patient must first see his or her primary-care physician and get that physician's approval before seeking treatment from a specialist. Patients who do not comply with this system receive lower reimbursements from the government.[16]

Private insurance in France is following suit. Insurers have introduced plans known as "responsible contracts" that require patients to seek care within an approved network of physicians and other providers. Insurers will not cover the copayments for patients who do not adhere to the approved network.[17]

The U.S. has already been down this road during our great experiment with managed care during the late 1980s and early 1990s. During that time employers switched their coverage to health maintenance organization plans that hold down costs by using restrictive networks and employing primary-care physicians as gatekeepers. In the process, the term "HMO" became a dirty word as Americans chaffed under the restrictions of these plans. Ultimately, employers switched to different types of plans as employees rejected the lack of choice offered by HMOs. At their height in 1996, HMOs covered about 31 percent of employees. By 2013, they covered only 14 percent.[18]

Conclusion

In summary, I think the chief benefit of an examination of other nations' health care system is to discover what policies we should avoid.

That said, it would be far more productive if we instead studied other markets rather than other nations. That would include other markets for insurance—such as life, homeowners, and auto insurance—and other markets for other vital products and services such as food and clothing. There you will find markets in which government tax policy hasn't distorted the purchase of goods, where tax policy and regulation have not resulted in a three-tiered system of insurance, and where consumers are not prohibited from buying products and services out of state. As a result, these markets reduce the cost of goods and services while also improving quality. It is in these markets that we should look for guidance in reforming the U.S. health care system.

Endnotes:

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