



Beyond Those Health Care Numbers

By N. Gregory Mankiw

With the health care system at the center of the political debate, a lot of scary claims are being thrown around. The dangerous ones are not those that are false; watchdogs in the news media are quick to debunk them. Rather, the dangerous ones are those that are true but do not mean what people think they mean.

Here are three of the true but misleading statements about health care that politicians and pundits love to use to frighten the public:

Statement 1: *The United States has lower life expectancy and higher infant mortality than Canada, which has national health insurance.*

The differences between the neighbors are indeed significant. Life expectancy at birth is 2.6 years greater for Canadian men than for American men, and 2.3 years greater for Canadian women than American women. Infant mortality in the United States is 6.8 per 1,000 live births, versus 5.3 in Canada.

These facts are often taken as evidence for the inadequacy of the American health system. But a recent study by June and Dave O'Neill, economists at Baruch College, from which these numbers come, shows that the difference in health outcomes has more to do with broader social forces.

For example, Americans are more likely than Canadians to die by accident or by homicide. For men in their twenties, mortality rates are more than 50 percent higher in the United States than in Canada, but the O'Neills show that accidents and homicides account for most of that gap. Maybe these differences have lessons for traffic laws and gun control, but they teach us nothing about our system of health care.

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Americans are also more likely to be obese, leading to heart disease and other medical problems. Among Americans, 31 percent of men and 33 percent of women have a body mass index of at least 30, a definition of obesity, versus 17 percent of men and 19 percent of women in Canada. Japan, which has the longest life expectancy among major nations, has obesity rates of about 3 percent.

The causes of American obesity are not fully understood, but they involve lifestyle choices we make every day, as well as our system of food delivery. Research by Harvard economists David Cutler, Ed Glaeser, and Jesse Shapiro concludes that America's growing obesity problem is largely attributable to our economy's ability to supply high-calorie foods cheaply. Lower prices increase food consumption, sometimes beyond the point of optimal health.

Infant mortality rates also reflect broader social trends, including the prevalence of infants with low birth weight. The health system in the United States gives low birth-weight babies slightly better survival chances than does Canada's, but the more pronounced difference is the frequency of these cases. In the United States, 7.5 percent of babies are born weighing less than 2,500 grams (about 5.5 pounds), compared with 5.7 percent in Canada. In both nations, these infants have more than ten times the mortality rate of larger babies. Low birth weights are in turn correlated with teenage motherhood. (One theory is that a teenage mother is still growing and thus

competing with the fetus for nutrients.) The rate of teenage motherhood, according to the O'Neill study, is almost three times higher in the United States than it is in Canada.

Whatever its merits, a Canadian-style system of national health insurance is unlikely to change the sexual mores of American youth.

The bottom line is that many statistics on health outcomes say little about our system of health care.

Statement 2: *Some 47 million Americans do not have health insurance.*

This number from the Census Bureau is often cited as evidence that the health system is failing for many American families. Yet by masking tremendous heterogeneity in personal circumstances, the figure exaggerates the magnitude of the problem.

To start with, the 47 million includes about 10 million residents who are not American citizens. Many are illegal immigrants. Even if we had national health insurance, they would probably not be covered.

The number also fails to take full account of Medicaid, the government's health program for the poor. For instance, it counts millions of the poor who are eligible for Medicaid but have not yet applied. These individuals, who are healthier, on average, than those who are enrolled, could always apply if they ever needed significant medical care. They are uninsured in name only.

The 47 million also includes many who could buy insurance but have not. The Census Bureau reports that 18 million of the uninsured have annual household incomes of more than \$50,000, which puts them in the top half of the income distribution. About a quarter of the uninsured have been offered employer-provided insurance but declined coverage.

Of course, millions of Americans have trouble getting health insurance. But they number far less than 47 million, and they make up only a few percent of the population of 300 million.

Any reform should carefully focus on this group to avoid disrupting the vast majority for whom the system is working. We do not nationalize an industry simply because a small percentage of the workforce is unemployed. Similarly, we should be wary of sweeping reforms

of our health system if they are motivated by the fact that a small percentage of the population is uninsured.

Statement 3: *Health costs are eating up an ever increasing share of American incomes.*

In 1950, about 5 percent of U.S. national income was spent on health care, including both private and public health spending. Today the share is about 16 percent. Many pundits regard the increasing cost as evidence that the system is too expensive.

But increasing expenditures could just as well be a symptom of success. The reason that we spend more than our grandparents did is not waste, fraud, and abuse, but advances in medical technology and growth in incomes. Science has consistently found new ways to extend and improve our lives. Wonderful as they are, they do not come cheap.

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Fortunately, our incomes are growing, and it makes sense to spend this growing prosperity on better health. The rationality of this phenomenon is stressed in a recent article by economists Charles I. Jones of the University of California, Berkeley, and Robert E. Hall of Stanford University. They ask, "As we grow older and richer, which is more valuable: a third car, yet another television, more clothing—or an extra year of life?"

Hall and Jones forecast that the share of income devoted to health care will top 30 percent by 2050. But in their model, this is not a problem—it is the modern form of progress.

Even if the rise in health care spending turns out to be less than they forecast, it is important to get reform right. Our health care system is not perfect, but it has been a major source of advances in our standard of living, and it will be a large share of the economy we bequeath to our children. As we look at reform plans, we should be careful not to be fooled by statistics into thinking that the problems we face are worse than they really are.