THE NEW ATLANTIS
A JOURNAL OF TECHNOLOGY & SOCIETY

Socialism and Cancer

David Gratzer

It was every parent's worst nightmare: California teenager Nataline Sarkisyan developed leukemia and struggled with complications after a bone marrow transplantation. She had just one hope left—a liver transplant. But in addition to her grave illness, Nataline and her family had to fight a corporate behemoth, because her health insurance company refused to cover the transplant.

The seventeen-year-old's death in December 2007 captured national media attention. Newspaper editorials raged at her story; presidential candidate John Edwards campaigned with her family; the insurance company explained that it would review its procedures. Nataline's sad tale seemed to confirm what many Americans already believed: that U.S. health care is scandalously expensive and not particularly good.

This is a conclusion constantly bolstered by widely-respected critics who compare the American health system to the systems of other nations. To point to just a few prominent examples from the last decade: In a 2000 assessment of the world's health systems, the World Health Organization (WHO) ranked the U.S. system thirty-seventh—lower than even that of Colombia. In *Sicko*, Michael Moore's 2007 documentary comparing health care systems, the U.S. system is portrayed as broken and cruel. A Commonwealth Fund study published in early 2008 surveyed nineteen nations in terms of preventable death and ranked the United States last.

This unrelenting stream of negativity has shaped the debate over U.S. health care reform. Consumers are souring on U.S. health care; policymakers are weighing the political and economic costs of changes to the system; and, according to one recent poll, even doctors—historically the most vocal opponents of socialized medicine—now support the idea of government-run health care.

But a closer look at American medicine shows many areas of strength. Far from dismal, American health care is by some important measures the best in the world. While no one would argue that American health care is perfect, there is excellence here—excellence that must be preserved and even built upon.

***David Gratzer**, M.D., is a senior fellow at the Manhattan Institute. His latest book,* The Cure: How Capitalism Can Save American Health Care *(Encounter Books, 2006), is now available in paperback.*

Measuring Real Results

Ask yourself a simple question: If your daughter had a bad cough, would you call your pediatrician—or get her on a flight to Bogota, Colombia?

While international comparisons make for good headlines and moving speeches—Democrats, in particular, like to cite the WHO findings on the stump—these studies are frequently quite limited and flawed. Most of the work is either highly ideological (Michael Moore's cannot withstand a basic fact-check) or confuses *health* with *health care* (the Commonwealth Fund study reflects the fact that Americans smoke more and exercise less than citizens in many other Western countries). The WHO study—intolerant of any patient-borne expenses, heavily rewarding "equity," and focusing on smoking rates and other public health measures—suffers from both these problems of ideology and confusion. That is how it could reach the conclusion that America's health care lags behind Colombia's—a conclusion no patient or doctor would second with his feet. (And indeed, even the WHO study had to concede that the American health care system was more responsive to citizens' expectations than any other nation's system.)

A better way to judge a health care system is to look at disease outcomes—how people fare after diagnosis. Generally speaking, the problem with this approach is that data can be limited; most family doctors—not to mention countries—don't collect data on strep throat or depression.

But one disease, cancer, offers an opportunity to make a reasonable international comparison. For one thing, every Western country collects good data (mainly five-year survival rates but, increasingly, ten-year outcomes as well). And the disease is common: In its first-ever study on cancer around the world, the American Cancer Society recently reported that twelve million people around the world were diagnosed with cancer in 2007 alone. Finally, cancer is a research and treatment priority, both in the United States and abroad.

Of course, there is more to health care than a response to one disease—yet, with the focus of so many governments on cancer care, with the common nature of this illness, and with the excellent statistics available, it's fair to use it as a proxy for health care performance. How does the United States fare? Excellently, two major studies suggest.

First, a working group associated with CONCORD (the European NGO Confederation for Relief and Development) recently completed a study comparing five-year cancer survival rates for several malignancies: breast cancer in women, prostate cancer in men, and colon and rectal

cancer in both women and men. Combining the efforts of some hundred researchers and drawing data from almost two million cancer patients in thirty-one countries, the study, published in the August 2008 issue of *The Lancet Oncology*, is groundbreaking.

Who's on top? Cuba—if you believe the numbers provided by the Cuban government, which records the best overall outcomes for breast cancer and colorectal cancer in women, and seems to beat U.S. health care in three out of the four categories. The study's authors are skeptical, however: these are remarkable results for a country that lacks basic chemotherapy agents. Thus, citing data quality issues, the study's authors (who abide by higher standards than filmmaker Michael Moore) set aside the Cuban performance.

The CONCORD study finds that the United States leads in the field of breast and prostate cancer. France excelled in treating women's colorectal cancer and Japan in men's colorectal cancer. And the United States clearly leads other nations in overall survival. Regrettably, great discrepancies do exist between white and black Americans and among residents of different cities. That said, given a cancer diagnosis, patients overall do better here than anywhere else.

These international results replicate those that appeared in a broader cancer review of Europe and the United States, published in September 2007 in *The Lancet Oncology*. For the sixteen types of cancer examined in that paper, American men have a five-year survival rate of 66 percent, compared with only 47 percent for European men. In Europe, only Sweden has an overall survival rate of more than 60 percent. American women have a 63 percent chance of living at least five years after a cancer diagnosis, compared with 56 percent for European women; only five European countries have an overall survival rate of more than 60 percent.

Looking at specific cancers yields striking results: For men, the bladder cancer survival rate in the United States is 15 percent higher than the European average. With prostate cancer, the gap is even larger: 28 percent. For American women, the uterine cancer survival rate is 5 percent higher than the European average; for breast cancer, it is 14 percent higher. The United States has survival rates of 90 percent or higher for five cancers (skin melanoma, breast, prostate, thyroid, and testicular), but there is only one cancer for which the European survival rate reaches 90 percent (testicular). Lung cancer, once considered a death sentence, now has better survival rates over five years—and Americans do better than Europeans, 16 percent versus 11 percent.

Hollow Victory?

Prostate cancer is one of the most common and most deadly carcinomas faced by men. But should it count in the cancer-survival statistics? Some critics wonder if American cancer results aren't perhaps overstated. Jonathan Cohn, for instance, recently made this argument in *The New Republic*:

> It's possible—indeed, many experts would say more likely—that those statistics ultimately reflect a cultural preference for aggressive treatment, sometimes to the point of over-treatment. That seems particularly true of prostate cancer, given mounting evidence that many patients receiving treatments—which come with serious side-effects—actually have slow-developing tumors that don't really threaten them. (In other words, they'd die of something else long before the cancer gets them.)

That is to say, Americans don't have better cancer care, just better cancer statistics, results inflated by excessive screening of some cancers (like prostate) that have good outcomes because of the nature of the cancer (slow growing). A recent U.S. Preventive Services Task Force report, published in the *Annals of Internal Medicine*, suggests that physicians should be less aggressive about screening for prostate cancer in men aged seventy-five and older—a boost to this argument.

Prostate cancer does represent something of a challenge, especially in light of ongoing research. But before discounting the survival results, consider some basic points. First, both of the aforementioned studies published in *The Lancet Oncology* include prostate cancer. Second, when prostate cancer is excluded—as it is in studies focusing on women—American medicine still shines. Survival rates among men in many cancers other than prostate are superior on this side of the Atlantic.

That said, the 2007 *Lancet Oncology* study does make special mention of prostate cancer, noting that the overall cancer statistics are influenced by the specific data set for prostate cancer:

> In Europe, the 5-year relative survival for all cancers combined was 47.3% for men and 55.8% for women, which are much lower than the 66.3% for men and 62.9% for women in the U.S.A. However, when excluding prostate cancer, the survival decreased to 38.1% in Europe and 46.9% in the U.S.A., so that, in men, over half of the difference in survival between Europe and the U.S.A. can be attributed to prostate cancer.

So in the final analysis, Cohn and other critics are right that prostate cancer skews the statistics—but not nearly enough to account for the superiority of American cancer survival rates.

Why then is the United States better in overall survival? There are several contributing factors. Certainly the ability of cancer patients to get access to new medicines is helpful. As Manhattan Institute senior fellow Paul Howard noted in the *Washington Post*: "In many European countries, companies must engage in lengthy negotiations with government health bureaucrats over prices for new cancer drugs. (Even afterwards, patient access to new medicines may be restricted.)"

A survey of cancer drugs across twenty-five countries supports this point. In the analysis, published in the *Annals of Oncology* in 2007, the Stockholm-based Karolinska Institute finds that "the United States has been the country of first launch for close to half of the oncology drugs brought to market in the last eleven years." From 1995 to 2005, the United States had twelve "first launches," compared to two in Germany, four in the United Kingdom, three in Switzerland, and one in France. And it isn't just that drugs originate here: of sixty-seven new drugs, the United States offered the most access (tied with France, Switzerland, and Austria). In some instances, the availability gap is striking: Erlotinib, a new lung cancer therapy, was ten times more likely to be prescribed for a patient in the United States than in Europe.

And socialized health care systems don't just lag on cancer drugs—new technologies, too, are less available. The problem is well illustrated by the story of Deb Maskens, a mother of two young children who suffers from kidney cancer. The Canadian woman couldn't get a PET scan in her home province of Ontario, so she needed to travel south of the forty-ninth parallel. The irony: almost daily, she walks past a Canadian hospital with the PET scanner she needs, but the government refuses to fund the test because it's considered experimental. If the Ontario government isn't convinced of the scan's utility, oncologists increasingly are: scan results changed the treatment plans in about one-third of cases in the United States, according to a new study of 23,000 patients published in the *Journal of Clinical Oncology*.

Government-managed and -funded health care systems are not simply averse to new drugs and technologies. These systems are often plagued by rationing through waiting. People wait for diagnostic tests and specialist consults, delays that allow cancers to grow and spread. The diagnostic gap is well documented. In a recent review of several nations, the Canadian Institute for Health Information finds that for every 1,000

people, 89 scans are performed in the United States. In Belgium, that falls to 43. Across other countries, the exams are even more sparse: 31 in Canada, 25 in England, and 17 in Denmark.

The British Example

From a distance, British cancer care would seem to be a model for the United States. "If I were designing a system from scratch, I would probably go ahead with a single-payer system," Barack Obama told some eighteen hundred people at a town-hall style campaign meeting on the economy in August 2008. The government solution seems clear: rid the system of the inscrutable insurance forms and middlemen, freeing doctors to practice medicine and patients to get care.

With rising rates of cancer, a recent trend among countries is to talk up prevention; in some nations, governments have appointed cabinet secretaries charged with "health promotion." Britain, though, sets a new standard for government focus on prevention. In late 2007, British Health Secretary Alan Johnson and Prime Minister Gordon Brown announced a new cancer strategy, largely aimed at preventing it. To this end, they will consider the regulation of suntan parlors and cigarette vending machines, as well as adding graphic warnings to cigarette packages, mounting an information campaign so that people can keep better track of their drinking, and developing a "cross-government strategy to tackle obesity."

Of course, prevention is a good thing. The new British prescription, however, seems heavy on PR and light on substantive policy. Will problem drinkers really change their ways once they read a government booklet? As a physician, I've never met a patient who believed that "fake baking" was actually healthy—but that doesn't stop them. Why is the U.K. government talking tough on suds and sunbeds? Because to talk about the efficacy of British cancer care instead is not a pleasant prospect for a politician seeking to please voters. Indeed, even after almost a decade of reform, British cancer care is simply a mess.

It wasn't supposed to be this way. In 2000, the Labour government boldly promised to make British cancer care the envy of Europe by boosting funding, hiring new managers, and drafting targets. While five-year survival rates have modestly improved, British rates trail those of every Western European nation, and are on a par with the results of former Communist countries.

Dr. Karol Sikora, dean of the University of Buckingham's medical school and the former chief of the WHO's cancer program, doesn't mince

his words. "We now spend more per person on cancer than any other European country," he explains. "However, we don't seem to get value for money." Dr. Sikora notes that the National Health Service is bested by Western European countries on a variety of measures. "We have funded managers to deal with targets while in France, Germany, and Italy that bureaucracy does not exist."

British cancer looks even worse when compared to U.S. care. The average five-year survival rate for cancer in men, for example, is 45 percent in England (slightly higher in Wales, lower in Scotland) but 66 percent in the United States. Some will argue that this may be due to cultural factors—perhaps the stereotypical Brit, eager for a pint but unsettled at the prospect of a trip to his physician, naturally fares worse. Studies suggest, however, that Britons see their doctors about as often as Americans, spend more days in the hospital, and—on the whole—are healthier (with less obesity, less smoking, and so forth).

A more plausible explanation is that British patients, as opposed to their American counterparts, have challenges with access to the care they need. For one thing, they wait much longer to see specialists. One cancer patient whose story was described in the British press had his specialist appointment cancelled forty-eight times, delaying specialist access by more than a year. Such delays affect outcomes: a *Clinical Oncology* study of British lung cancer treatment found in 2000 that 20 percent "of potentially curable patients became incurable on the waiting list." Novel drugs offered here often aren't available there. Avastin, a new pharmaceutical for advanced colon cancer, is prescribed ten times more often in the United States than in the United Kingdom. Screening standards are different. In the United States, internists recommend that men fifty and older get screened for colon cancer; in the British National Health Service, screening begins at seventy-five.

British newspapers are filled with stories of low standards: unwashed patients, super-infections, long waiting lists. Dental care is so difficult to get that some patients extract their own teeth.

That isn't quite the picture of British health care Americans are usually presented with. Michael Moore waxes poetic on the British system in *Sicko*, showing satisfied patients and happy, chic docs. Paul Krugman claims in the *New York Times* that "there's very little evidence that Americans get better health care than the British." And while the reality of U.K. cancer care is nothing to be celebrated, the *idea* still wins supporters. In 2008, for example, the American College of Physicians, the nation's second largest doctor association, endorsed a single-payer health care system.

Government-run health care systems control costs by rationing care. In contrast, for all its flaws, the American health care system does not hesitate to spend, eager to embrace new technologies and treatments. And that's why Americans do so much better.

Lessons for Health Care Reform

Cancer care in London or Paris may not seem relevant to Americans in Las Vegas or Providence. But in the coming years, Americans will need to think very hard about their health care system. With a Democratic-controlled Congress and White House, the forces are aligned for far greater government involvement. Former Senator Tom Daschle, coauthor of a recent book that recommends much greater government management of care, will be the key administration official charged with health care reform.

In *Critical: What We Can Do About the Health-Care Crisis*, Daschle and his coauthors talk up the idea of a federal health care board charged with "recommending coverage of those drugs and procedures backed by solid evidence. It would exert influence by ranking services and therapies by their health and cost impacts." The inspiration? He cites Britain's National Institute for Clinical Evaluation and Excellence. Given the CONCORD results, he would be wise to reconsider. Value in health care—as in the other five-sixths of the economy—will come from competition and choice, not a government committee.

American cancer care is a success story. What then should we make of Nataline Sarkisyan's case? Clinical details are lacking, but the evidence suggests that a liver transplant wouldn't have saved her—she was killed by leukemia, not heartless insurance executives. (One internist even wrote a letter to the editor of his local newspaper suggesting that, given the limited supply of organs available for transplantation, it would be unwise to give a liver transplant to a cancer patient who has failed her chemotherapy.)

Meanwhile, the millions of Americans like Ms. Sarkisyan who are in the fight of their lives are better off here than in any other country. That is why American health care reform demands an American-made solution, one that respects the power of markets and competition instead of putting trust in government bureaucrats.